



BRIEFING PAPER

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Mental health policy in England

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Summary

Coronavirus and mental health

Section 1 of the briefing provides information on mental health and the Coronavirus pandemic.

The *Coronavirus Act 2020* provides for temporary changes to the detention and treatment of patients under the *Mental Health Act 1983*. The Government and NHS have published resources to support people's mental health during the pandemic, including specific resources for health and social care staff. Studies are being developed which examine the emerging impact of the pandemic on the nation's mental health, including for specific groups such as BAME communities. Additional funding has been provided to mental health charities to support people experiencing mental health problems during the pandemic. There have also been calls for the Government to establish a [mental health renewal plan](#) to prevent a national "mental health crisis" following the pandemic.

This Library briefing provides information 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 committed to support their implementation.

The [NHS Long Term Plan](#), published on 7 January 2019, provided a number of further commitments to improve mental health services. On adult mental health services, the Plan committed to providing an additional 380,000 people per year with access to adult psychological therapies by 2023/24. It also stated that new services to support patients going through a mental health crisis would be introduced.

To support the ambitions within the Plan NHS England has made a renewed commitment that expenditure on mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24.

In October 2017, the Government commissioned an independent 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. The final report was published in December 2018 ('[Modernising the Mental Health Act: Increasing choice, reducing compulsion](#)'). The Government had originally said it would publish a White Paper in early 2020, setting out their response in full, followed by a consultation period and legislation when Parliamentary time allows.

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 *Mental Health Units (Use of Force) Act 2018* was introduced, as a Private Members Bill, by Labour MP Steve Reed, following the death of a constituent,

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Seni Lewis, in 2010. Most of the provisions of the Act have not yet come into force, but it will increase the oversight and management of the use of force in mental health units.

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 7 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 and women's mental health, are provided in section 8.

1. The Coronavirus pandemic and mental health

1.1 The Coronavirus Act 2020

The *Coronavirus Act 2020* makes temporary changes to the detention and treatment of patients under the *Mental Health Act 1983*, to provide flexibility if staff numbers were severely affected during the pandemic period.

To date, it has not been necessary to commence the provisions of the *Coronavirus Act* relating to compulsory admission to hospital for assessment or treatment under the *Mental Health Act 1983*.¹

Applications for compulsory admission to hospital for assessment or treatment under the Mental Health Act 1983 (England and Wales)

The *Coronavirus Act 2020* (The Act) amends the usual requirement that two doctors must recommend the compulsory detention (“sectioning”) of a patient under the *Mental Health Act*, for treatment or assessment in hospital, if this is impractical or would involve undue delay. The Act enables just one doctor to carry out this function:

An application by an approved mental health professional under section 2 or 3 made during a period for which this paragraph has effect may be founded on a recommendation by a single registered medical practitioner (a “single recommendation”), if the professional considers that compliance with the requirement under that section for the recommendations of two practitioners is impractical or would involve undesirable delay.²

Guidance on the Bill published by the Department of Health and Social Care (DHSC) said:

This will ensure that those who were a risk to themselves or others would still get the treatment they need, when fewer doctors are available to undertake this function.³

This provision applies to applications for detention under Section 2 (detention for assessment) and Section 3 (detention for treatment). The existing requirement, that one of the doctors must know the patient personally, is removed. Currently, an application for detention under the 1983 Act must be supported by two medical recommendations (Section 12 of the Act). There is a requirement that at least one of the doctors is familiar with the patient, and for one to be a Section 12 approved doctor (usually a psychiatrist). The Bill retains that a medical recommendation must be given by a Section 12 approved doctor, but there is no requirement that they have previous acquaintance with the patient.

¹ [PO 84375 \[on Coronavirus: Quarantine\]](#), 10 September 2020

² The Coronavirus Act 2020, [Schedule 8, Part 2](#)

³ DHSC, [Guidance: What the coronavirus bill will do](#), 17 March 2020

Extend or remove time limits in the Mental Health Act 1983

The Act extends or removes some time limits for compulsory detention contained in the *Mental Health Act*. The DHSC has said these would be temporary changes to allow for greater flexibility where services are less able to respond:

These temporary changes would be brought in only in the instance that staff numbers were severely adversely affected during the pandemic period and provide some flexibility to help support the continued safe running of services under the Mental Health Act.⁴

The Bill contains various provisions which extend time limits.

For detention in places of safety (Sections 135 & 136), the Act increases the length of time someone may be detained in a place of safety from 24 to 36 hours.

For applications for compulsory admission for patients already in hospital, the Act allows any registered medical practitioner or approved clinician to provide a report for their detention, and not the patient's responsible clinician if this is impractical or would involve undesirable delay. It also increases the period that a patient may be detained in hospital waiting for assessment for detention from 72 to 120 hours, under powers given to doctors, and from 6 to 12 hours, under powers given to nurses.

The Act also contains various provisions on patients concerned in criminal proceedings or under sentence. For Sections 35 and 36, the Act removes the time limit of 12 weeks relating to a period of remand to hospital for a report on the accused's mental condition, and a period of remand to hospital for treatment. The Act also extends from 14 to 28 days the maximum period within which accused or convicted persons are transferred to hospital.

During the House of Commons debate on the Coronavirus Bill the Secretary of State for Health and Social Care, Matt Hancock, said that these measures are not what the Government would choose to do during normal times and will only be necessary in circumstances where staff numbers are severely affected.⁵

Matt Hancock also noted that it would be "far worse to not detain someone under the Mental Health Act" if they are a risk to themselves or to others:

It is important that we take those measures in case they are needed in the circumstances where staff numbers available are low, to make sure we can get the support needed as appropriate and make the interventions that are sometimes difficult to make. For instance, it can be, in some circumstances, far worse not to detain somebody under the Mental Health Act where they are a danger to themselves or others. If there is not the availability of a second doctor, because of staff shortages due to the virus, then I

⁴ DHSC, [Guidance: What the coronavirus bill will do](#), 17 March 2020

⁵ [HC Deb 23 March 2020 c42](#)

think that is appropriate, but the safeguards are an important part of getting this right and an important part of why this is time limited ([HC Deb 23 March 2020 c43](#)).

Detailed information on the changes is available in section 4 of the Library briefing [Coronavirus Bill: health and social care measures](#) (20 March 2020).

1.2 NHS pandemic response

First phase

On 25 March 2020, NHS England & NHS Improvement issued guidance on [Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages](#).

The guidance recognised that the national measures to delay the spread of the virus would inevitably have a significant impact on both demand for and capacity to deliver support for people with mental health needs. It noted that difficult decisions may have to be made in the context of increased demand and reduced capacity:

In preparing for and responding to COVID-19, staff in mental health/ learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision making, providers may choose to use an existing patient panel or an ethics committee to advise on decisions.⁶

The guidance also noted that services will be reimbursed for additional costs as a result of the pandemic and as such, financial concerns should not impact on service provision:

Simon Stevens and Amanda Pritchard wrote to the NHS on 17 March 2020 with a letter entitled IMPORTANT AND URGENT – NEXT STEPS ON NHS RESPONSE TO COVID-19, which set out more detail on the financial regime under COVID-19.

This confirmed that specific financial guidance on how to estimate, report against, and be reimbursed for additional costs is being issued soon. The Chancellor of the Exchequer said in Parliament that, “Whatever extra resources our NHS needs to cope with coronavirus – it will get”. Therefore financial constraints must not and will not stand in the way of taking immediate and necessary action – whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.⁷

The guidance also set out ways to maximise capacity in mental health services, such as redeploying staff to work in more critical areas and reducing non-essential activity.⁸

⁶ NHS, [Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages](#), 25 March 2020, page 3

⁷ Ibid, page 4

⁸ NHS, [Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages](#), 25 March 2020, page 4-5

The NHS mental health director said:

The NHS is stepping up to offer people help when and how they need it, including by phone, facetime, skype or digitally enabled therapy packages and we also have accelerated plans for crisis response service 24/7.

We are determined to respond to people's needs during this challenging time and working with our partners across the health sector and in the community, NHS mental health services will be there through what is undoubtedly one of the greatest healthcare challenges the NHS has ever faced.⁹

In March, the UK Government announced a £5 million grant, administered by Mind, to fund additional services for people struggling with their mental wellbeing during the coronavirus outbreak.¹⁰ In May, the Government announced that a further £4.2 million would be awarded to mental health charities, such as Samaritans, Young Minds and Bipolar UK, to continue to support people experiencing mental health challenges throughout the outbreak.¹¹

NHS pandemic response: Second phase

On 29 April 2020, NHS England published information on the [second phase of NHS response to Covid-19](#). This set out priority actions for mental health providers in this next phase after the peak of the virus:

We are going to see increased demand for Covid19 aftercare and support in community health services, primary care, and mental health. Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex.¹²

The high priority actions for mental health and learning disability/autism services were:

1. Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
2. For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
3. Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.

⁹ Department of Health and Social Care, [New advice to support mental health during coronavirus outbreak](#), 29 March 2020

¹⁰ Department of Health and Social Care, [New advice to support mental health during coronavirus outbreak](#), 29 March 2020

¹¹ Department of Health and Social Care, [£22 million awarded to life-saving health charities during virus outbreak](#), 22 May 2020

¹² NHS, [SECOND PHASE OF NHS RESPONSE TO COVID19](#), 29 April 2020

4. Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
5. Annual health checks for people with a learning disability should continue to be completed.
6. Ensure enhanced psychological support is available for all NHS staff who need it.
7. Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.¹³

NHS pandemic response: Third phase

In a [letter dated 31 July 2020](#), NHS organisations were told by NHS England and NHS Improvement that the third phase of the NHS response to the pandemic is effective from 1 August 2020.

As part of the third phase, the NHS has been advised to accelerate the return of non-Covid health services, “making full use of the capacity available in the window of opportunity between now and winter”.¹⁴ The [letter lists a series of priorities](#). Mental health services have been asked to proactively review all patients on community mental health teams’ caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with severe mental illness in the community.

Priority A4, relating to the restoration of mental health, learning disability and autism services, is quoted below:

Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

In addition, we will be asking systems to validate their existing LTP mental health service expansion trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime: - IAPT services should fully resume - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working - maintain the growth in the number of children and young people accessing care - proactively review all patients on community mental health teams’ caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community; - ensure that local access to services is clearly advertised - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.¹⁵

In response to a PQ, Health Minister Nadine Dorries MP said the Government is assessing how to support an increased demand for mental health services:

¹³ NHS, [SECOND PHASE OF NHS RESPONSE TO COVID19](#), Annex, 29 April 2020

¹⁴ NHS England, [Third phase of NHS response to Covid-19](#), 31 July 2020, page 3

¹⁵ NHS, [IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19](#), 31 July 2020

There is broad consensus that there is the potential for an increase in demand for mental health services as a result of COVID-19 and we are working with the National Health Service, Public Health England and others to ensure ongoing assessment of the potential longer-term impacts and to plan for how to support mental health and wellbeing throughout the 'recovery' phase.¹⁶

A coalition of mental health charities have also called for the Government to establish a [mental health renewal plan](#) to prevent a national "mental health crisis" following the pandemic.

1.3 The impact of the pandemic on mental health

There are various studies which examine the emerging impact of the pandemic on mental health.

The House of Lords Library have published a briefing, [Coronavirus: The impact on mental health](#) (22 June 2020), which looks at:

- the impact of lockdown on an individual's mental health;
- the impact on individuals with pre-existing mental health conditions prior to the pandemic; and
- the loss of funding and operational capacity for mental health services and charities

The Parliamentary Office of Science and Technology (POST) analysis of [mental health and well-being during the COVID-19 outbreak](#) (7 May 2020) provides a summary of the evidence so far.

A Library insight article also looks at the [impact of coronavirus on the mental health of health and social care workers](#) (18 May 2020).

NHS Confederation's report on [MENTAL HEALTH SERVICES AND COVID-19 PREPARING FOR THE RISING TIDE](#) (August 2020) considers what mental health services need to prepare for the expected surge in demand. It also highlights how the health and care system can 'reset' the way care and support are planned and delivered in aftermath of COVID-19.

The charity Mind's report [The mental health emergency: How has the coronavirus pandemic impacted our mental health](#) (June 2020) highlighted that more than half of adults and over two thirds of young people said that their mental health had deteriorated during the period of lockdown restrictions.

The Children's Society report [Life on hold: children's well-being and Covid-19](#) (July 2020) raises concerns about the profound implications that the coronavirus lockdown has had on children's wellbeing.

Barnado's also produced a report on [Generation Lockdown](#) (June 2020), which found at least third of children and young people are experiencing increased mental health difficulties.

¹⁶ [PO 82325 \[on Coronavirus: Mental Health\]](#), 10 September 2020

BAME groups

The Centre for Mental Health has published a briefing on [Covid-19: understanding inequalities in mental health during the pandemic](#) (June 2020). This explains that people from the ethnic groups where the prevalence of Covid-19 has been highest and outcomes have been the worst, notably people from Black British, Black African, Bangladeshi and Pakistani backgrounds, are at far greater risk of worsening mental health.

The briefing also explains that people from some ethnic groups may be finding it especially difficult to get appropriate mental health support:

The need for culturally appropriate support is relevant for several communities which experience mental health inequalities. For example, young people, especially from Black communities, frequently report that they do not trust NHS mental health services and do not believe that they will help them or be safe to engage with. Research has shown that these young people respond better to mental health support when it is offered in a culturally appropriate format, for example, in informal settings commonly run by third sector providers or grassroots organisations (Khan et al., 2017; Stubbs et al., 2017). These small, holistic, community and relationship-based programmes often rely on building trust face to face. For them, and for the marginalised young people who rely on them for support, lockdown presents a significant challenge to the continuity of support.¹⁷

The briefing also explores some of the concurrent inequalities faced by people from BAME groups, which may worsen their mental health during the Coronavirus pandemic:

We know, too, that people from some BAME backgrounds experiencing mental distress as a result of coronavirus may be doubly disadvantaged due to economic circumstances and services which frequently fail to respond to their needs in a timely and culturally informed fashion. Differences in community experiences are influenced by a range of deeply intersecting factors including geography, ethnicity and socio-economic status. People from certain ethnicities are more likely to be in lower paid work or persistent poverty, particularly Pakistani and Bangladeshi, Black African, and Black Caribbean communities. There are strong associations of poverty with mental illness and mental distress, and links between those ethnic groups which face the greatest levels of poverty and those experiencing the most restrictive forms of mental health intervention (Bhui et al., 2018).¹⁸

Public Health England's report on [Understanding the impact of COVID-19 on BAME groups](#) (June 2020) highlights poorer health outcomes for people with mental health problems, and within this a disproportionate impact on BAME communities:

Stakeholders highlighted their knowledge of emerging evidence of increased acquisition risk and poorer health outcomes for people with mental illness. This was especially compounded for BAME communities for whom problematic access to primary mental healthcare and mental health promotion have been well

¹⁷ Centre for Mental Health, [Covid-19: understanding inequalities in mental health during the pandemic](#) (June 2020), page 3

¹⁸ Centre for Mental Health, [Covid-19: understanding inequalities in mental health during the pandemic](#) (June 2020), page 7

described. There were concerns that the importance of mental ill health as a risk factor for COVID-19 was not adequately acknowledged and therefore poorly managed, with many missed opportunities for early intervention and support.

Many feel that lockdown restrictions will significantly impact those with mild, moderate and severe mental illness (SMI) and those who are caring for them. Social distancing measures place restrictions on access to social support networks which are a fundamental part of BAME communities' infrastructure and culture.

“Ethnic minority groups also face particular risks of social isolation and loneliness, linked to higher levels of deprivation and potential exclusion from structures and processes that promote social connectedness and a sense of belonging.”¹⁹

1.4 Resources and guidance

Guidance on mental health and wellbeing

In the UK, there have been several initiatives set up by Government bodies or the third sector to support mental health and wellbeing. Public Health England (PHE) has published new guidance on mental health support:

- PHE, [COVID-19: guidance on supporting children and young people's mental health and wellbeing](#) (29 March 2020)
- PHE, [COVID-19: guidance for the public on mental health and wellbeing](#) (29 March 2020)

PHE has also updated its [Every Mind Matters](#) platform with specific advice on maintaining good mental wellbeing during the outbreak. In September 2020, PHE published a new Every Mind Matters campaign to [support the wellbeing of children, young people and their parents](#).

¹⁹ Public Health England, [Understanding the impact of COVID-19 on BAME groups](#) (June 2020), page 37

2. Mental health policies

2.1 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.²⁰ 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.²¹

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.²² 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".²³ 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).

2.2 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

²⁰ Department of Health, [No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages](#), February 2011, page 2

²¹ Department of Health, [No Health without Mental Health: Implementation Framework](#), July 2012

²² 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.

²³ 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.²⁴

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.²⁵

2.3 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

²⁴ NHS England, [Five Year Forward View](#), October 2014, page 26

²⁵ NHS England, [Forward View into action: planning for 2015-16](#), December 2014, page 5

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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.²⁶

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.²⁷ 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.²⁸

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

²⁶ [HC Deb 23 February 2016 c153-4](#)

²⁷ Department of Health, [The Government's mandate to NHS England for 2016-17](#), page 18

²⁸ [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.²⁹

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.

2.4 The NHS Long Term Plan

Mental health in the [NHS Long Term Plan](#) (7 January 2019) provided a number of commitments to improve mental health services. For example, on adult mental health services it committed NHS England to providing an additional 380,000 people per year with access to adult psychological therapies by 2023/24. It also stated, by 2023/24, the NHS 111 service would act as a single point of contact for NHS services for people experiencing mental health crisis, and new services intended to support patients going through a mental health crisis would be introduced.³⁰ The Government has said that mental health services for adults and children will be backed with additional funding of at least £2.3 billion a year by 2023/24.³¹

On 23 July 2019 NHS England and NHS Improvement published the [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#) to provide guidance for local areas on how to deliver the mental health ambitions within the Long Term Plan through the development and delivery of their local plans for the next 5 years. The guidance is primarily aimed at the leaders of local Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) and sets out information on funding, transformation activities and indicative workforce numbers to support the development of local plans, which are due to be completed by the end of 2019.

The [Royal College of Psychiatrists](#) has also produced a useful [commentary paper](#) on the mental health proposals in the Long Term Plan.

Preventing mental ill health

²⁹ DH, [Five Year Forward View for Mental Health: government response](#), 9 January 2017

³⁰ [NHS Long Term Plan](#), 7 January 2019; see chapter 3, from page 50 (children's mental health) and page 68 (adult mental health).

³¹ See for example, Lords PQ response [HL16476, Mental Health Services, 2 July 2019](#)

Chapter 2 of the NHS [Long Term Plan](#) also set out action the NHS will take to strengthen its contribution to prevention and health inequalities, and on 22 July 2019 the Government published its Prevention Green Paper, [Advancing our health: prevention in the 2020s](#). This noted a number of actions that had already been taken to prevent mental ill health, including the 2017 Green Paper, [Transforming Children and Young People's Mental Health Provision](#), and making mental health a mandatory part of the school curriculum. It also noted the launch of the mental health prevention package, [Every Mind Matters](#).

In April 2019, the Government published a consultation ([Online Harms](#)) setting out its plans to tackle online content that harms individual wellbeing.

2.5 Mental health expenditure

The NHS England website provides an overview of mental health service information and data, including national mental health expenditure. This provides the following on mental health services funding and investment:

The NHS's recently published [Long Term Plan](#) reaffirms our commitment to putting mental health care on a level footing with physical health services.

To support the ambitions within the Plan the NHS has made a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ringfenced local investment fund worth at least £2.3 billion a year by 2023/24.

In consecutive years the NHS in England has met its commitment that the increase in local funding for mental health (excluding learning disabilities and dementia) is at least in line with the overall increase in the money available to them. This is called the mental health investment standard (MHIS).

Since it was introduced in 2015/16 the MHIS has been met nationally.

The latest data shows that:

1. All of the 195 CCGs – covering every part of England – have met the Mental Health Investment Standard in 2018/19, an increase from 186 (90%) out of 207 CCGs that achieved it in 2017/18.
2. The consistent increases in mental health spend means it now makes up 13.9% of local health spend in 2018/19, compared with 13.7% in 2017/18 and 13.1% in 2015/16.

Some mental health services are paid for with funding delivered at the national level. When this is added to local spending, mental health funding (including learning disabilities and dementia) has gone up from £10,979m in 2015/16 to £12,513m for 2018/19, with further investment expected on top of that during the year.³²

³² NHS England, [national mental health expenditure](#)

2.6 Stevenson/Farmer 'Thriving at Work' review

In 2017 the Government commissioned an independent review into mental health and employment led by Dennis Stevenson and Mind CEO Paul Farmer, as part of a range of measures aimed at transforming mental health support in schools, workplaces and in the community. The review's report, [Thriving at Work](#), was published in October 2017 and recommended "mental health core standards" that all employers can adopt to better support the mental health of their staff.

The core standards include that employers should:

- Produce, implement and communicate a mental health at work plan.
- Develop mental health awareness among employees.
- Encourage open conversations about mental health and the support available when employees are struggling.
- Provide employees with good working conditions and ensure they have a healthy work life balance and opportunities for development.
- Promote effective people management through line managers and supervisors.
- Routinely monitor employee mental health and wellbeing.

In November 2017, the joint DWP/DHSC Work and Health Unit (WHU) published the Government's response, [Improving Lives: the Future of Work, Health and Disability](#), setting out their response to Thriving at Work. Recent PQ responses state that WHU is now overseeing progress across the 40 recommendations in the report.

Further information on the implementation of the review's recommendations can be found in the response to [PQ 264730](#) (24 June 2019). The response to a further PQ on implementation of the recommendations in the Thriving at Work report notes actions taken across the wider public sector (see PQ 210676 [[Mental Health and Employers Independent Review](#)] 28 January 2019). In particular this noted that in July 2018, the WHU and the Local Government Association held a Public Sector Summit which brought together public sector leaders and experts "to share best practice on mental health support and how the review's recommendations are being implemented and championed by employers in this sector."

On the 17 January 2019 there was a [Backbench Business Committee debate on Mental Health First Aid \(Official Report columns 1366-1395\)](#), and the Library prepared a briefing pack for this debate ([CDP-2018-0281](#)).

2.7 Cross-Government Suicide Prevention Workplan

In January 2019, the Department of Health and Social Care (DHSC) [announced](#) the publication of its first [cross-government suicide prevention workplan](#). This was created in response to the [Suicide](#)

[prevention inquiry](#) led by the Health Select Committee, which had called for a clearer implementation strategy for the overall [Suicide Prevention Strategy](#).

This plan sets out aims for each relevant Government department. The plan also explains that a National Suicide Prevention Strategy Delivery Group, comprising of officials across Government and delivery agencies, will track progress against the Workplan. [Pages 11-41](#) set out a wide range of actions that Government departments and public bodies either have taken or will take in the coming years.

Alongside this, the Government published [Preventing suicide in England: Fourth progress report of the cross-government outcomes strategy to save lives](#). As well as describing progress so far, the report notes the next priority areas for the Government, including:

- working in partnership with local government to embed their local suicide prevention plans in every community; and
- delivering the ambition for zero suicide in mental health inpatients and improving safety across mental health wards and extending this to whole community approaches.

Further information can be found in the Library briefing paper [Suicide prevention: policy and strategy](#) (CBP-8221, October 2019).

3. Reform of the Mental Health Act 1983

In October 2017, the Government commissioned Sir Simon Wessely, former President of the Royal College of Psychiatrists, to lead an independent review of the *Mental Health Act 1983* (the Act).³³

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 (BAME) groups. The [Five Year Forward View for Mental Health](#) (February 2016) recommended that there should be action to substantially reduce *Mental Health Act* detentions and targeted work should be undertaken to reduce the significant overrepresentation of BAME and any other disadvantaged groups within detention rates.³⁴

The Department of Health & Social Care asked the independent review to make recommendations for improvement in the following areas:

1. rising rates of detention under the act
2. the disproportionate number of people from black and minority ethnicities detained under the act
3. stakeholder concerns that some processes relating to the act are out of step with a modern mental health system, including but not limited to:
 - a) the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
 - b) 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
 - c) that detention may in some cases be used to detain rather than treat
 - d) questions about the effectiveness of community treatment orders, and the difficulties in getting discharged
 - e) the time required to take decisions and arrange transfers for patients subject to criminal proceedings.³⁵

An [interim report](#) was published in May 2018 summarising the review's progress and the priority issues that had emerged. The interim report highlighted concerns about high rates of detention for people from black Caribbean, black African and mixed black ethnic groups, and collated evidence on the reasons behind this trend – such as

³³ [Written Statement HCWS143](#), Independent Review of the Mental Health Act, 9 October 2017

³⁴ [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

³⁵ Department of Health and Social Care, [Terms of Reference – Independent Review of the Mental Health Act 1983](#), 4 October 2017

discrimination, poverty and social exclusion, as well as higher rates of mental illness among some ethnic groups.

The final report of the Independent Review - [Modernising the Mental Health Act: Increasing choice, reducing compulsion](#) - was published in December 2018. The review made a series of recommendations to reform the Act in order “to rebalance the system to be more responsive to the wishes and preferences of the patient, to take more account of a person's rights, and to improve as much as possible the ability of patients to make choices even when circumstances make this far from easy.”³⁶

The report set out four key principles that the Review believed should underpin a reformed Act:

a. **Choice and Autonomy:** all practicable steps must be taken to:

- support a person subject to this Act to express their will and preferences;
- have particular regard to the person's will and preferences, even where an intervention in the absence of consent is expressly authorised by this Act;
- promote the person's dignity, and accord them due respect, including respecting their social and caring relationships; and
- take steps to ensure that the person understands their rights and entitlements whilst they are subject to the Act

b. **Least Restriction:** The exercise of any power under this Act shall be done in the least restrictive and least invasive manner consistent with the purpose and principles of this Act.

c. **Therapeutic Benefit:** care and treatment must be designed to meet the person's needs in a timely manner within a supportive, healing environment with a view to ending the need to be subject to coercive powers under this Act.

d. **The person as an Individual:** care and treatment must be provided and commissioned in a manner that:

- respects and acknowledges the person's qualities, strengths, abilities, knowledge and past experience; and
- In particular, respects and acknowledges person's individual diversity including any protected characteristics under the Equality Act.³⁷

The review made 154 recommendations grouped under the four key principles, covering areas such as decision making about care and treatment, family and carer involvement, tackling rising rates of detention and the experiences of people from ethnic minority communities.³⁸

On the day of the review's publication, the Government accepted two recommendations to give people more choice and control: the

³⁶ [Modernising the Mental Health Act: Increasing choice, reducing compulsion](#), Final report of the Independent Review of the Mental Health Act 1983, December 2018, page 16

³⁷ Ibid, page 67

³⁸ For the full list of recommendations, see pages 297-314.

establishment of new statutory advance choice documents, so that people's wishes and preferences carry far more legal weight, and the creation of a new role of 'nominated person' to be chosen by the patient to replace the current nearest relative provisions.³⁹

In June 2019, the Government accepted further recommendations made by the review, to tackle the disproportionate number of people from BAME groups who are detained under the Act, and further steps to end the use of police stations as a place of safety. The [NHS Long Term Plan](#) also set out actions to improve crisis care and community mental health services, in line with the review's recommendations to improve community provision of people with serious mental illness.⁴⁰

The Prime Minister also set out a number of Government plans for early action:

- the first ever Race Equality Framework will ensure NHS mental healthcare providers work with their local communities to improve the ways in which patients access and experience treatment, and ensure data on equality of access is monitored at board level and acted on
- working with Black African and Caribbean community groups alongside others to develop a White Paper formally setting out a response to Sir Simon's review
- further work towards eradicating the use of police cells as a place to detain people experiencing mental illness ahead of banning it in law, building on the Prime Minister's work to end this practice for under-18s
- launching a pilot programme of culturally-sensitive advocates in partnership with local authorities and others, to identify how best to represent the mental health needs of ethnic minority groups
- a partnership between the Care Quality Commission and Equality and Human Rights Commission to review how they can use their regulatory powers to better support equality of access to mental health services
- an open call for research into how different ethnic minority groups experience mental health treatment and how this can be improved – to be launched later this year by the National Institute for Health Research.⁴¹

The Government has said it will publish a White Paper in early 2020, which will set out the Government's response, in full, to the independent review. There will be a subsequent period to publicly consult on the proposals, followed by the introduction of a Bill to amend the *Mental Health Act* "when parliamentary time allows".⁴²

³⁹ [Final report of the Independent Review of the Mental Health Act: Written statement - HCWS1149](#)

⁴⁰ [PO 284614](#) [on Mental Health Act 1983 Independent Review], 9 September 2019

⁴¹ No 10 press release, [Measures to end unequal mental health treatment kickstarted by PM](#), 17 June 2019

⁴² [PO 3763](#) [on Mental Health Act 1983 Independent Review], 22 January 2020

4. Use of force in mental health settings

4.1 Policies on the use of force

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:

- 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
- end or reduce significantly the danger to the patient or others.⁴³

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:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.⁴⁴

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.⁴⁵

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.⁴⁶

⁴³ Department of Health, [Mental Health Act 1983 Code of Practice](#), January 2015, para 26.36

⁴⁴ *Ibid.*, para 26.37

⁴⁵ *Ibid.*, para 26.175

⁴⁶ *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.⁴⁷

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:

1. 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.
2. If restrictive intervention is used it must not include the deliberate application of pain.
3. If a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need.
4. Staff must not use seclusion other than for people detained under the Mental Health Act 1983.
5. People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support.
6. 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.⁴⁸

[Positive and proactive care](#) also introduced new monitoring and governance mechanisms to hold services to account for making these

⁴⁷ *Ibid.*, para 26.72

⁴⁸ 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.⁴⁹

In February 2017, the Health Minister Nicola Blackwood (now Baroness Blackwood) gave an update on the implementation of the Positive and Safe programme:

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.⁵⁰

The Government consulted 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. The Government response and [finalised guidance](#) was published in June 2019.

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,

⁴⁹ Department of Health, [New drive to end deliberate face down restraint](#), 3 April 2014

⁵⁰ [PO 63005 \[on mental health services: restraint techniques\]](#), 10 February 2017

including a doctor trained in resuscitation, should be immediately available.⁵¹

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*⁵², 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.⁵³

⁵¹ NICE guideline, [Violence and aggression: short-term management in mental health, health and community settings](#), p30-31, 28 May 2015

⁵² Cabinet Office, [Race Disparity Audit](#), October 2017, page 49

⁵³ 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.⁵⁴

4.2 The Mental Health Units (Use of Force) Act

The [Mental Health Units \(Use of Force\) Act 2018](#) makes provision about the oversight and management of use of force in relation to patients in mental health units and similar settings. It received Royal Assent on 1 November 2018 and applies to England only.

The Act introduces 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 Act requires 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 Act also places a new duty on the Secretary of State to produce an annual report on the use of force at mental health units.

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

The Government has said it is committed to implementing fully the provisions within the Act and will work closely with key stakeholders in preparing the relevant statutory guidance and bring the legislation into force "in due course".⁵⁵

Background information on the passage of the Bill is available in the Library briefing: [Mental Health Units \(Use of Force\) Bill 2017-19: Committee Stage Report](#) (17 May 2018)

⁵⁴ Inquest, [Deaths in mental health detention](#), February 2015

⁵⁵ [PO 251343, 15 May 2019](#)

5. 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.⁵⁶

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.⁵⁷

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.⁵⁸

In February 2014, the Department of Health and signatories published the [Mental Health Crisis Care Concordat](#) - a national agreement

⁵⁶ Department for Health and Social Care, [The Government's mandate to NHS England for 2018-19](#), March 2018, para 1.9

⁵⁷ Department of Health and Social Care, [£15 million boost for local mental health crisis services](#), 15 May 2018

⁵⁸ 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.

5.1 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:

1. the behaviour of the person poses an imminent risk of serious injury or death to themselves or another person;
2. because of that risk, no other place of safety in the relevant police area can reasonably be expected to detain them, and
3. so far as reasonably practicable, a healthcare professional will be present at the police station and available to them⁵⁹

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.

⁵⁹ 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.

In June 2019, the then Health Minister gave details of funding to increase health and community-based places of safety:

Dr Dan Poulter: To ask the Secretary of State for Health and Social Care, how many patients held in designated places of safety have breached the statutory 24-hour detention target in each year since 2017.

Jackie Doyle-Price: In 2015, the Government announced a £15 million capital funding programme to improve health-based places of safety provision and in 2017, the Prime Minister announced a further £15 million to support a wider range of places of safety in the community. This funding has been provided to increase the number of places of safety across the country which is helping to reduce the inappropriate use of police cells for detentions made under Section 135 and Section 136 of the Mental Health Act 1983. Projects led by NHS trusts and foundation trusts, local government and the voluntary sector were awarded the funding. Data is not held on the number of people in a place of safety that have been detained under the Mental Health Act 1983 for longer than 24 hours.⁶⁰

⁶⁰ [PQ270770 \[on Compulsorily Detained Psychiatric Patients\] 8 July 2019](#)

6. 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.⁶¹

In [Implementing the Five Year Forward View For Mental Health](#) (July 2016), the NHS set out how it intended to improve access to mental health treatments. This included the development of 'treatment pathways' to set out "expectations regarding referral to treatment waiting times, interventions provided and outcomes measured."⁶²

More about these pathways can be found on the [website for the Royal College of Psychiatrists](#), which develops these pathways. Beyond those for [IAPT](#) and [Early Intervention in Psychosis](#), there are additional treatment pathways, including for perinatal mental health and urgent and emergency mental health care. NHS England's website on [Adult Mental Health](#) has more details about their progress so far in several mental health service areas.

The [NHS Long Term Plan](#) (January 2019) expanded on the plans for better emergency mental health services coverage, and committed to testing four-week waiting times for adult and older adult community mental health teams in selected areas.

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.

⁶¹ Gov.uk, [First ever NHS waiting time standards for mental health announced](#), 8 October 2014

⁶² Ibid.

7. 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.⁶³

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 has funded an online mental health and suicide prevention training resource, published in May 2019. It will be distributed to all local authorities and will aim to reduce suicide in Scotland by 20% by 2022.⁶⁴

Wales

In August 2018 the Welsh Government published a 10-year strategy for improving the lives of people using mental health services, their carers and families.

The main themes of the strategy, Together for Mental Health, are:

4. promoting mental wellbeing and, where possible, preventing mental health problems developing,
5. establishing a new partnership with the public, centred on:
 - a) Improving information on mental health
 - b) Increasing service user and carer involvement in decisions around their care

⁶³ [Scottish Government press release, New Mental Health Strategy \(30 March 2017\)](#)
See also Scottish Government, '[Mental Health Strategy 2017-2027: First Progress Report](#)', 26 September 2018, and Scottish Government, '[Better Mental Health in Scotland](#)', 19 December 2018.

⁶⁴ Scottish Government, [Suicide prevention training launched](#), 28 May 2019

- c) Changing attitudes to mental health by tackling stigma and discrimination
- 6. 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,
- 7. 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,
- 8. identifying how we will implement the Strategy.⁶⁵

The Strategy is focused around 6 high level outcomes and supported by a [Delivery Plan](#).

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

Northern Ireland

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

⁶⁵ Welsh Government, ['Together for Mental Health- A Strategy for Mental Health and Wellbeing in Wales'](#), 16 August 2018.

8. 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](#) (October 2019)
- [Women's mental health](#) (September 2019)
- [Reform of the Mental Health Act 1983](#) (July 2019)
- [Children and young people's mental health – policy, CAMHS services, funding and education](#) (July 2019)
- [Perinatal mental illness](#) (July 2018)
- [Mental health statistics: prevalence, services and funding in England](#) (February 2020)
- [NHS Key Statistics: England \(May 2018\)](#)
- [Access and waiting time standards for early intervention in psychosis](#) (March 2018)
- [Support for UK veterans](#) (November 2019)

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