CENTRE FOR MENTAL HEALTH

CARE BEYOND BEDS

Exploring alternatives to hospital-based mental health care

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CONTENTS

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We would like to express our immense gratitude to each and every person who took the time to participate in our interviews, workshops, and surveys. Your valuable input has helped us create this review, which is a reflection of your thoughts and priorities.

We are also extremely grateful for the literature and research that was shared with us to enhance our understanding of the complex mental health system and the people within it.

We would like to thank NHS England for commissioning this work and for their support and feedback throughout the project.

EXECUTIVE SUMMARY

"Can we be bold? Can we be radical? Can we really, really rethink things?" (System leader)

At their best, mental health services offer compassionate, relational care that responds to people's needs quickly, safely and effectively at every life stage. They seek to mitigate or heal traumas that people have experienced. And they work equitably by providing support that meets people's unique needs. In these instances, inpatient care is part of a comprehensive and holistic system of support that seeks, where possible, to provide care quickly and compassionately, at or close to home.

At their least effective, however, mental health services are fragmented and intervene late, not at earlier stages, nor in intermittent episodes of poor mental health after such a crisis. Inpatient care in particular is too often characterised by coercion and restriction, in environments that are not conducive to recovering from a mental health crisis. A stay in inpatient care can be traumatic in itself, and it may reflect wider patterns of discrimination and disempowerment in people's lives.

This report draws on qualitative research and a review of relevant literature, and finds that a radical overhaul of the system is required, with a reorientation to meeting people's needs far earlier, providing care closer to home, in settings that are familiar, therapeutic and accessible.

During the last five years, through the NHS Long Term Plan, work to expand and transform community mental health services for people of all ages has provided a vital stepping stone on the way towards better and more compassionate support. But there is more to do for children, adults, and older adults alike.

Whether we need more, fewer, or different inpatient beds may vary from place to place and types of provision. But it is clear that we need a much wider range of options, less reliance on inpatient services than today, and an end to the harmful and costly use of out-of-area placements.

VISION

With research participants we co-created this vision:

By 2030, mental health systems in England will be fully inclusive and embody compassionate, trauma-informed practices. Services and care will be non-discriminatory and person-centred, providing evidence-based, accessible and timely interventions for all individuals facing mental health challenges. Our commitment is to enable everyone to lead healthy, fulfilling lives and receive the care and support they need when they need it.

RECOMMENDATIONS

1. The Government should fund the NHS in England sufficiently to invest in further expansion of mental health support, to create comprehensive systems of care for people of all ages, and to enable a safe and sustained shift towards community-based services. This must include funding to boost local services so that out-of-area admissions are no longer necessary.

2. The Government and NHS England should ensure a fair share of NHS capital funding is dedicated to mental health services so that outdated facilities can be updated or replaced.

3. NHS England should give integrated care boards (ICBs) the freedom to reimagine, innovate and build systems of support that meet local needs, including the ability to distribute funding equitably across organisations within the system.

4. NHS England should create measures of patient experience and outcomes by which to hold providers and systems to account.

5. ICBs should redesign mental health care, shifting resources from traditional inpatient provision, and ensuring that services are codesigned with communities and responsive to all groups of people's needs.

6. ICBs and provider collaboratives should come together at place level with local authorities, voluntary, community and social enterprise (VCSE) sector organisations and other local agencies to develop an integrated offer for mental health and social care, where possible pooling resources across agencies so that people's needs (not organisational budgets) determine what, where and how care is provided. The aim should be to develop holistic, therapeutic services that meet people's mental and physical health needs in the context of their lives.

7. Providers should adopt trauma-informed principles, practices and environments in all mental health services, coproducing spaces that seek to mitigate and minimise trauma.

8. ICBs and providers should ensure VCSE organisations receive sufficient and secure funding to be long-term partners in service provision; not an adjunct to the mainstream, but a part of it.

9. ICBs and providers should commit to the Patient and Carer Race Equality Framework to create equitable provision of mental health inpatient and community care.

10. ICBs and providers should develop more, and more varied, peer support roles, either directly employed or via VCSE partners (or both).

INTRODUCTION

Centre for Mental Health was commissioned by NHS England to carry out research that supports a bold and radical vision for the future model of mental health support and services for people of all ages – including alternatives to inpatient care and accessible and appropriate care for people with complex needs, including autistic people and people with learning disabilities. NHS England's Mental Health, Learning Disability and Autism Quality Transformation programme consulted with hundreds of colleagues across the sector to agree its scope. The resounding ask from the system was to support the development of a "bold, reimagined model of care for the future". NHS England commissioned Centre for Mental Health to carry out research to support this ask.

RESEARCH METHODS

We have taken a broad and systemic approach to reviewing current models of mental health inpatient care and the vast and complex variants, stakeholders and processes within. The methodological approach drew strongly on qualitative research and coproduction processes in order to ground the review in rich data on the experiences of people seeking treatment and working within the current model.

The aim was not to carry out a systematic review; instead we prioritised listening to different people in order to learn from their experiences and knowledge. These contributors have been recruited from across the system, from different roles and levels of responsibility, from different geographies and demographics. A key goal has been to include both professionals and people with lived experience (of both acute mental health crises and long-term complex needs). We engaged over 100 people in these discussions and have combined the key themes and priorities which emerged within the report, including in the co-designed vision and directional statements.

Interviews

We conducted 30 interviews across different sectors and agencies, as well as with people with lived experience of mental health difficulties and complex needs, and with carers. Our questions took a broad approach, with open-ended questions enabling interviews to explore the barriers and strengths of the current mental health care system, the perceived purpose of the current model, and alternatives to inpatient care. Through the interview questions and subsequent analysis of the interview data, we identified stakeholder priorities and systemic changes needed to the current model.

Workshops

We facilitated a roundtable workshop with over 30 participants from across and within the system, in which we presented initial findings and gathered further insights around the data. We also began to coproduce the set of vision and directional statements as a tool for future action, shared understanding and collaboration. We also spoke with a group of 12 forensic mental health service users (who are part of a broader advisory group) over two sessions, where discussions covered their experiences, recommendations and contributions to the vision statement.

Survey

We carried out a survey to gather a wider still range of views while synthesising the findings from data and the initial drafts of the vision and directional statements. We received 33 survey responses, more than half of which were from people with lived experience of mental illness and complex needs.

Literature review

We conducted a literature review focused on five key areas of concern raised in the interviews. They were:

- Trauma and mental health services
- LGBTQ+ people's experiences of mental health care
- Autism
- Children and young people
- Alternatives to inpatient care.

The findings from this activity provided context for the primary data collection, especially in regard to existing evidence on experiences of inpatient psychiatric care with a focus on people with complex needs.

We also carried out a brief economic analysis of the costs of mental health inpatient care, and specifically of out-of-area hospital admissions.

HISTORICAL CONTEXT

This research was carried out at the conclusion of the five years of the NHS Long Term Plan. At the time of writing, a new ten-year health plan is being developed for England by the UK Government. It is nonetheless important to recognise what has come before in setting the scene for this report.

The focus of the Long Term Plan for mental health services was predominantly on community and primary care settings – for adults and children alike. This programme was one of many over recent decades aiming to improve both the quality and coverage of mental health services in England. Previous reform programmes saw the closure of the long-stay 'asylums', the development of community mental health services, and the creation of specialist services for groups with specific needs. Successive strategies have sought to improve crisis care, for example by investing in community services and fostering greater partnership working in local areas.

The history of these initiatives shows that large-scale change is possible in mental health care, but that resistance to reform, under-investment, and short-termism can be major barriers. When mental health services get the right investment for long enough, they can change significantly. But periods of austerity and policy drift can leave them vulnerable to disinvestment and inertia.

This suggests that with the right support, further change in mental health services is possible. Building on the Long Term Plan and its predecessors, a paradigm change can be achieved over the next decade in the role of inpatient services and their alternatives.

EVIDENCE FROM LITERATURE

The literature review explored the evolving landscape of mental health care, spotlighting both the strides and gaps in current practices within the UK and drawing inspiration from international success stories. It underscores the burgeoning motivation amongst health care providers to cultivate cultural competence – a move aimed at embracing the diverse needs of racialised communities, LGBTQ+ individuals, autistic people, and those with learning disabilities. While the foundation for a more inclusive and understanding approach to mental health crisis care is being laid, there is still a considerable journey towards fully embedding these practices into everyday mental health care scenarios, and concerning evidence remains about the traumatic impacts where these are not in place.

The review examined a range of alternatives to traditional inpatient care, spotlighting models and services that champion deinstitutionalisation and the destigmatisation of severe mental illness. Significantly, it highlights the role of peer-staffed crisis support, crisis cafes, houses and home treatment teams in reducing hospitalisations, though it also points to persisting challenges within inpatient settings, especially for people with complex needs where a deeper integration of trauma-informed knowledge and practice is essential. Encouragingly, various models from European countries with demographics akin to the UK demonstrate effective strategies for minimising the use of restrictive and coercive practices. However, the literature reveals substantial evidence gaps in evaluating alternatives to inpatient care, the need for more inclusive services tailored to specific mental health difficulties, and geographical variations in service availability.

POST-TRAUMATIC STRESS DISORDER AND TRAUMATISING EXPERIENCES

The literature review aimed to address identified knowledge gaps or areas of interest, which included the potential for inpatient psychiatric hospitalisation to cause or exacerbate complex post-traumatic stress disorder (PTSD) or complex PTSD (C-PTSD). The literature reveals that detentions under the Mental Health Act and community treatment orders (CTOs) are frequently traumatic, characterised by coercive practices and significant liberty deprivations. International studies underscore a high incidence of trauma among people who have been hospitalised, with poor practice contributing to the dehumanisation of patients, erosion of trust in mental health services, and adverse outcomes like deteriorating mental health or suicidality post-discharge.

Qualitative research points to a pervasive sense of mistrust and hopelessness among those with lived experience of being detained under mental health legislation, often linked to a perceived absence of preventative care. However, studies also highlight that the establishment of caring relationships, collaborative practices, and transparent information sharing can alleviate the adverse effects of coercive treatments (Bartl *et al*., 2024). In Ireland, for instance, initiatives such as staff training in person-centred care, consistent and clear communication, and a cultural shift towards minimising trauma have been implemented to address the impacts of involuntary hospitalisation (Health Service Executive, 2016). The variability in coercion and restraint levels across European nations further indicates that the traumatic potential of psychiatric hospitalisation can be mitigated through comprehensive systems, policies, and a committed shift towards more humane and empathic mental health care practices (O'Donovan *et al*., 2022).

The inevitably coercive nature of involuntary psychiatric hospitalisation is seen as a risk factor for PTSD and C-PTSD (Moth *et al*., 2018; Warrington, 2019; Martinaki *et al*., 2021). The high proportion of traumatic experiences is related to instances of forced medication, excessive restraint and even cases of systematic abuse of patients (Parksarian *et al*., 2014; Akther *et al*., 2019; Belcher, 2022; Jina-Pettersen, 2022; Thomas, 2022a; Thomas 2022b). In our research, we also heard patients describing their profound trauma associated with witnessing the violent and distressing behaviours of other patients, noting that such experiences could lead to mimicry in terms of self-harming practices. Additionally, the presence of male staff restraining women and girls was particularly triggering for those with a history of sexual abuse. This dynamic not only exacerbates patients' distress but also raises significant concerns about the sensitivity and appropriateness of the approaches used with vulnerable people in these settings.

Forward Thinking Birmingham collaboratively developed a 'wellbeing passport' (Goodyear, 2023) aimed at enhancing the continuity of care for young people accessing mental health services. This innovative approach is designed to mitigate the need for young people to repeatedly recount their personal histories, thereby improving communication about triggers and medication plans. Notably, this passport has been effective in diminishing the re-traumatising impact that can arise each time a young person is required to discuss their circumstances with a new professional or doesn't have their routines and preferences understood. Coproduced with input from the young people it serves, the passport features dedicated sections where they can document their experiences, identify crisis triggers, specify their preferred methods of communication, and provide crucial medication details, ensuring a more personalised and responsive care experience.

LGBTQ+ PEOPLE'S EXPERIENCES

Research has found that, across nations, LGBTQ+ individuals have an elevated risk of mental health difficulties and suicidality (Duffy, Henkel and Earnshaw, 2016; Mind and MindOut LGBTQ Mental Health Service, 2016; Plöderl *et al*., 2017; Bränström *et al*., 2018). This increased likelihood of experiencing a mental health problem has been plausibly linked to LGBTQ+ experiences of systemic stigma and discrimination (Perone, 2014; Mind and MindOut LGBTQ Mental Health Service, 2016). Additionally, adverse or traumatic experiences related to homophobia, transphobia or heterosexism, including those in psychiatric or other health care settings, will further exacerbate mental ill health and deepen health inequalities (Duffy *et al*., 2016; Plöderl *et al*., 2017; Bränström *et al*., 2018; Gizunterman *et al*., 2020). Inpatient psychiatric care delivered by staff who hold prejudice or lack knowledge on LGBTQ+ identity and experiences increase the risk of such adverse experiences.

For example, LGBTQ+ individuals have reported inpatient staff conflating struggles related to gender identity, sexuality or 'coming out' with symptoms of mental health difficulties in ways which were received as dismissive, insensitive or even abusive (Saw, 2017; Acosta *et al*., 2019; Barnes *et al*., 2021). Such experiences are particularly harmful given the long history of pathologising both sexualities and gender identities that fall outside cis-hetero norms and then subjecting LGBTQ+ individuals to unethical medical and psychiatric treatment (King and Bartlett, 1999; Smith, Bartlett and King, 2004; Perone, 2014).

Suggested strategies to improve the experiences of LGBTQ+ individuals include: correct use of names and pronouns and acknowledgement of mistakes; reduced assumptions, especially around heteronormativity (Fadus *et al*., 2020; Barnes *et al*., 2021; Mental Health Welfare Commission for Scotland and LGBT Health and Wellbeing, 2022); visual signalling of LGBTQ+ acceptance in the space; and inclusive, affirming communication including during (medical) history-taking (Mind and MindOut LGBTQ Mental Health Service, 2016; Saw, 2017; Acosta *et al*., 2019; Fadus *et al*., 2020).

AUTISTIC PEOPLE'S EXPERIENCES

Research indicates a significant prevalence of mental health difficulties among autistic people: estimates suggest between 54% and 94% may experience at least one mental health difficulty throughout their lives (Underwood *et al*., 2023). Approximately 70% of autistic people are likely to have a mental health difficulty such as anxiety, attention deficit hyperactivity disorder (ADHD), depression, or obsessive compulsive disorder (OCD), and about 40% of this group may face two or more such challenges. Often emerging in childhood, these conditions are frequently described as co-occurring or co-existing with autism (Bailey, 2022).

From limited data and with wide-ranging estimates, studies have reported that autistic people are overrepresented in inpatient psychiatric settings and that autism is more prevalent in inpatient psychiatric settings relative to community populations (Tromans *et al*., 2018). There have also been changes in the comparative numbers of autistic people (with no learning disability), and those with a learning disability only, who are in inpatient psychiatric settings. The number of the former increased by 19% from March 2017 to January 2022 and the number of the latter decreased by 39% in the same period (House of Lords Library, 2023).

The average length of a stay in inpatient psychiatric settings for autistic people is approximately 5.5 years. Autistic people may be subjected to such long stays due to a lack of suitable alternatives in mental health and social care to enable them to return to a community setting (National Autistic Society, 2023). This is despite the ongoing Transforming Care policy which for almost a decade has been attempting to reduce the hospitalisation of autistic people and people with learning disabilities and facilitate the discharge of those who have been subjected to protracted stays in hospitals and care homes.

Reportedly, more specialist psychiatric services or wards for autistic people are available in the UK than in other countries (Melvin *et al*., 2022) but a lack of any systematic approach to supporting autistic people in psychiatric hospitals is likely to be contributing to prolonged patient stays and excessive distress during treatment (Jones *et al*., 2021). The then Department of Health stated in 2015 that "compulsory treatment in a hospital setting is rarely likely to be helpful for a person with autism" (DoH 2015: para. 20.20, cited in Quinn *et al*., 2023).

Existing community services struggle to manage high-risk behaviours in some autistic people or those with intellectual disabilities, making it necessary to admit people to hospital and use the Mental Health Act. The proposed adjustments to the Act section 3 align with United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) principles, aiming to reduce lengthy hospital stays by emphasising the development of quality community care plans for this vulnerable population (Tromans *et al*., 2023). Centring care on individual preferences and engaging with their perspectives can refine mental health care, helping autistic people and people with intellectual disabilities thrive in their communities (Quinn *et al*., 2023).

A conflation of autistic traits and needs with the symptoms of mental health problems is another factor (Au-Yeung *et al*., 2019; Camm-Crosbie *et al*., 2019; Martini *et al*., 2022; Ribolsi *et al*., 2022). Misdiagnosis of autism as borderline personality disorder (especially among women) is thought to be a more common occurrence than existing data is able to explain (May *et al*., 2021; Belcher *et al*., 2023; Cheney *et al*., 2023; Engelbrecht and Bercovici, 2023). While late or misdiagnosis is known to have a negative impact on mental health, this has not been extensively covered in academic sources, appearing more often in qualitative or anecdotal accounts in the media (Moth *et al*., 2018; Choi, 2022; Mandy *et al*., 2022; Darling Rasmussen, 2023; Ghanouni and Seaker, 2023). Misdiagnosis could also be exacerbating existing high rates of depression among autistic women (Pugachevsky, 2023).

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

Children and young people's mental health services (CYPMHS) have for a long time been under-funded relative both to adult mental health care and other health services. Redressing this imbalance has been the focus of successive government and NHS-led strategies. They have sought to expand CYPMHS provision, reduce waiting times, and improve the quality of care available, including in inpatient services.

The impact of these strategies has been mixed. The children's mental health workforce has grown significantly since 2019 (NAO, 2023) and the New Care Models programme has been shown to reduce reliance on out-of-area hospital admissions (O'Shea, 2020). At Central and North West London NHS Foundation Trust, for example, this was implemented through the North West London New Model of Care (NMOC) youth mental health project. This initiative demonstrates the impact of collaboration between community services, inpatient clinical staff, and local treatment providers. Over a four-year period, the project has achieved notable outcomes, including a 66% decrease in youth out-of-area patient beds, a 28% reduction in admissions, and substantial budget savings. These savings have been reinvested into enhancing community services (Tolmac *et al*., 2021).

Nationwide, however, demand for children's mental health care has risen sharply since 2020 in particular, meaning that attempts to facilitate earlier and speedier access to support have been less successful (NAO, 2023).

In 2023, data from the NHS Benchmarking Network showed that 38% of children and young people received treatment within four weeks of referral but 27% waited over 18 weeks (Bell, 2024). Additionally, 78% of all children who were referred to mental health services were accepted in 2023 (ibid).

According to the Care Quality Commission's analysis of NHS data, in 2021/22, children and young people experienced an average 40-day wait for mental health treatment, with open referrals peaking at nearly 497,000 by November 2023 (Care Quality Commission, 2024). However this is area-dependant and we have heard first hand accounts of 2-11 year waiting periods for neurodevelopmental assessments, and 12-18 months or more for mental health support.

During this waiting time, there is significant concern that children and young people's mental health deteriorates. YoungMinds' analysis of NHS data found that over half of children and young people's conditions worsened in the waiting period, with record highs of under-18s being reported to mental health crisis teams (YoungMinds, 2023; Care Quality Commission, 2024).

"11 years it took me to get him his diagnosis, and by then he was in mainstream school, the cracks had started to show [...] but he was actually developing a panic disorder. [...] age 12, he tried to kill himself. [...] he had a mental health breakdown, had school trauma and historical unmet needs [...] CAMHS weren't interested. I got him to a Tier 4 hospital, [...] they basically saved his life." (Parent-carer of an autistic young person)

Data about children and young people's inpatient services shows a steady but significant shift over the last few years, with fewer but longer admissions to hospital. According to NHS England's Mental Health Dashboard (NHS England, 2024), in 2018/19, there were 4,657 admissions to hospital for children aged 0-17 years in England; by 2023/24, this number had fallen to 2,268. During the same period, however, average lengths of stay in hospital rose from 95 days to 129. Notably, over the last year, bed occupancy rates for children and young people were consistently between 60-70%, far below the 90% plus observed in adult acute wards.

ALTERNATIVES TO INPATIENT CARE

UK and international alternatives to psychiatric hospitalisation include: home-based treatment or crisis teams (Johnson *et al*., 2022; Pugachevsky, 2023), peer-staffed programmes (Bouchery *et al*., 2018; Johnson *et al*., 2022), acute day units (Heekeren *et al*., 2020; Johnson *et al*., 2022), telephone support (Johnson *et al*., 2022), crisis houses and community residential alternatives (Mosher, 1999; Johnson *et al*., 2022).

Preventative interventions can divert some people from the need for inpatient care or those alternatives listed above, alongside the primary benefit of alleviating distressing symptoms and experiences of mental ill health.

Of many interventions which have been tested, only a few have shown clear evidence of reducing the risk of admission to hospital, including crisis planning and self-management interventions (Centre for Mental Health, 2019). Across five trials of crisis planning interventions (or 'advance choice documents'), compulsory admissions for people with bipolar disorder or psychosis were reduced by an average 25% (Molyneaux *et al*., 2019). In contrast, evidence shows that crisis resolution teams – an 'in the moment' rather than preventative alternative – do not impact the risk of detention but do reduce overall risk of being admitted to hospital (Centre for Mental Health, 2019).

Maintaining evidence bases for both alternative and preventative approaches is challenging, especially as services change their delivery models over time (Rojas-García *et al*., 2023). For instance, while trials have demonstrated the impact of crisis planning interventions, further evidence is needed to show which components, with what content and intensity, contribute to that impact (Molyneaux *et al*., 2019).

In another example, home treatment is linked to the broader goals of deinstitutionalisation and destigmatisation of mental illness, with numerous trials and reviews suggesting it can reduce inpatient service usage, enhance clinical outcomes, improve patient care experiences, and lower costs. However, a 2016 survey highlighted significant variations in response times by crisis resolution and home treatment teams in England, and recent organisational changes have led to the separation of crisis assessment and home treatment into distinct teams in over a third of English health care regions, with no studies yet comparing the effectiveness of split versus integrated models (Johnson *et al*., 2022).

ECONOMIC ANALYSIS

Mental ill health carries an economic and social cost of £300 billion a year in England (Cardoso and McHayle, 2024). Statutory mental health services cost a very small proportion of that, at just under £14 billion in 2023/24. This spending on mental health was forecast to be 9.0% of all recurrent NHS spending in 2023/24 (compared to a forecast of 8.9% made in January 2023) (UK Parliament: Hansard, 2024). The National Audit Office's report on progress in improving mental health services (NAO, 2023) identified that spending on community-based mental health services is similar to that on inpatient services – they each account for about half of all spending, even though the vast majority of people access their support through community settings.

A significant proportion of NHS mental health inpatient care spending is in the independent sector, especially for more specialised services. In 2019, market analysts LaingBuisson reported that the UK independent mental health hospitals market grew by 4.1% in 2018, with the NHS funding 90% of hospital places at that time and four top providers holding a market share of 65% (LaingBuisson, 2019).

Staffing shortages, especially among mental health nurses, are also reported to be critical, as 30% will reach retirement age in the next five years (Financial Times, 2024). For CYPMHS alone, the number of children and young people in contact with services has expanded since 2016, at over three and a half times the pace of the psychiatry workforce (BMA, 2024). Inability to meet demand places huge strain on practitioner and management workforces, pushing many trusts to rely on the private sector and incur growing costs.

According to calculations by the Financial Times (2024) based on NHS England reporting on monthly costs and FOI requests, NHS mental health trust spending on private out-of-area beds in England is 43% higher than it was five years ago, reaching a record level. The Royal College of Psychiatrists recommends a limit on bed occupancy of 85%, but in the second quarter of 2023/24 more than 75% of mental health trusts surpassed this limit, compared to 63% of trusts in 2017/2018 (Royal College of Psychiatrists, n.d.; Future Care Capital, 2024). While these pressures have been felt across systems, some trusts are spending notably high amounts on overspill capacity. In Northamptonshire, for example, mental health placements have been over full capacity since 2021, with the trust spending £3.6m in the first eight months of 2023 compared to a total spend of £1.8m in 2019 (Future Care Capital, 2024).

Similarly, the South London and Maudsley Foundation Trust spent £3.1m between April 2022 and January 2023 on bed and breakfast rooms to ease pressure on hospital spaces (Future Care Capital, 2023). In the 2022/2023 financial year, the trust was reported to have spent £7m on private sector mental health inpatient beds, exceeding its planned budget for this overspill capacity by £6.4m. Board papers also showed that the trust had seen 1,356 private overspill occupied bed days at the time of reporting in the 2022/2023 financial year (Future Care Capital, 2023).

VIEWS AND EXPERIENCES OF RESEARCH PARTICIPANTS

In the following sections we present the findings from the qualitative research. We have included quotations from a range of participants to illustrate the themes that emerged from what people told us.

STRENGTHS IN THE CURRENT SYSTEM

Participants identified strengths in the current system, including the underpinning ethos of the NHS and other public sector bodies, and their commitment to providing services that meet the needs of local people. The commitment and compassion of workers across the sector remain its biggest assets, despite the impact of Covid-19, not least on NHS staff.

Recent developments – including the establishment of integrated care boards, system-wide planning and coordinated resourcing of services – are making differences in a number of places. In some, there is evident commitment to coproduction and codesign with people with lived experience and their families, where voluntary, community and social enterprise (VCSE) sector organisations are helping to identify approaches and deliver services, and where innovation is being nurtured, piloted, and rolled out.

There are examples of good practice, such as those captured in a recent guidance document (NHS England, 2023) which showcases where developments have had impact, and from which other systems can learn. These include examples where pathways have been revised in close discussion with people with lived experience, and where VCSE sector organisations have workers in A&E departments to support people (including children and their families) when they present in crisis and have no alternative axes of support. Crisis cafes and crisis houses – which support people with complex needs for whom hospitalisation would be inappropriate but rapid and specialist support is needed – are being evaluated across the country and showing promise. These, and other examples, are discussed in the 'Developing alternative models and settings' section (see page 21).

PEOPLE'S LIVED EXPERIENCE OF MENTAL HEALTH SERVICES

"I only had severe depression and anxiety. I came out with PTSD" (Patient)

The experiences people shared with us varied, depending on the quality of the services they had used, and the support they had received in periods of both poor and good health. It was also dependent on what is accessible locally: what resources, collaborations, commissioning and criteria are in effect.

"Every time I have been admitted and then released 'back into the community', you have to start all over again. You have been institutionalised, by the routine and semi-structure of hospital life. You have to pick up the pieces and come to terms and recover from having been in one of the most scariest and traumatic environments ever. Once returned to 'normal life' there is a different level of care for patients." (Person with lived experience)

Participants' experiences of inpatient services were not positive. They described mental health services in general as fragmented, difficult to navigate and under-resourced. Strikingly, many wards are not fit for purpose and are ill-equipped to deliver good quality care. Some participants talked about their experiences of wards with mouse infestations and faeces on floors and walls.

There was much criticism of the inadequacy of current inpatient services, primarily in relation to people not feeling safe. But responses also reflected a pervasive sense of monotony, marked by uninspiring settings and a scant selection of activities which can contribute to a detrimental environment. Add to this a lack of genuine therapeutic intervention, there are valid concerns that current inpatient services may in fact be exacerbating people's mental illness and complex needs.

"You can't reinforce a state of feeling safe or wanting to open up, or wanting to engage with these services or enter into a practice of self love, because you're in a state of fight or flight." (Patient)

A common theme was that of (re)traumatisation, where people's experiences of being in hospital were disturbing, and brought up intense feelings of despair and, on occasion, suicidality – within the confines of the ward and on return home. Coercion, restraint, and overuse of sedation were discussed at length. These experiences were in opposition to expectations that the hospital would keep them safe, provide respite, and support recovery. For children, there were numerous safeguarding issues that arose on wards, including neglect and abuse.

Criticisms of overly medicalised approaches were frequently discussed, noting that being mindful of the role of social factors, such as friendships and safe housing, is essential in helping individuals to stabilise and experience better health over the long term.

Of particular concern is the use of out-of-area placements, which take people far from home in moments of disorientation and distress, for indeterminate lengths of time. This separates individuals from their friends and families, impeding regular contact, and making maintaining relationships, so key to recovery and re-entry into everyday life, difficult.

"It's what leaves people damaged a lot longer, because it makes you not want to work with services (in your recovery journey)" (Patient)

Figure 1: The impact of delayed interventions on mental health and NHS budgets

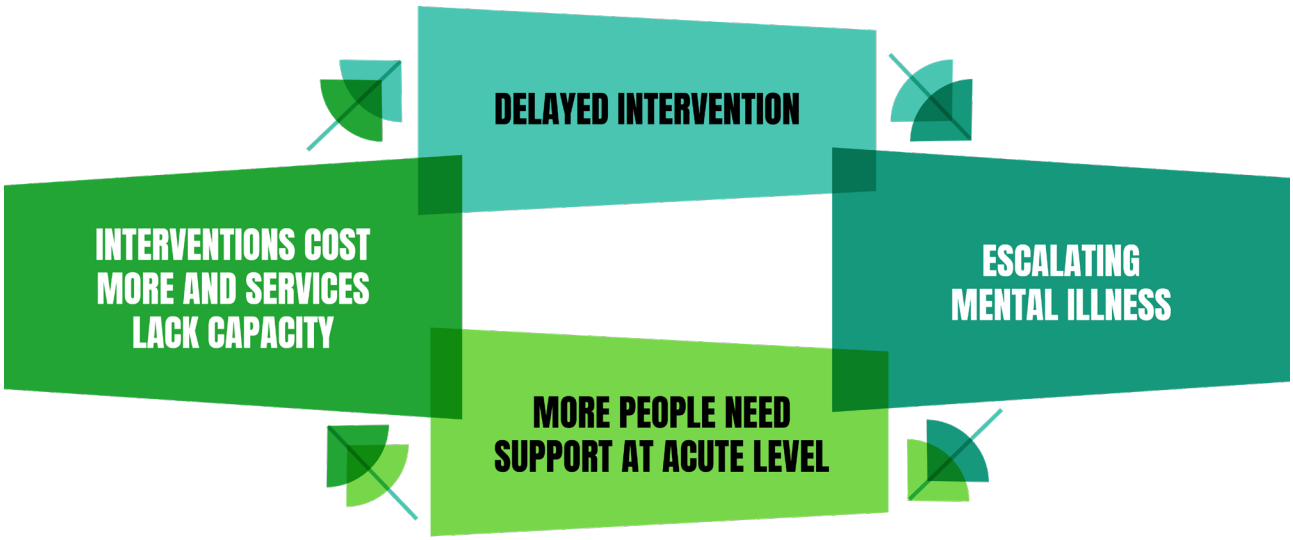
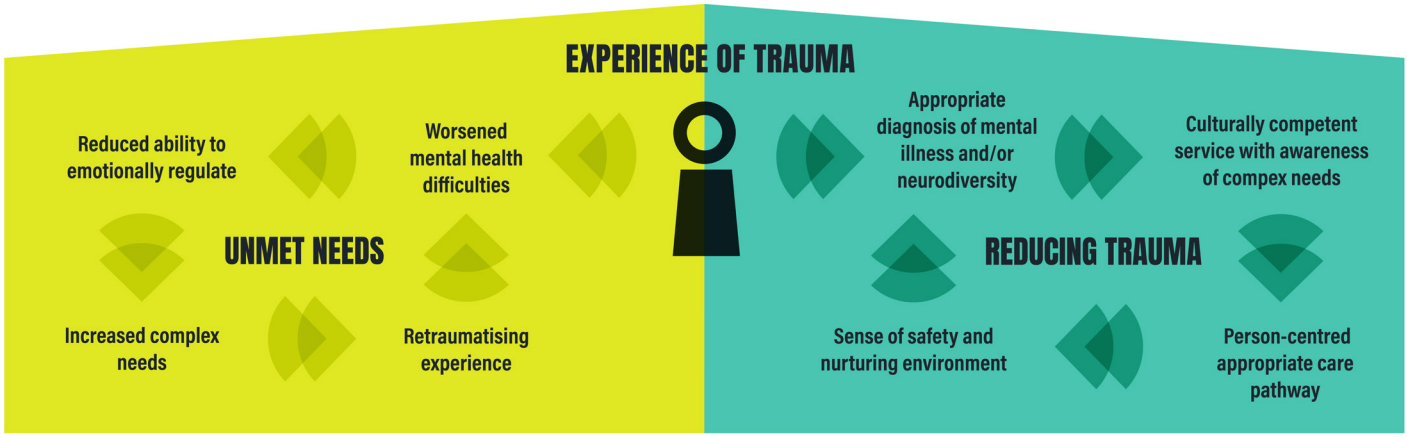


Figure 1 details what happens when there is a delay, or indeed a complete lack of appropriate intervention, which can increase the severity of someone's mental illness. This also leads to higher costs for the NHS in acute care and beds, and can be costly to the person, their family and the state if it leads to a loss of livelihood and income for them and their carers. Figure 2 explores this in the context of trauma and complex needs, including those relating to 'personality disorder' diagnoses and autism.

Figure 2: The impact of trauma and unmet complex needs, and how person-centred care can reduce trauma



EQUITY

Poverty and other associated factors, such as poor housing and unemployment, give rise to high levels of mental health problems in more deprived areas. Similarly, unstable housing and the challenges of the cost-of-living crisis create obstacles for people with a mental illness who are seeking to get their lives back on track after a period of ill health.

Racism and other forms of discrimination, such as homophobia and transphobia, cause poor mental health, yet services are often inaccessible and stigma-laden for people from minoritised and marginalised communities. Participants spoke particularly about the over-representation of men from racialised communities in hospital.

People from racialised communities often encounter significant barriers in accessing mental health support, facing a greater risk of being subjected to involuntary psychiatric interventions, including detention under the Mental Health Act. A notable shortfall within the current system is its inability to fully embrace and integrate culturally sensitive practices, failing to cater to the varied cultural nuances that influence wellbeing. For instance, understanding the cultural importance of a Black woman's hair or the comfort derived from specific dietary preferences can significantly impact a person's mental health journey.

Intergenerational trauma and a profound mistrust of statutory services, driven by experiences of systemic racism, exacerbate these challenges. Such factors not only detrimentally impact the mental health of people from racialised communities but also shape their interactions with the mental health system. Fear and scepticism towards these services often result in delayed or foregone treatment and an increased likelihood of being sectioned, adding to the cycle of mistrust and coercive care.

Additional barriers may relate to language, culture, and religious practice, which services do not often take into account when communicating with people with lived experience or when planning services and interventions. The extent to which services and staff provide appropriate support or tailoring related to specific languages, cultures and religious practices is also shaped by factors including systemic racism.

Addressing these experiences of inequality requires the mental health system to not only enhance its delivery of culturally appropriate advocacy but also to confront and mitigate the effects of systemic racism head-on. Acknowledging and tackling these underlying issues are vital steps in fostering trust, offering compassionate and effective care, and ultimately refining the mental health system to better serve racially diverse and marginalised groups, who are disproportionately impacted by these systemic flaws.

Organisations such as Adira, a survivor-led mental health and wellbeing organisation supporting Black people with mental health difficulties, feel they:

> **"have the answers, and they have shared them multiple times over the past 12 years. Adira have created a service that is culturally appropriate and competent in helping people from the black community to manage and improve their mental health. Through this service, Adira have prevented numerous people from entering inpatient care, going to prison or the cemetery, in turn saving the NHS considerable money."** (Statement from Adira)

It was reported that for young transgender people, clinicians sometimes mistakenly see their desire to address the incongruence of their gender as a mental health problem in itself, rather than seeking to properly understand how the exclusion and discrimination (and oftentimes violence) that they experience contribute to their poor mental health.

Neurodivergent people face multiple challenges, as noted in the literature review, including the risk of misdiagnosis (e.g. autism being misread as a 'personality disorder') and a lack of personalised treatment. Autistic people and those with intellectual disabilities can also face challenges while in hospital; participants spoke about worryingly long stays in testing circumstances. While ward-based routines might bring welcome structure, for people who are sensitive to sensory overload, the noise and bright lights of a hospital can be difficult to tolerate – as too can the changes in routine and the lack of awareness relating to such triggers. There is an evident need to support and understand emotional regulation, with some feeling that people are over-medicated which can prevent progress and healthy expression.

SYSTEMIC CHALLENGES

> **"We're offering people a model of care that doesn't work, and we're spending so much money on it. And we don't have enough money to meet all of the needs that we want to meet. […] So we've got a huge opportunity to think really radically differently about how we might use that resource to better meet people's needs."** (System leader)

Participants explored the systemic reasons why the current model of mental health care isn't working for so many people. The overall challenge for systems nationwide is that demand is outstripping supply. Waiting lists are long, assessment processes are elongated, and early discharge is sometimes evident. These phenomena, which squeeze either end of the patient journey, can exacerbate poor mental health and put a greater burden on people and their families. Early intervention and flexible options to access support could enable people to manage better and, on occasion, stave off future episodes of poor health.

From the perspective of colleagues working in mental health services in both public and VCSE sector organisations, integrated care boards and the systems they direct have a long way to go to improve outcomes for people with lived experience. The hand-off points between organisations – for example primary care and social care – are not sufficiently well aligned, especially in the transition for young people and their families from children's to adults' services, which can be disruptive to longstanding relationships and rupture trust between people and the services they use. The incompatibility of IT systems is flagged as a notable challenge, not least when facilitating communication about individuals' needs and care plans between NHS and VCSE sector organisations.

Financial barriers

Local budgets are stretched, which makes delivering even the most basic of services challenging on occasion. The role of out-of-area placements was much discussed in this regard. We were told multiple times of mental health trusts spending up to 80% of their budgets on private beds, and consequently restricting investment in local community-based services, despite widespread belief that they would be beneficial.

"I will always be buying [beds] and that's costing me far more, twice as much as it would cost me if I ran them myself." (CEO of a mental health trust)

People told us they are concerned by the NHS's approach to capital investment, feeling it can be a barrier. Private sector businesses have the advantage of securing funding for capital projects based on their commercial viability. In contrast, the NHS faces limitations in funding allocation, even if the clinical case for investment is compelling. This can lead to missed opportunities for improving clinical outcomes, and limits the expansion and improvement of facilities, potentially affecting the quality of care provided.

Local systems are fragmented because partner organisations, despite making commitments to collaborate and integrate services, are subject to unexpected reductions in funding, or have to take remedial actions to address longstanding cost pressures. The sometimes-rapid changes in organisational priorities and available resources, notably in local authorities, can have seismic impacts on system-wide plans. This leaves people with lived experience in difficult situations as they struggle to adapt to changes and reductions in available support.

"Everyone is fighting for the same pots of funding in the voluntary sector. You can do pilots, [...] but can't continue because there's no funding. [...] it's not going to the right places. The grassroot organisations are becoming burnt out [...] they don't have data and impact reports, they can't get the funding. No one is benefitting." (Senior manager, VCSE sector)

Workforce challenges

Mental health inpatient services face very significant workforce challenges, with high sickness and vacancy rates, and notably less multidisciplinary skill mix than for community mental health services. These were raised repeatedly during our research interviews and focus groups.

Staff, despite working hard, and seeking to make the best from a system under pressure, are struggling to meet the demands upon them. Psychiatrists, nurses, therapists and others report challenges in maintaining the safety of patients when working in poorly maintained and understaffed workplaces. Participants reported high levels of burnout and post-pandemic exhaustion. Clinicians and others with experience, knowledge and skills are leaving in large numbers.

There are significant challenges in replacing colleagues when they leave, which brings additional pressures on teams forced to constantly reprioritise and, on occasion, revise thresholds for support. Training is a major issue, as services are struggling to recruit staff with sufficient skills or to train new and existing staff to work in new ways, for example in mental health law, the use of alternatives to restraint, new medications, or technologies. The high costs of agency staff, brought in to keep services safe, are a significant drain on small budgets.

Barriers to establishing alternatives to inpatient care

Efforts are being made by the VCSE sector, some mental health trusts, ICBs, and social care where budgets permit, to support localised care. The aim is to centre such care around the person, supporting them and their networks to access local, integrated services. Successful examples of this include crisis resolution and home treatment teams. These are not a new part of the mental health system, but one that people feel is beneficial, if they have enough resources. Participants believed, however, that these teams are currently hugely overstretched and burning out, in turn delaying earlier intervention and local care.

> **"We need more interventions supporting the system supporting that child or young person. Interventions for families, parents and carers, parents and family systems, the care system, education and that includes looked after care, criminal justice, seeing children in the context of the system they're in."** (Children and young people's clinician)

There is concern about the lack of evidence base for many mental health interventions, especially alternatives to inpatient care, including crisis houses and cafes.

Alternatives to inpatient care are too often described as experimental, varying widely between localities, and lacking a strategic approach to achieve a significant level of diversion from inpatient care. The absence of a strategic approach is attributed to potentially high costs (including 'double running' while alternatives get established but existing services cannot yet be reduced) and the need for a sound evidence base to secure long-term funding.

> **"I think that's just the NHS, which isn't really ready, it isn't best placed to be coming up with a model to work specifically with mental health and probably neither is adult social care, but bits of them are, [...] there needs to be a specific organisation which would be like an ICB [...] with other people contributing to it as well."** (Head of service development at a mental health trust)

WHAT A BETTER SYSTEM OF CARE WOULD LOOK LIKE

Participants called for a determined and sustained move away from instilling fear to inspiring hope. To succeed, there has to be a commitment to building a shared understanding of trauma and its effects, and the role of services in alleviating them. In parallel, there need to be efforts to make services more aware of and attuned to the needs of racialised, marginalised and minoritised communities and groups.

People of all ages need to be able to easily access a safe rehabilitative environment that serves as a reset when experiencing a mental health crisis. We spoke to one children and young people's service lead who acknowledged the negative connotations associated with traditional rehabilitation, but stressed the importance of providing a therapeutic space for those who require mental health support. This is not limited to children and young people, and a choice to access safe and compassionate respite spaces will continue to be needed, particularly for women and those without supportive networks.

Hospitals are one of the options for respite, rehabilitation and reset, and need to be focused on enabling people back into the community with the tools and support required to be active citizens.

The importance of re-enablement and the need for a process that helps people to transition to independent living after being discharged from a hospital is critical. Much focus is required in step-down care with continued access to integrated, local mental health support. There is however a significant gap in this type of provision, which can hinder individuals' ability to successfully reintegrate into society.

Localised and joined-up care

Support networks and familiar surroundings are often a major part of supporting a person's mental health and ongoing management of their mental illness. Of course, not everyone has positive support networks; many may indeed have the opposite. But there is still a need for familiar surroundings, particularly at a time when the world appears so terrifying and unrecognisable.

"Get more early intervention and more higher tier support before they get into crisis" (Parent-carer)

It was suggested that integrated care pathways need to be able to better support fluctuating mental health and illness, with lower thresholds for intervention, and an open door process, providing swift and inclusive routes back into acute care if needed. Many of our participants said they would like to be able to return for a respite stay if they needed it, but feared this was not possible or could lead to them getting stuck in inpatient care. They would like services to have a greater focus on re-integration back into communities, with fulfilling and effective pathways to increase citizenship and wellbeing. This would include a variety of paid peer support roles and training, and employment support, using the evidence-based Individual Placement and Support (IPS) approach.

"Prioritise love and money, not just pills and monitoring" (Service manager at a mental health trust)

The role of ICBs

At the time of our research, ICBs and partnerships were in their infancy, and participants were not all clear about their roles and purpose. But there was consensus that they needed to feature greater representation of people with lived experience of using mental health services to make better decisions about the types of support needed.

"The role of the integrated care board and integrated care partnerships are an opportunity to build on and address some of the fragmentation, we do have some more funding coming into children's mental health. It's how we utilise that kind of funding [...] how do we share our resources? How can we end up with a more joint narrative of what the issues are and what the solutions are?" (Children and young people's psychiatrist)

The tension here lies primarily between the conceptual ideal of integrated care systems and the practical challenges they face in implementation. On one hand, there's a clear recognition of the need for these systems to incorporate the voices of those with lived experience, aiming to tailor services more closely to actual needs. Yet on the other hand, these integrated care boards and partnerships describe themselves as being constrained by national policies that limit their operational autonomy, hindering their ability to innovate, collaborate with other sectors and respond to local priorities.

Participants believed such policies restricted how far systems could really innovate. But they also described feeling that the lack of specifically earmarked funding for mental health services exacerbates this tension, as it challenges the ability of these entities to prioritise and allocate resources effectively to meet local needs. This situation creates a paradox where the goals of integrated care – to provide tailored, localised services – are undermined by structural limitations and funding practices that do not align with these objectives, highlighting a significant gap between the envisioned benefits of integrated care models and the realities of their implementation.

"We need an integrated commissioning framework to encourage ICBs, ICPs and provider collaboratives to integrate in their commissioning models [...] and be really clear about what good looks like." (Clinical director)

DEVELOPING ALTERNATIVE MODELS AND SETTINGS

The National Institute for Health and Care Research (NIHR) Mental Health Policy Research Unit (MHPRU) funded a recent study which mapped alternatives to inpatient mental health care and a brief summary of who accesses them (Griffiths *et al*., 2023). However, they found evidence of inequitable access, something we have also heard, especially affecting "people who are compulsorily detained, younger children and young people transitioning between children's and adult services" (ibid).

We also found that people with complex needs, including autism, intellectual disabilities, addictions and homelessness, were often unable to access certain alternatives to inpatient services due to the multiplicity of their needs and a lack of staff capacity and expertise to accommodate them.

Many of the alternatives are promising, but greater investment and piloting is needed to deliver robust evaluations which can determine the effectiveness of different treatment approaches.

"We need to measure what matters, and use the science we have about the early warning signs of closed culture to drive what people and families want and need." (System leader)

There is clear consensus that a person-centred approach is vital in recovery and fulfilled living, which requires multiple care options, catering for people in varying degrees of crisis, recovery and fluctuating mental health issues. The next step is to widen the availability, equity and inclusiveness of these alternative services so that anyone, regardless of background or financial situation, has a menu of effective options to support the breadth and complexity of need.

The VCSE sector are often more trusted (particularly by people who have faced systemic discrimination in mainstream support) and are significant providers of many of these alternative interventions. To fulfil this role, they need more, and more reliable, funding to be able to provide support longer term within local systems.

"Increase the influence and power of service users, so they define what constitutes quality. Give service user groups a large chunk of the commissioning budget to spend on services they value." (Patient advocate)

Alternatives to inpatient care have a more flexible approach to service access. Cross-setting models such as Clubhouse International (Clubhouse International, n.d.) or Trieste (Council of Europe, 2023) have a more fluid, open-door approach, as too do crisis cafes. People are able to drop in, or attain specialist support, through much lower thresholds.

Table 1 outlines various priorities highlighted as being important in alternative care, along with examples and characteristics that have been shared with us during the review. This is not an exhaustive list and is meant to illustrate the range of options, characteristics and examples of effective alternative modalities, that could in combination create a more systemic approach to reducing reliance on inpatient care. The primary aim of these alternatives is to prevent hospitalisation in acute psychiatric settings and reduce the need for prolonged and traumatising stays in A&E. Many also offer ongoing access to support fluctuations in mental health and an open-door approach that allows people to access extra support after a crisis if needed.

Table 1: Examples and characteristics of effective alternatives to acute inpatient care

(drawn from interviews; Council of Europe, 2023; Drayton Park Women's Crisis House, n.d.; STRM, MtOTAS and Essex Family Forum, 2023; Mental Illness Recovery – Clubhouse International, n.d.; Griffiths *et al*., 2023)

Priority	Good practice characteristics	Examples of service providers
Accessible to neurodivergent children, young people and adults	▪ Small groups ▪ 1:1 support ▪ Different types of talking therapies ▪ Providing activities in relation to specialist interest as a means of engaging adults, children and young people. ▪ Flexible to people, children and families' needs in their current domestic situations ▪ Some offer support even before a diagnosis or crisis, and offer ongoing mental health support ▪ Online support ▪ Family/carer support including support and information packs (STRM *et al*., 2023) ▪ Can act as stepping stone to other therapies and services and offer signposting and advice ▪ Safe and nurturing environment and awareness of potential triggers ▪ Cultural competence among staff ▪ Open-door approach.	Emotional Dysregulation in Autism Send the Right Message (STRM) Essex Family Forum
Bridge to community and citizenship	▪ Attention to re-integration and step-down care ▪ Offer a connection to the community while in hospital ▪ Supporting employment pathways such as opportunities with companies and paid peer support roles ▪ Bring people who have been in inpatient facilities for extended periods back to their local area and provide them with intensive wrap-around support.	Bethlem Gallery Community Rehabilitation Enhanced Support Teams (Crest)

Open access community and citizenship	As above, plus: ▪ Non-coercive means of support, avoiding restraint ▪ Open-door approach ▪ Family and community involvement ▪ Treated like a respected citizen.	Trieste model Hope services
Peer support models	▪ Peer support check-ins and contact ▪ Shared experience ▪ Person-centred.	Leeds Survivor Led Crisis Service
Local and community settings such as crisis cafes	▪ Drop in ▪ 1:1 and group support ▪ Therapeutic ▪ Trauma-informed ▪ Cultural competence ▪ Safe and nurturing environments ▪ Refreshments and activities as means of engagement and support ▪ Access to other services and resources ▪ Person centred and flexible ▪ Coproduced decisions between staff and members.	The Circle Mosaic Clubhouse
Crisis houses	▪ Short-term residential in a homely setting ▪ Therapeutic ▪ Voluntary admission ▪ Focus on respite ▪ Prioritise early intervention, crisis support and safety ▪ Intermediary support between home and hospitalisation ▪ 24/7 care.	Oasis House Maytree
Treatment at home and in the community	▪ Home treatment teams ▪ Mental health foster care placements ▪ Crisis phone lines and support ▪ Integrated support ▪ Person-centred ▪ Collaborative working between sectors and agencies ▪ Family and carers' involvement.	Central and North West London NHS Foundation Trust

Women-only facilities	▪ Cultural competence ▪ Residential ▪ Ongoing support (group work, workshops) ▪ Trauma-informed.	Drayton Park Women's Crisis House and resource centre
Assessments and care	▪ Early interventions ▪ Arts-based activities ▪ Local and integrated care ▪ Person-centred ▪ Safe, inclusive and accessible environments ▪ Access to community mental health teams (with enough capacity and funds) ▪ Advanced care planning ▪ 24-hour crisis support lines.	
Collaboration and alliances	▪ Representing various key actors, including people with lived experience, different sectors and expertise ▪ Active listening in relation to local contexts and priorities ▪ Taking on commissioning decisions for mental health funding ▪ Collective approach to shared decision-making.	Lambeth Living Well Collaborative and Alliance Wakefield Mental Health Alliance

COPRODUCED VISION AND DIRECTIONAL STATEMENTS

> **"I would love a world where the people who pay for and use our services are actually the ones who design and hold the budget and commission the services. [...] the experiment of clinical commissioning I think has kind of failed, not because it was the wrong thing, but it's the same, nothing changed. It was managers who did a lot of it because clinicians are busy being clinicians a lot of the time."** (Strategic director)

Crafting vision and directional statements provides clarity, guides decision-making, promotes accountability, and enhances engagement. We coproduced a vision and directional statements as part of the research to pool the knowledge of the participants and build consensus about what needs to change, and how.

There was a general consensus that mental health support needs to focus on relational approaches and delivery. People felt this was where trust could be built, trauma could be reduced and a greater understanding of effective and desirable support could be achieved, particularly where a range of people are involved in the coproduction of care plans.

The vision and directional statements we coproduced apply to all age and diagnostic groups as principles that can be used to inform future service development and improvement.

VISION

By 2030, mental health systems in England will be fully inclusive and embody compassionate, trauma-informed practices. Services and care will be non-discriminatory and person-centred, providing evidence-based, accessible and timely interventions for all individuals facing mental health challenges. Our commitment is to enable everyone to lead healthy, fulfilling lives and receive the care and support they need when they need it.

DIRECTIONAL STATEMENTS

1. All people with mental health challenges and their carers will find easy and equitable access to support and services, responsive and flexible to individual needs – including health, social care, housing, legal and community support, employment and education – with culturally competent approaches, welcoming, well-resourced, respectful and safe environments, as well as being, essentially, close to where they live.

2. All people with mental health challenges will be fully supported and actively engaged as experts in a respectful way to collaboratively develop and implement personalised and positive approaches, where the individual has all the choice possible to improve the challenges they face with agency and in an atmosphere of transparency.

3. All people with mental health challenges, their families, carers, peer supporters and all services and staff who work with them will have clear and honest communication and share an understanding of the impact an individual's trauma has on their daily life. Professionals will actively listen to ways to reduce and prevent further traumatic experiences through collaborative, therapeutic, safe and trauma informed care.

4. Mental health systems will be characterised by meaningful collaboration that will embrace well-resourced, transformative coproduction approaches. These systems will value shared power and a diversity of voices and decision makers to build meaningful, trusted, and respectful relationships among commissioners, councils, social care, community and mental health services, housing, people with mental health challenges, their families, and carers. By doing so, we can improve local priorities and integrated care, and make a positive impact in the lives of those who need it most.

5. In pursuit of shared goals, with joined up, collaborative working and support across services, all sectors – voluntary and community, public, and private – will provide person centred care on behalf of, and with people with mental health challenges to prevent declining mental health. They will intervene early, as well as offering information about legal rights, crisis-related help, longer-term care, and rehabilitation.

6. A focus on ensuring sustainable and equitable funding to the levels and sectors will enable services to proactively meet the full range of mental health support of the population, enabling them to effectively respond early to emerging concerns and accurate diagnosis, as well as being available to provide support in preventative, urgent, or crisis situations.

CONCLUSIONS

This report draws on a series of interviews and workshops with people who have personal or professional experience of mental health inpatient services in England. With an additional review of literature in some key areas of concern, and a brief economic analysis of the current system, it sets out the scale of the challenge facing mental health services in England to modernise their inpatient provision and expand the range of preventive and alternative interventions.

ASSETS TO BUILD ON

Over the last five years in particular, focused investment has brought about an expansion of community mental health services for adults and children. More people than ever are using mental health services in England (NAO, 2023) and the NHS mental health workforce is growing once again as a result of the additional investment.

The inclusion of mental health practitioners in schools and primary care services has the potential to increase earlier intervention and make mental health services more accessible to the broader population.

The commitment and compassion of mental health staff, dedicated to supporting individuals' recovery and enabling them to lead fulfilling lives, is at the heart of the mental health system, and the new Government's pledge to expand the mental health workforce holds promise for the much needed improvements to longstanding staffing challenges.

The indispensable role of VCSE mental health organisations remains paramount, as they strive to fill service gaps and provide timely support wherever possible. Improvements are happening, with more focus on the need for collaboration across sectors and agencies.

The formation of provider collaboratives and cross-sector alliance contracts represents a significant opportunity to improve the navigation of what can all too often be a fragmented mental health system.

Covid-19 also highlighted effective examples of crisis support that showcased what is possible when adaptability is promoted (and permitted). This includes the establishment of crisis assessment wards adjacent to A&E departments, offering individuals a calmer environment for assessment during times of crisis. This adaptability not only provided immediate support but also illustrated the potential for future improvements in crisis management within the mental health sector. However, funding ceased and many of these initiatives have since closed.

THE NEED FOR SYSTEMIC CHANGE

Over the same period, inpatient services have been the focus of quality improvement work, but remain largely unchanged. After a long history of reductions in the number of inpatient mental health beds over many decades, numbers have stabilised in recent years. Yet concerns continue about the workforce for mental health inpatient services, with high vacancy and sickness absence rates, particularly among nurses. And while revenue funding for NHS mental health services has grown since 2019, capital funding is poorly distributed and mental health trusts have not received a fair share of resources to repair or replace an estate which is disproportionately outdated and ill-equipped to meet people's needs.

The views and experiences shared with us for this report provide a vivid picture of the consequences of this inertia. With data showing that inpatient mental health services in England have high occupancy rates – well over recommended safe levels – and long lengths of stay by international comparisons, it is clear that the system is under enormous pressure.

Small-scale, incremental improvement will not be enough to create the systemic change needed to offer people safe, therapeutic and compassionate care when they most need it. A paradigm shift is needed. Without it, people will still be at risk of hospital admissions far from home, in closed institutions, for long periods, dislocated from families and friends. Services will struggle to find beds when they are needed urgently, relying on overcrowded wards that fall short of 21st century standards of a therapeutic environment. And the risks will continue to be borne disproportionately by Black people, by neurodivergent people, by the poorest and most marginalised, and by children and young people, with massive impacts on future generations and ongoing costs to society.

THE CHALLENGE FOR THE NEXT FIVE YEARS

Recent investment in community mental health care and alternative crisis services is an important start. While a dramatic rise in referrals has overwhelmed services since 2020, the job that began with the Long Term Plan must be sustained beyond this year, so that community mental health services are better able to meet more people's needs more of the time. The NHS in England has made impressive progress at a difficult time, which needs to continue as demand keeps rising. This is vital to reduce reliance on inpatient services: both by preventing crises from happening in the first place and by offering alternative places to get help when a crisis does occur, while having sufficient beds available where and when they are required.

The option of an inpatient bed may always be needed to keep people safe at times; as long as it is close to home, adequately staffed, and of a high quality. But for many people, there may be alternatives, either to stay at home or to receive care in an intermediate space. And when people do need inpatient care, it should be for as short a period as possible, in an environment that is safe, therapeutic, trauma-informed, affirming, culturally appropriate, and conducive to compassionate care and evidence-based treatment.

Making this possible requires systemic change, and investment in both the estate and the workforce. It means replacing outdated facilities with modern spaces that are inclusive, open, and wherever possible outward-looking. It means building and nurturing a multi-disciplinary workforce, with alliances between health, social care, housing, and VCSE sector organisations to provide people with the right support for them.

The next five years could be an opportunity to engender that systemic change. With the right investment and a clear message that staying still is not an option, integrated care boards have the power to build better systems of support that will reduce reliance on hospital beds, taking the pressure off local inpatient services and making out-of-area placements unnecessary.

RECOMMENDATIONS

1. The Government should fund the NHS in England sufficiently to invest in further expansion of mental health support, to create comprehensive systems of care for people of all ages, and to enable a safe and sustained shift towards community-based services. This must include funding to boost local services so that out-of-area admissions are no longer necessary.
2. The Government and NHS England should ensure a fair share of NHS capital funding is dedicated to mental health services so that outdated facilities can be updated or replaced.
3. NHS England should give integrated care boards (ICBs) the freedom to reimagine, innovate and build systems of support that meet local needs, including the ability to distribute funding equitably across organisations within the system.
4. NHS England should create measures of patient experience and outcomes by which to hold providers and systems to account.
5. ICBs should redesign mental health care, shifting resources from traditional inpatient provision, and ensuring that services are codesigned with communities and responsive to all groups of people's needs.
6. ICBs and provider collaboratives should come together at place level with local authorities, voluntary, community and social enterprise (VCSE) sector organisations and other local agencies to develop an integrated offer for mental health and social care, where possible pooling resources across agencies so that people's needs (not organisational budgets) determine what, where and how care is provided. The aim should be to develop holistic, therapeutic services that meet people's mental and physical health needs in the context of their lives.
7. Providers should adopt trauma-informed principles, practices and environments in all mental health services, coproducing spaces that seek to mitigate and minimise trauma.
8. ICBs and providers should ensure VCSE organisations receive sufficient and secure funding to be long-term partners in service provision; not an adjunct to the mainstream, but a part of it.
9. ICBs and providers should commit to the Patient and Carer Race Equality Framework to create equitable provision of mental health inpatient and community care.
10. ICBs and providers should develop more, and more varied, peer support roles, either directly employed or via VCSE partners (or both).

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