

# Is mental health care improving?

by Felicity Dormon

This is one of a series of overviews looking at key areas of quality: safety, waiting times, mental health, person-centred care and international comparisons.

See: [www.health.org.uk/qualityoverview](http://www.health.org.uk/qualityoverview)

## £105bn

*Estimated annual societal and economic costs of poor mental health in England*

This overview uses the available data to assess the quality of health care services for people with mental health problems in England.<sup>\*</sup> It focuses on three different groups: adults with common mental health problems, adults with severe and enduring mental health problems, and children and young people.<sup>†</sup>

### Key points

- **Around 20% of the population of England have a mental health problem**, and the societal and economic costs of poor mental health are estimated at £105bn a year.<sup>1</sup> More than two million people a year have some sort of contact with mental health services. However, many who need support do not access any through the NHS.
- **There is a paucity of useful national information on mental health services.** In many areas there is no national information at all (for instance, services for children and young people in the community), and in others national information is incomplete or unlikely to be representative of the true picture. This means quality of services cannot be definitively assessed.
- **The availability of services for adults with common mental health problems, such as depression and anxiety disorders, is improving.** Access to treatment has increased since 2010, and the number of people reaching recovery through ‘talking therapies’ is steadily rising. However, recovery rates still fall short of what is possible and more capacity is needed.
- **Demand for secondary care (which generally treats people with severe mental health problems) is increasing**, and there is evidence to suggest services are becoming less accessible and treatment more coercive. There is little information available on the outcomes that services achieve.
- **There is very little national information about mental health services for children and young people, and what information there is suggests quality is declining.** Information from mental health providers and families using services indicates substantial cuts to services, increasing demand, increasing thresholds for treatment, very long waits (more than a year) for specialist services, and a resultant decline in accessibility.
- **There is wide variation in all services for people with mental health problems.** Older people, black and minority ethnic communities, and certain areas of the country experience a poorer service and outcomes.<sup>2,3,4</sup>

<sup>\*</sup> This paper does not assess the availability or quality of preventative or wellbeing services, nor does it consider dementia services, or services for people with learning disabilities.

<sup>†</sup> For complementary information, see pages 13-16 of *Cause for concern: QualityWatch annual statement*, on which many of the charts in this document are based. [www.qualitywatch.org.uk/annual-statement/2014](http://www.qualitywatch.org.uk/annual-statement/2014)

# 20%

In 2007, 20% of adults in England were estimated to have a diagnosable mental health problem

## Mental health in context

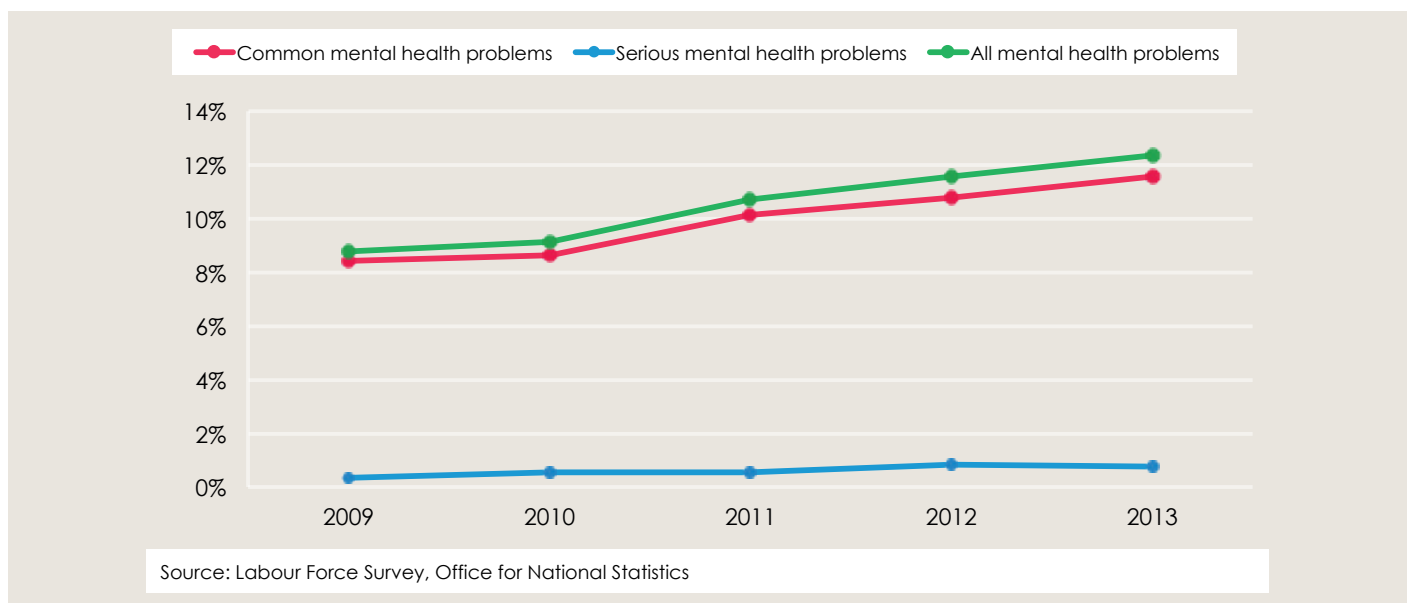
In 2007, around 10.2 million adults in England (20% of the population) were estimated to have a diagnosable mental health problem.<sup>5</sup> Of these, the majority had a common mental health problem, with as many as 6.1 million adults living with depression and anxiety disorders. Around 0.7% of the population have a personality disorder and 0.5% experience psychosis.\* There is substantial overlap between physical and mental health problems: around 30% of all people with a long-term physical health condition also have a mental health problem. This equates to around 4.6 million people.<sup>6</sup>

People with mental health problems are over-represented in the criminal justice system. In 1998 (the most recent information available), it was estimated that more than 70% of people in prison had two or more mental health disorders.<sup>7</sup>

In 2004 (the most recent information available), 10.1% of children were estimated as having diagnosable mental health problems.<sup>8</sup>

The number of working days lost to mental health problems is rising. In 2013, 12.3% of total working days lost to sickness were due to mental health problems, and this proportion is increasing over time (figure 1). The estimated economic and social cost of mental health problems in 2009/10 in England was £105 billion a year.<sup>9</sup>

Figure 1: Proportion of all working days lost to sickness due to mental health problems



More than 90% of people with mental health problems experience some form of discrimination.<sup>10</sup> Levels seem to be reducing and attitudes improving among the general population; however there is a long way to go.<sup>10</sup>

\* This is likely to be an underestimate because of the survey methodology used.

## Services for adults with common mental health problems: primary mental health care

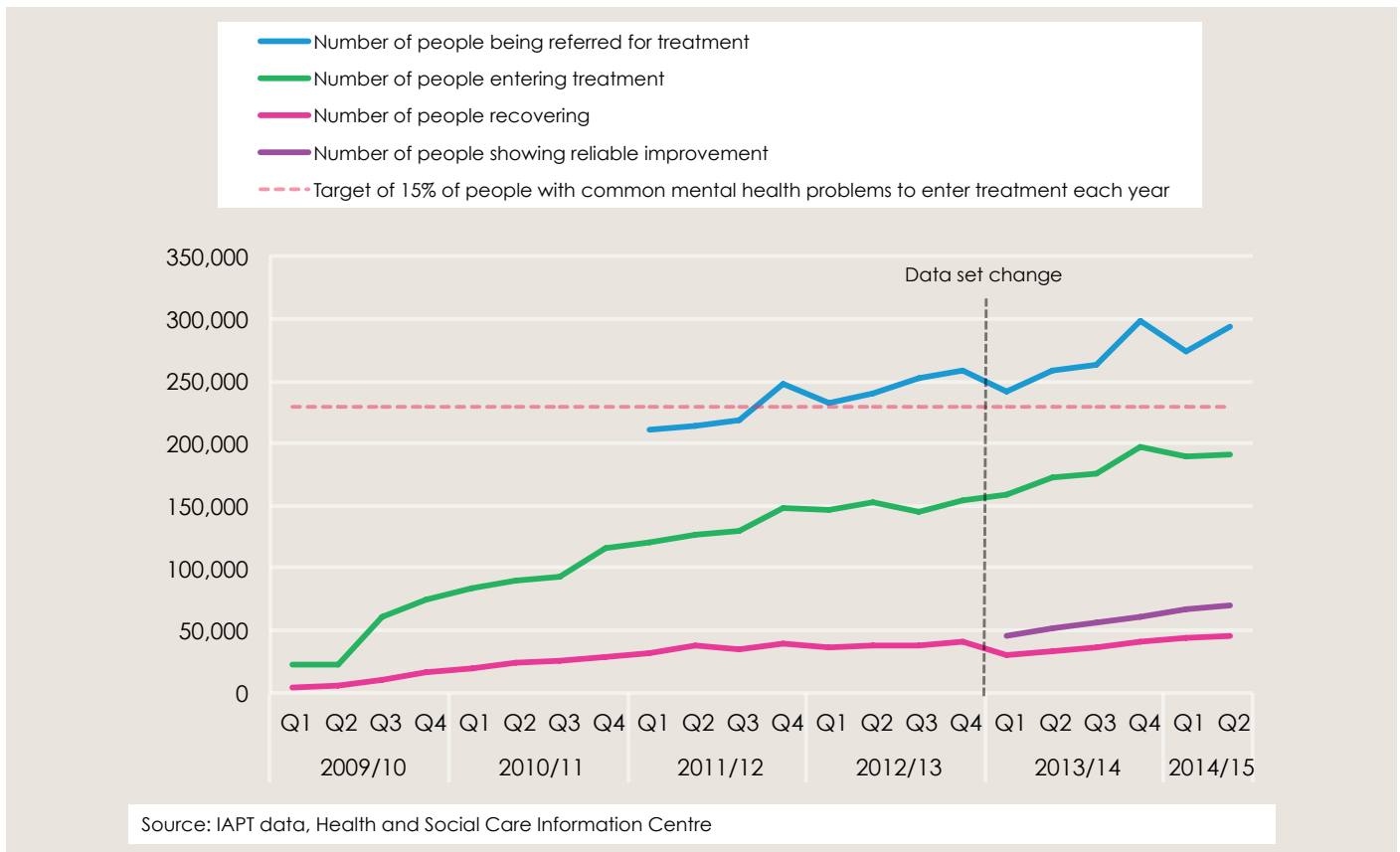
The majority of people treated for mental health problems in the NHS have a common mental health problem – mostly depression or anxiety disorders. The individuals concerned are, in the main, treated in primary care: in general practice and through primary care psychological therapies.

Services are making progress towards the target of 15% of people with common mental health problems entering treatment each year

### Access

The number of people accessing psychological therapies for common mental health problems has risen steadily over this parliament as the Improving Access to Psychological Therapies (IAPT)\* programme has been expanded (see figure 2). Services are making progress towards the target of 15% of people (around 900,000) with common mental health problems entering treatment each year.<sup>11</sup> The ‘right’ number of people entering treatment to meet the need of all people with common mental health problems is not clear; however, it is certainly below current levels.<sup>12</sup>

Figure 2: IAPT referrals, people entering treatment and people recovering

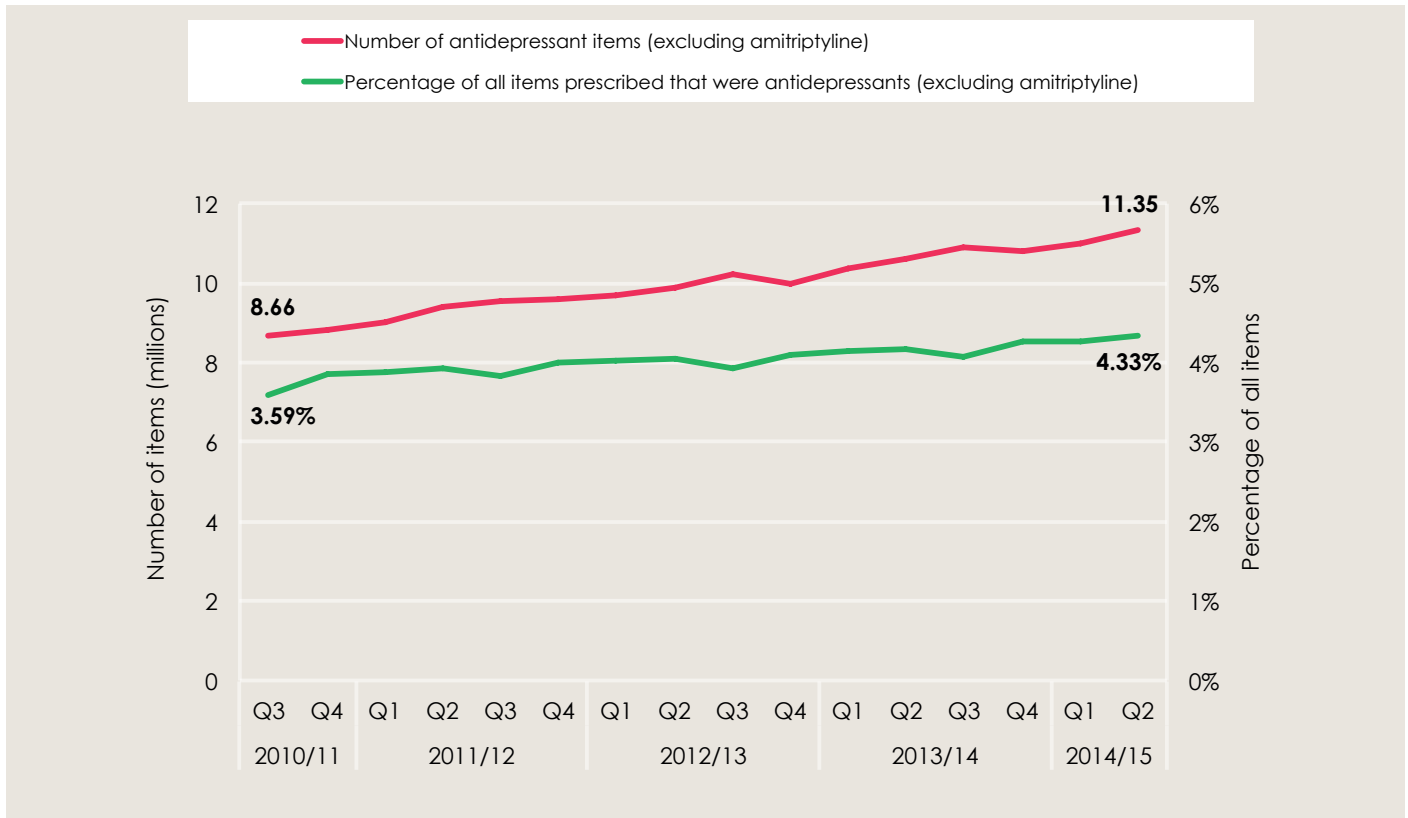


In 2013/14 there were 2.9 million adults with depression listed on registers in general practice, corresponding to 6.5% of all adults registered with GPs. This is below the estimated prevalence of people with depression: 4.8 million people, or 13.4% of adults.

\* IAPT is an NHS programme rolling out and expanding services across England, offering interventions approved by the National Institute of Health and Care Excellence (NICE) for treating people with depression and anxiety disorders.

Prescriptions for antidepressants are rising (see figure 3). This may imply a rising prevalence of depression, better identification and treatment, insufficient access to talking therapies, or unwarranted variation in prescribing behaviour.<sup>13</sup>

**Figure 3: Trend in primary care prescribing of antidepressants in England, 2010-2014\***



### Waiting times

IAPT service standards recommend that treatment starts within 28 days of referral.<sup>2</sup> This happened for 64% of people using IAPT services between June and September in 2014/15. However, 10% of people waited longer than 90 days.<sup>†</sup> The proportion of adults waiting longer than 28 days has remained relatively stable since the beginning of 2013/14 (the period for which comparable data are available).<sup>14</sup>

### Experience

Despite good information in other areas, there are no national data relating to people's experience of IAPT services.

In general practice, people with mental health problems appear to have a similar experience to other patients

In general practice, people with mental health problems appear to have a similar experience to other patients: 85% of respondents to the 2014 GP survey who have a long-term mental health problem rate their experience as good or very good, compared to 86% of all patients.<sup>15</sup> When asked if they have enough support to manage their condition, respondents with long-term mental health problems are slightly more likely than those with other conditions to respond positively, although the view of both groups is declining over time.<sup>16</sup>

\* Figure 3 is an updated version of a graph used in the QualityWatch publication *Focus on: Antidepressant prescribing*, 2014

† From April 2015 a waiting times target will apply to IAPT services: 75% of people should start treatment within six weeks of referral, and 95% within 18 weeks

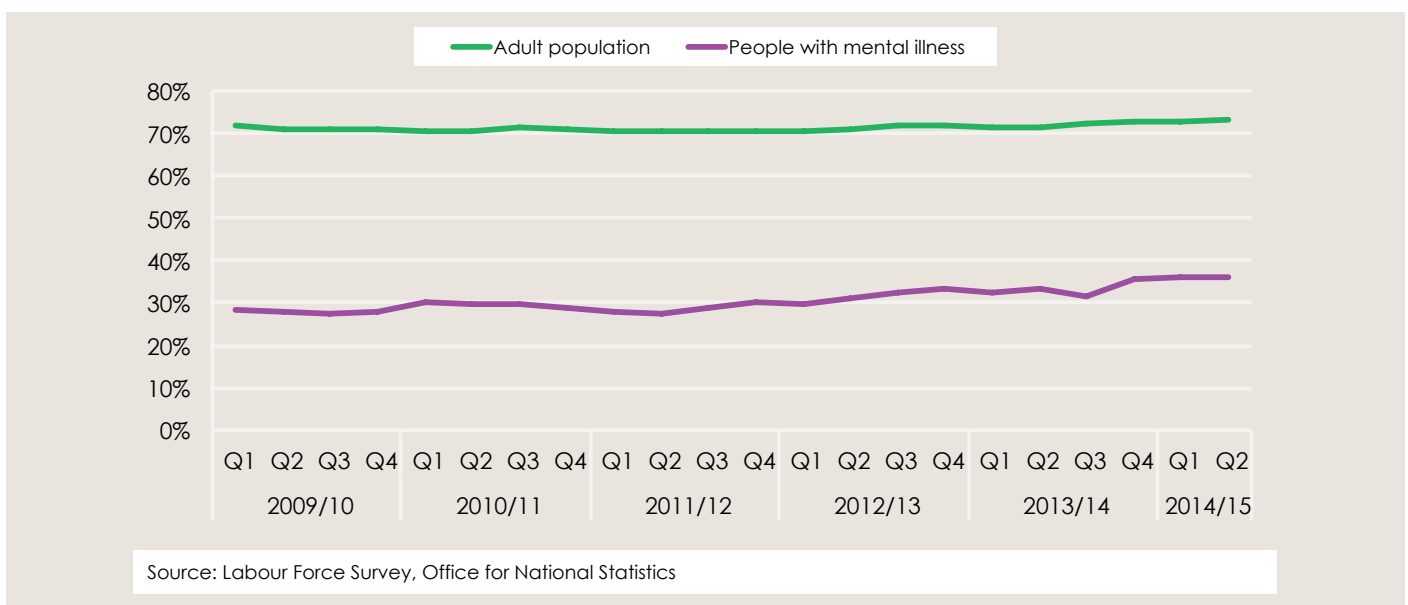
## Outcomes

The number of people moving to recovery\* through IAPT treatment is increasing, with more than 197,000 people recovering in the last four quarters of available data (September 2013 to August 2014). The national recovery rate is 44%,<sup>17</sup> below the government target of 50%,<sup>18</sup> and recovery varies between 25% and 71% in different clinical commissioning groups.<sup>19</sup>

There is no national information on people's outcomes from medication given in primary care.

Being in employment is one aspect of a person's recovery from mental health problems. The employment rate for all people with mental health problems<sup>†</sup> is improving faster than the rate for the general population (see figure 4), increasing by 8.5 percentage points since 2009/10.<sup>20</sup> However, we do not know if this is related to improving NHS services.

**Figure 4: Employment rates for the general adult population and adults with mental health problems**



## Services for adults with severe and enduring mental health problems: secondary mental health care

People with serious mental health problems may be supported by their GP for their mental health needs, or by secondary mental health services.<sup>‡</sup> A substantial proportion of people don't access any support at all: for instance, only 65% of people with psychotic disorders are thought to receive treatment.<sup>21</sup>

\* Moving to recovery is defined as a person's symptoms reducing to non-clinical levels over a course of treatment.

† There is no data set comparing the employment of people with common mental health problems to those with serious mental health problems. However, this trend is likely to represent mainly those with common mental health problems, both because they make up the majority of people with mental illness, and because the employment rate for those with serious mental health problems may be worsening (figure 7).

‡ Secondary mental health services are hospital and community services that offer more specialist mental health support for people than are available through GPs and primary care talking therapies.

## Access

The number of people in contact with secondary mental health services is rising, with 156,000 more people using these services in 2013/14 than in 2012/13 (see figure 5). Referrals to community mental health teams have also risen, by 13%.<sup>21</sup>

The number of interactions between secondary mental health services and the people they are supporting dropped by 4.3% between 2011/12 and 2012/13

However, the intensity of contact people have with services is falling. The number of interactions\* between secondary mental health services and the people they are supporting dropped by 794,000 (4.3%) between 2011/12 and 2012/13.<sup>22</sup> In 2014, only 52% of service users surveyed saw a mental health professional in the last month, compared to 59% in 2011.<sup>†</sup>

The number of people being supported through the Care Programme Approach<sup>23</sup> (case management in secondary care with a named care coordinator<sup>24</sup>) has not risen in line with the numbers of adults accessing secondary services. This means the proportion of people receiving this coordinated care has fallen: from 25.3% of adults in contact with secondary services in 2011/12 to 20.5% in 2013/14.<sup>22</sup>

The NHS Constitution includes a commitment that 95% of adults discharged on the Care Programme Approach (CPA) will be followed up within seven days. This standard has been consistently met since 2010/11, with a 97.3% follow up rate between October and December in 2014.<sup>25</sup>

The number of people receiving social care support for mental health problems (practical support to live independently – eg help with washing, bills, shopping or rebuilding confidence and skills) has fallen by 25.5% since 2009/10.<sup>26</sup> There is no evidence that need for this sort of support has fallen.

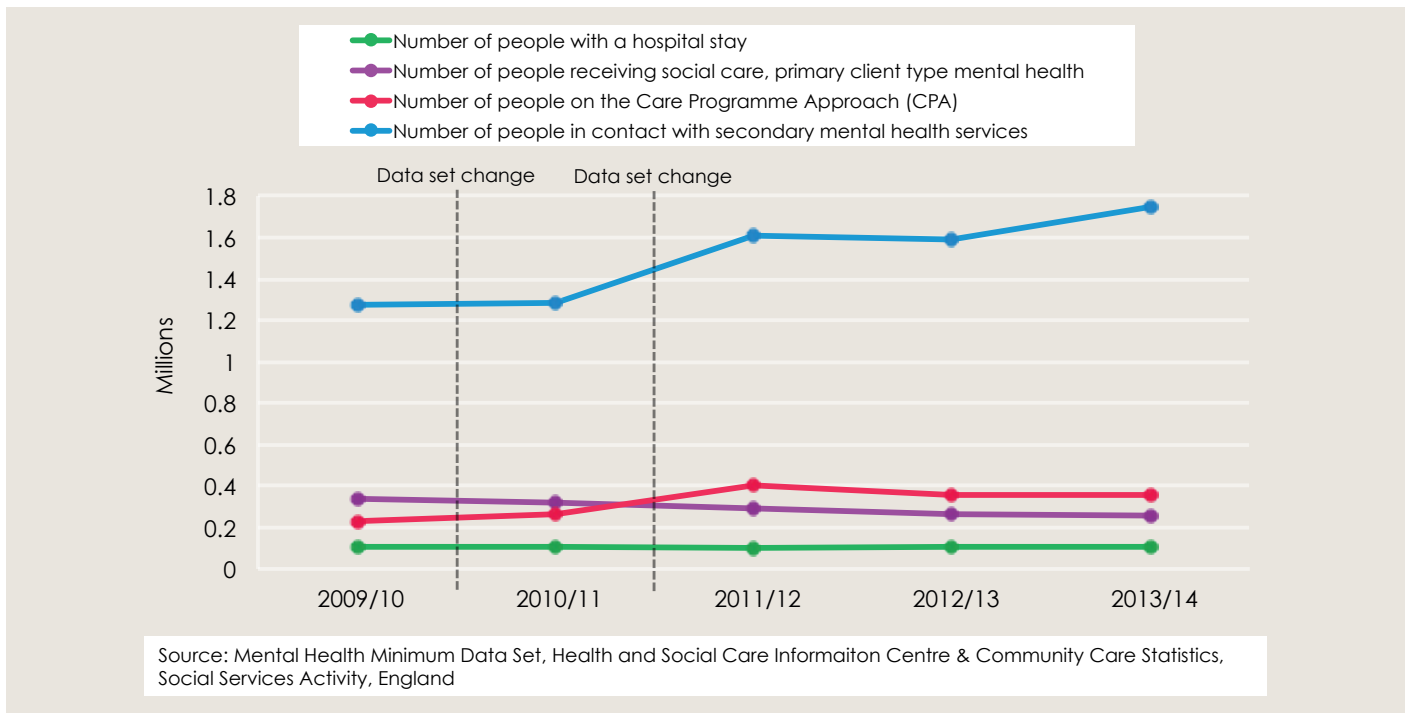
A relatively small number of people are admitted to hospital for mental health care; their numbers and how long they stay in hospital have remained relatively consistent over the current parliament (figure 5, page 7).<sup>22</sup>

However, decreasing capacity is causing rising pressure on inpatient services; the number of available beds fell by 16% (from 25,503 to 21,446) between 2009/10 and October–December 2014, with a corresponding rise in bed occupancy.<sup>27</sup> Information gained through Freedom of Information requests suggests the numbers of people being treated a long way from home (‘out of area placements’) is rising, with one suggestion it doubled in some trusts between 2011 and 2013.<sup>28,29</sup> New data in October 2014 showed 5.1% of people in mental health inpatient care were more than 100km from home.<sup>30</sup>

\* Excluding IAPT, dementia, learning disability and autistic spectrum disorder services.

† CQC Community Mental Health Team patient survey. Please note, due to differences in survey design these figures are not directly comparable (however, the same question wording was used in each case).

**Figure 5: Number of people accessing secondary mental health services and social care mental health support**



Routine national data on the availability of specialist mental health services are not available. What evidence there is (for instance, from surveys and audits) suggests access is insufficient and variable. For example:

**40%**  
40% of CCGs have no specialist mental health services for women relating to childbirth

- 40% of CCGs have no specialist mental health services for women relating to childbirth<sup>31</sup>
- 39% of people with psychosis were offered talking therapy in 2014<sup>32</sup>
- there was inadequate capacity in services for people with personality disorders in the East Midlands in 2011, and significant disparity in interventions<sup>33</sup>
- 62% of accident and emergency departments did not have ‘adequate’ liaison psychiatry (as defined by the Royal College of Psychiatrists) in 2014.<sup>34</sup>

### Waiting times

There is no high quality national information on waiting times for secondary mental health services. What evidence there is suggests that waits are variable, and waits for and within specialist services are a particular problem. In 2013/14, national analysis suggested one in five people referred directly to personality disorder services were likely to have waited longer than a year;<sup>35</sup> average waits for early intervention in psychosis services were between 10 and 17 weeks<sup>36</sup> (compared to a recommended waiting time of two weeks); and in a 2014 survey, 20% of people with severe mental illness who were offered talking therapy reported waiting more than a year to access it.<sup>37</sup>

\* Liaison psychiatry services are specially trained teams that can provide timely diagnoses of co-morbid mental health conditions for people who are admitted to hospital. They can enable people to receive appropriate treatment quickly.



## Mental health and waiting times targets

The government has announced its intention to apply waiting times standards across mental health services by 2020.<sup>38</sup> Existing general waiting times targets apply to some of the services people with mental health problems access:

- The four-hour A&E waiting time target applies to people with mental health problems, and mental health is estimated to be the primary cause for 5% of attendances to A&E.<sup>39</sup>
- Ambulance response times also apply to mental health. In addition, the Crisis Care Concordat suggests locally agreed response times for people in mental health crisis, with people in mental health crisis not waiting more than 30 minutes for an ambulance.<sup>40</sup>
- The 18-week referral to treatment target for elective secondary care theoretically applies to mental health, but in practice the majority of mental health services are excluded because they are not consultant-led.<sup>41</sup>

## Coercion

Mental health services are unusual in that they have the power to impose treatment on people either in hospital or the community against their will. There are three main forms of coercion:

- Detention and/or compulsory treatment in hospital, which may include seclusion and physical restraint (using powers outlined under several sections of the Mental Health Act 1983).
- Detention in a place of safety by police (using powers outlined in Section 136<sup>42</sup> of the Mental Health Act 1983) when they have concerns about a person's mental health in a public place.
- Community treatment orders (under Section 17 of the Mental Health Act 1983) which allow patients to be treated compulsorily in 'the community'.

Uses of these powers are increasing steadily (see figure 6, page 9).

Between 2009/10 and 2013/14 there was a 14% rise in all detentions. There is some evidence that this has been a response to difficulty in accessing inpatient care.<sup>43</sup>

Not all providers report their use of restraint to the national mandatory system, meaning the extent of the use of restraint in services is not clear.<sup>44</sup> High levels of restraint may indicate good reporting practices rather than more coercive services: the use of restraint was reported for 5.4% of inpatients in 2013/14, around a quarter of these during the first week of admission.<sup>45</sup>

Since 2009/10 there has been a 41% rise in the number of people temporarily detained by police (Section 136). Individuals detained in this way are either placed in a health-based place of safety (for instance, in a hospital), or other facilities, often police cells. The use of health-based places of safety over other options is increasing – used in 74% of Section 136 cases in 2013/14, compared to 63% in 2011/12.<sup>46</sup>

The majority of people, 83% in 2013/14, detained under Section 136 are not detained further – and so are released back to their homes.<sup>47</sup>

14%

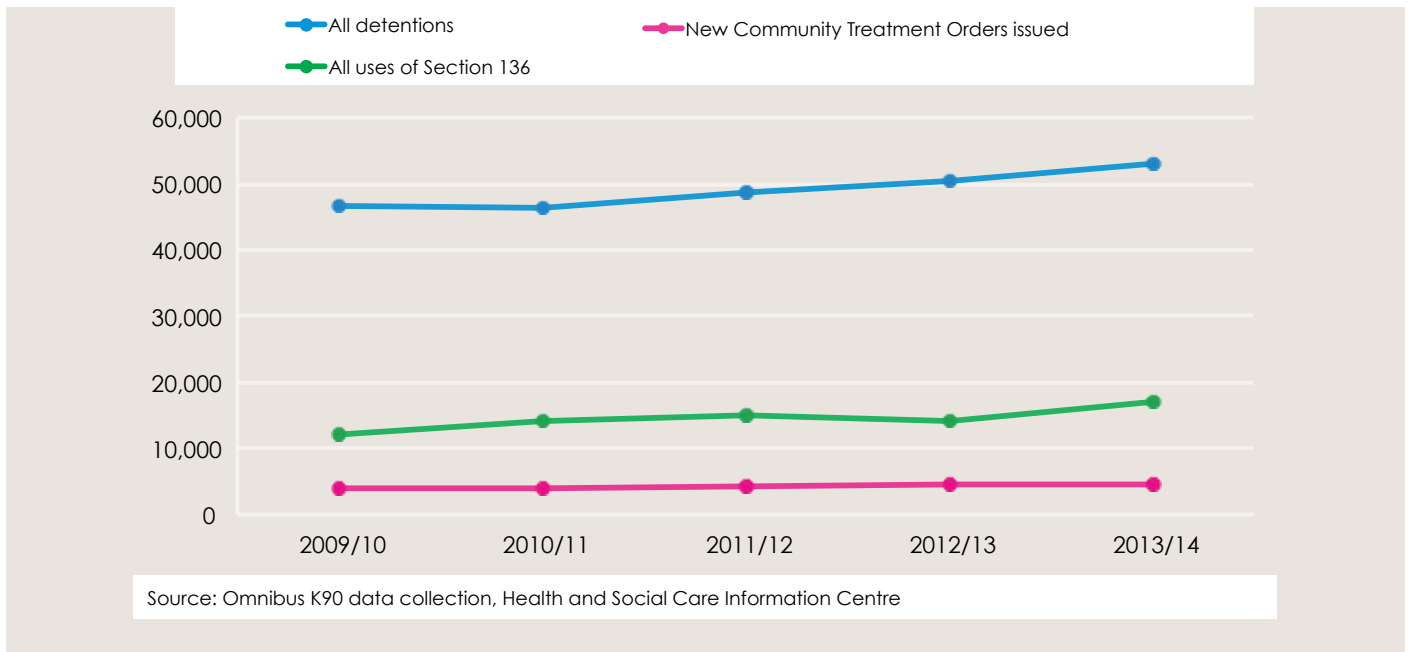
Between 2009/10 and 2013/14, there was a 14% rise in detentions



There was a 5% decrease in community treatment orders in 2013/14 compared to 2012/13, after yearly increases since their introduction. This may suggest that numbers are now ‘levelling off’.<sup>46</sup>

People from black and minority ethnic backgrounds are more likely to be subject to compulsory treatment. In 2012/13 they made up 28% of detentions, despite only accounting for 14% of the population.<sup>46</sup> The main reasons for this are not clear; some analysis suggests that differences may be due to variation in services in different areas of the country,<sup>49</sup> or differing health needs, while others raise concerns about racial discrimination.<sup>50</sup>

**Figure 6: Number of detentions and community treatment orders under the Mental Health Act**



In 2014, two thirds of people surveyed rated their experience of services as at least seven out of 10

### Experience

Due to changes in the community mental health team patient survey, comparable data on the experiences of people using mental health services over time are not available. In 2014, two thirds of people surveyed rated their experience of services as at least seven out of 10. Nearly three quarters of those surveyed felt listened to by the person who they saw most recently, and people on the CPA rated services slightly more positively than others.<sup>51</sup>

### Outcomes

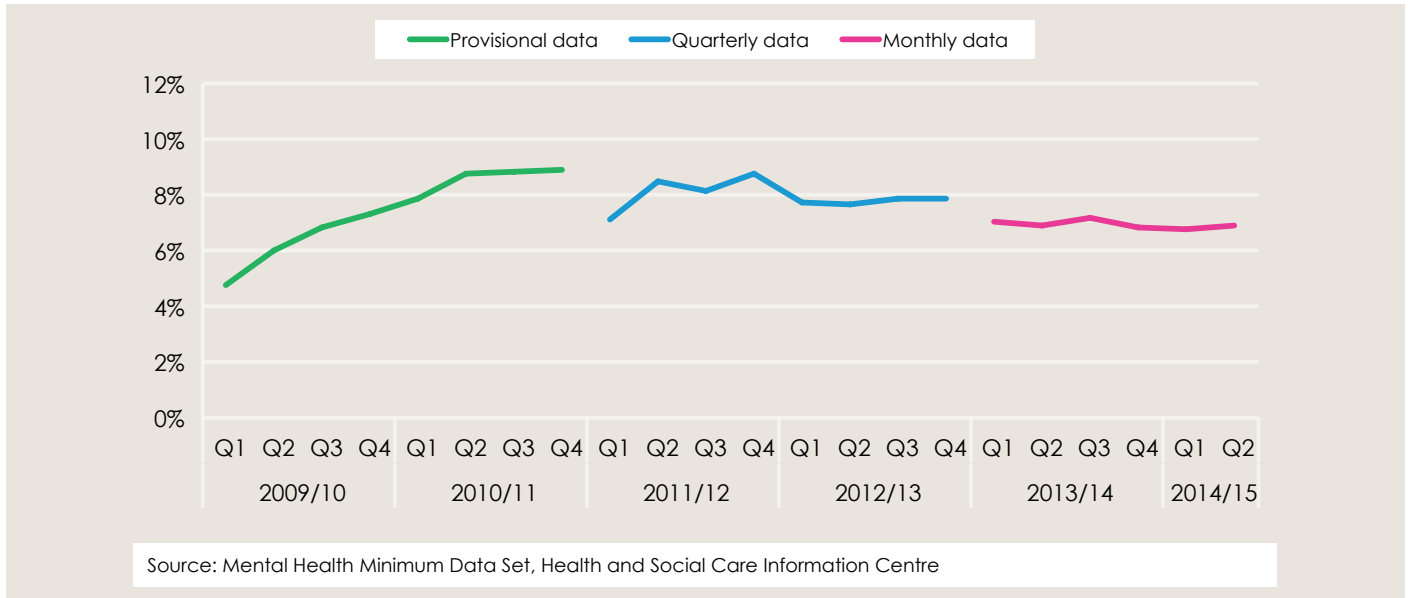
Secondary mental health services started collecting clinician-reported outcome measures for people using their services in 2014, and data completeness is not yet sufficient to draw conclusions. For the very small proportion of people entering and being discharged from services in 2013/14 who had valid scores recorded (2.7%), outcome measurements for ‘emotional wellbeing’ and ‘severe disturbance’\* showed some improvement.<sup>52</sup>

There are reports from providers of declining quality of services in the face of financial pressure.<sup>53</sup> In 2014, for instance, 53% of providers of early intervention in psychosis services reported their quality had decreased in the last year.<sup>54</sup>

\* ‘Emotional wellbeing’ and ‘severe disturbance’ refer to dimensions of the Health of the Nation Outcomes Scale (HoNOS).

Employment and settled accommodation contribute to a person's recovery from mental health problems. However, employment levels for people on the CPA are decreasing (figure 7), which perhaps reflects the increasing complexity of needs in this cohort. In contrast, the number of people in settled accommodation and receiving the CPA have stayed relatively constant.<sup>22</sup> No information on employment or housing is available for those in contact with secondary mental health services and not on the CPA.

**Figure 7: Percentage of people on the Care Programme Approach who are in employment**

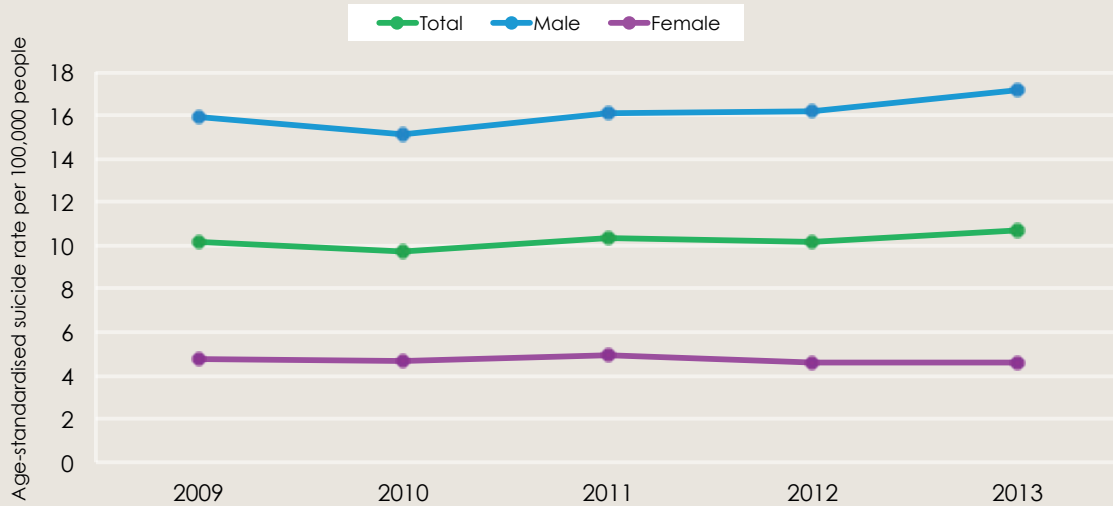


### Suicide and mortality

Among the general population there was a rise in the suicide rate in 2013, with the rate for males at its highest level since 2001 (figure 8, page 11). Men aged 45 to 59 have the highest suicide risk, with a rate of 25.1 deaths per 100,000 people in 2013.<sup>55</sup>

However, the suicide rate among those who are in contact with mental health services fell in 2012 to 80.6 per 100,000 secondary mental health service users (the latest year information is available for), continuing a downward trend from 2010.<sup>56</sup>

Figure 8: Suicide rate in England



Source: Suicides in the United Kingdom (England data), Office for National Statistics

Premature mortality is 3.4 times higher for people with severe mental health problems than among general population (figure 9).<sup>57</sup> Studies have found that premature mortality is also higher for people with common mental health problems;<sup>58,59</sup> however, this is not measured nationally. Most premature mortality among those with mental health problems is not due to suicide, but other preventable health problems such as cancers, circulatory problems, and respiratory diseases.<sup>60</sup>

Figure 9: Mortality rates for under 75s in England



General population:  
**383 people per 100,000**

People in contact with secondary mental health services: **1,319 people per 100,000**

Source: Health and Social Care Information Centre, Hospital Episodes Statistics and Mental Health Data Set Linkage, 2012/13 data

## Services for children and young people with mental health problems

There is no national information on mental health services for children and young people beyond information about admissions to secondary care. As such, no definitive assessment of the quality of care in child and adolescent mental health services (CAMHS) is possible.

### Access

The majority of children and young people with a mental health problem are unlikely to receive treatment. In 2010, more than three quarters of GPs said they could rarely get access to needed psychological therapy for their young patients,<sup>61</sup> and in 2004 (the latest data available) only 25% of children with mental health problems were in treatment, and only 13% of adolescent males.<sup>62</sup>

Providers report year-on-year increases in referrals for all CAMHS services, some as high as 20% per year since 2010

Against this backdrop of historic under-treatment, demand for CAMHS is likely to be increasing. Providers report year-on-year increases in referrals for all CAMHS services, some as high as 20% per year since 2010.<sup>63</sup> Psychiatrists cite rising pressure on community, social care and inpatient services.<sup>64</sup> Referrals for inpatient care rose between 2012 and 2013,<sup>65</sup> and providers also report that children and young people being referred now have greater levels of need than their predecessors.<sup>63</sup>

The picture on hospital admissions for young people is mixed. The rate of admissions for mental health problems in under 18s has fallen by 19.8% between 2010/11 and 2012/13 – which may be due to better community support, increasing need thresholds for admission, or poor reporting of admissions by independent sector providers.<sup>66</sup> Conversely, the recorded rate of admissions of 10- to 24-year-olds for self-harm is increasing, with the three-year average rising by 6.9% between 2009/10 and 2012/13.<sup>66</sup>

Inpatient provision is geographically very variable, and in 2014 some areas had no inpatient beds available within a 50 mile radius for children and young people needing some forms of mental health care.<sup>65</sup>

Parents and service users talk of 'battles' to access services and some young people wait more than a year to access specialist care for eating disorder services

Some areas have responded to this increased demand by raising referral thresholds or increasing waiting times.<sup>63</sup> Partial information from providers suggests that children and young people waited an average of 15 weeks for treatment in 2013, and less than 40% of areas offered expedited pathways for those in urgent need.<sup>67</sup> Parents and service users talk of 'battles' to access services,<sup>63</sup> and there are examples of young people waiting more than a year to access specialist care for eating disorder services.<sup>68</sup>

### Experience

There are no nationally available data on the experience of people using CAMHS services. However, there are recognised issues in some services being stigmatising and inaccessible to young people.<sup>62</sup>

### Outcomes

There are no nationally available data on the outcomes of care for CAMHS services. Some providers report reductions in quality over this parliament due to funding pressures,<sup>63</sup> and there is acknowledged inconsistent use of evidence-based treatment within services.<sup>69</sup>

## Conclusion

Historically, mental health services have been lower quality than those for physical health. They have had lower funding relative to need;<sup>70</sup> struggled to offer sufficient access to services,<sup>70</sup> and tended to focus on containment rather than recovery.<sup>71</sup> Despite improvements, these issues are still present, particularly for those with severe mental illness and for children and young people.

Significant gaps in data (particularly for CAMHS) mean there is not enough information to make an accurate judgement of the quality of mental health services (Figure 10). A national data collection for CAMHS is in development, due to go live by 2016,<sup>72</sup> meaning by 2017 reliable data on a number of measures should be available.

Figure 10: Availability of national information on mental health services

	Secondary adult mental health services	Primary adult mental health services: IAPT	Primary adult mental health services: general practice	Child and adolescent mental health services (CAMHS)
Access to services	National information available	National information available	National information available	Extremely limited national information available
Waiting times	Some national information available	National information available	Some national information available	No national information available
Outcomes	Some national information starting to be available	National information available	No national information available	No national information available
Service user experience	National information available	No national information available	Some national information available	No national information available

What information there is on quality in mental health services shows a declining picture outside of IAPT. Many recognise that mental health services have suffered from greater funding pressures than other areas of health care,<sup>63,73</sup> with a recent report suggesting funding has been cut by 8% (or £700m) during this parliament.<sup>74</sup> This is likely to have impacted on the availability of services.

Policy attention is now being paid to mental health, with well received initiatives such as the children and young people's IAPT programme, access standards from April 2015, and recent announcements of an extra £250m a year for mental health.<sup>75</sup> There is also a good cost-effectiveness case for many of the interventions currently in short supply,<sup>12,76,77</sup> and examples of good and improving services – including services taking more of a recovery focused approach.<sup>78</sup>

The question remains, however: will the current action go far enough? The next government will need to consider whether evolution or revolution is needed in mental health services.

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Errors or omissions remain the responsibility of the author alone.

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