

BMA

Lost in transit?
Funding for mental health
services in England



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Summary

Over recent years, welcome commitments have been made to increased funding for mental health services. There are concerns, however, that this is not reaching frontline services. This briefing explores the funding of mental health services in England – as well as looking at overall funding, it examines the funding of perinatal mental health services, CAMHS (Child and Adolescent Mental Health Services) and psychological therapies.

Overall funding for mental health services

Despite some geographical variation, there appears to be no obvious uplift in spending in recent years. Many CCGs (clinical commissioning groups) across England are either maintaining or decreasing current spending levels and a significant number are not meeting the Mental Health Investment Standard set out by NHS England. Data from FOI (Freedom of Information) requests indicate that half of CCGs plan to decrease their spending on mental health services this year. At the same time, various indicators show the mental health sector is under increasing pressure.

Perinatal mental health services

Despite the high prevalence rate of perinatal mental health problems, the provision of perinatal services has been poor. In 2014, fewer than 15% of CCGs provided services at the recommended level and around 40% of CCGs provided no service at all. As a result of ring-fenced funding commitments, tangible improvements to the provision of perinatal mental health services in England have been realised, though service provision remains far from optimal.

CAMHS

Data from FOI requests show that many CCGs are not increasing their spending on CAMHS. In a 2017 BMA survey of CAMHS professionals, 91% of respondents felt that CAMHS is poorly funded, and 58% felt that changes to CAMHS funding levels had made them less able to do their job.

Psychological therapies

FOI requests found that just over a quarter of CCGs and only half of mental health trusts are increasing their real-terms spending on psychological therapies. When comparing spending between IAPT (Increasing Access to Psychological Therapies) services and psychological therapies in secondary care, the majority (83% of CCGs and 64% of trusts) spent more on the former than on the latter. This reflects concerns that IAPT services are being prioritised over the commissioning of psychological therapies in secondary care.

Key areas for action:

- The Government should increase funding for mental health services to more closely match the burden of disease of mental health problems in England. Other commitments to mental health, such as expansion of the mental health workforce, also need to be adequately funded.
- The Mental Health Dashboard should be expanded to include spending on other crucial services, and local authorities should publish their spending on promoting public mental health.
- CCGs must meet the Mental Health Investment Standard. Those who are failing to do so should be required to produce robust spending plans, and be provided with extra support.
- Measures should be taken to ensure that funding committed to mental health is only spent on mental health services, particularly where provision is poor. This may be achieved by ring-fencing funding where necessary.

Introduction

Doctors have repeatedly raised concern about the state of mental health services and the need to improve outcomes for their patients with mental health problems. Highlighted in the 2017 BMA briefing *Breaking down barriers – the challenge of improving mental health outcomes*, there are a range of multi-factorial reasons why the mental health sector is unable to provide the same standard of care as physical health. Insufficient funding for mental health services is one of the most significant barriers that limits doctors' ability to provide optimal mental health care to their patients.

Historically, mental health has been chronically underfunded as it has not had the same level of political prioritisation as physical health care. Recent years have seen an increased commitment to parity of esteem (PoE) for mental health in England, supported by commitments to increased funding. Despite these welcome commitments, there are concerns that in some areas this funding is not reaching frontline mental health services. The impact of this is seen across the country, where there is continued evidence of variations in the quality of care, and patients unable to access the care they need in a timely way.

This briefing investigates how adequately mental health services are being funded overall, whether this has changed in line with recent funding commitments, and the impact on service provision. There are a range of settings in which mental health care is delivered, but this briefing brings together data^a specifically on perinatal mental health services, CAMHS and psychological therapies; exploring any variation in how these services are funded.

The mental health sector under pressure

Before looking at mental health funding, it is useful to consider recent changes in demand and service provision.

- QOF (Quality and Outcomes Framework) data show that the prevalence rate of depression increased from 7.3% in 2014/15 to 8.3% in 2015/16,¹ to 9.1% in 2016/17.²
- NHS Digital data show a 44% increase in patients in contact with mental health and learning disability services at some point in the year, between 2014/15³ and 2016/17.⁴
- A 2017 BMA FOI request found that between 2014/15 and 2016/17, 79% of trusts increased their number of out-of-area placements;^b some by as much as eight times.⁵ Over the same time period, there was a significant decrease in inpatient beds by 13%, with the bed occupancy rate increasing.⁶

These indicators show the pressure being placed upon mental health services. Any lack of increased investment in mental health therefore cannot be seen as a rational response to a reduction in demand. Although there are some complexities in analysing overall mental health spending, there does appear to be a lack of transparency about how much and where mental health funding is being spent.

a It is important to be aware of several limitations with the data analysed throughout this briefing. There are gaps and inconsistencies in how spending has been recorded (eg the Mental Health Dashboard only began in 2016; prior to this, data is based on trust accounts from those which data could be obtained) which makes it difficult to directly compare data from different sources and years. For data obtained from FOI requests, this will not be fully representative depending on the response rate, and there will be variation in how different organisations collect the data.

b An 'out-of-area placement' for acute mental health in-patient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services.

How are mental health services in England funded overall?

Over recent years, there has been renewed political focus on mental health care, with various funding commitments being made.

Box 1 – Funding commitments to mental health services

2013/14 – NHS England developed a programme with a set of commitments to promote parity of esteem. One of the commitments was that CCGs should increase their mental health spending in real terms^c, by at least the same proportion as their overall budget increase (PoE funding commitment).⁷

March 2015 – as part of the Spring Budget, the Chancellor announced an extra £1.25 billion to help children and young people, and expectant or new mothers, with mental health problems.⁸

November 2015 – as part of the Autumn spending review, the Chancellor announced an extra £600 million for mental health, with the intention of significantly more people accessing talking therapies every year by 2020.⁹

January 2016 – in a keynote speech, then prime minister David Cameron announced an extra £1 billion for mental health care by 2021,¹⁰ to deliver the Five Year Forward View for Mental Health^d, including:

- £290 million to provide specialist perinatal care to mothers before and after having their babies
- Nearly £250 million for liaison mental health services in hospital emergency departments
- Over £400 million to enable 24/7 treatment in communities, as a safe and effective alternative to hospital

February 2016 – NHS England published the Five Year Forward View for Mental Health,¹¹ which recommended that NHS England and the Department of Health should continue to require CCGs to meet the PoE funding commitment. This commitment was introduced as the 'Mental Health Investment Standard' in the NHS Operational Planning and Contracting Guidance published in September 2016.¹²

January 2017 – in a charity speech, prime minister Theresa May announced an extra £15 million for community mental health care.¹³

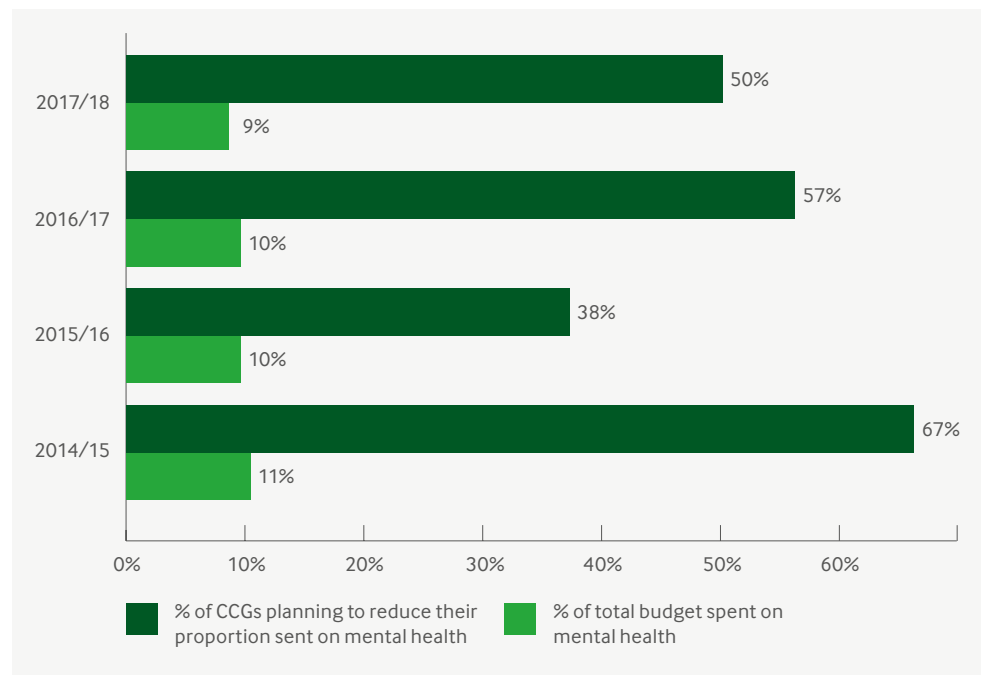
c Real terms means that it has taken into account inflation, enabling direct comparison between values. Nominal terms means that it has not taken into account inflation.

d Formed in March 2015, the independent Mental Health Taskforce brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England.

Given these commitments, the mental health sector should be seeing an uplift in funding. Determining whether this is the case is challenging, due to complexity in tracking how mental health funding filters from budget allocations, to frontline services.^e Data from various sources broadly illustrate levels of funding for mental health services.

- The Mental Health Dashboard^f shows that NHS England’s actual spend on mental health was 12.5% of their total CCG budget in 2015/16, and 12.7% in 2016/17.¹⁴
- A FOI request¹⁵ from the Shadow Minister for Mental Health, Luciana Berger, found that, on average, CCGs spent 11% of their total budget on mental health in 2014/15, 10% of their total budget in 2015/16 and 2016/17, and planned to spend 9% in their 2017/18 budget (see **figure 1**).
- According to the same FOI request, in 2015/16, 38% of CCGs planned to decrease their proportion of mental health spending. In 2016/17, more than half (57%) of CCGs planned to decrease it, and in 2017/18, half of CCGs plan to decrease it (see **figure 1**).

Figure 1 – CCGs’ spending on mental health since 2014/15 (based on FOI requests)



The percentage of CCGs planning to reduce mental health spending as a proportion of overall spending, and the average percentage of their total budget CCGs spent on mental health, between the financial years 2014/15 and 2017/18. Based on a series of FOI requests.

- Analysis of mental health trust annual accounts demonstrates that between 2013/14 and 2015/16, around 40% of mental health trusts saw year-on-year reductions to their income.¹⁶
- An NHS Providers survey of 58 mental health trusts found that only 52% reported receiving a real-terms increase in funding in 2015/16.¹⁷
- Data from the Mental Health Dashboard show that between 2015/16 and 2016/17, 22% of CCG’s spending plans did not meet the PoE funding commitment, with there being wide regional variation.⁷

e Broadly speaking, funding from the Department of Health is given to 211 CCGs, with a certain amount allocated for mental health. CCGs commission all mental health services, (including IAPT), by paying providers in mainly block contracts. 41 foundation trusts and 20 mental health NHS trusts provide about 80% of all mental health services, the rest is provided by third sector and private organisations.

f The Mental Health Five Year Forward View Dashboard, published in October 2016, is a response to the recommendation in the Five Year Forward View for Mental Health that NHS England create a tool that identifies metrics for monitoring key performance and outcomes data, to hold national and local bodies to account.

Despite the new funding commitments, and some geographical variation, there appears to be no obvious uplift in spending, or clarity around how the committed funding is being spent. It seems that many CCGs across England are either spending the same proportion of their budget on mental health, or decreasing it; with many not meeting the PoE funding commitment set out by NHS England. There also seems to be a discrepancy between spending data from the Mental Health Dashboard and from FOI requests. These discrepancies could be attributed to mental health funding not being ring-fenced (see **box 2**), meaning that not all the funding that CCGs plan to spend on mental health, is spent on it.

Box 2 – Ring-fencing

Mental health funding generally has not been ring-fenced, which means that it could have been diverted for purposes other than mental health. The NHS being under significant financial pressure increases the likelihood of funding being diverted to balance finances, including paying off deficits. For example, the King's Fund has suggested that mental health funding may have been diverted to pay off large deficits in the acute sector (in 2015/16, 88% of acute trusts were in deficit compared to 55% of mental health trusts.) This suggestion is supported by the fact that 77% of acute trusts saw an increase^g in their operating income, compared to 60% of mental health trusts.¹⁶

Perinatal mental health services

During pregnancy or in the first year after childbirth, one in five mothers experiences a mental health problem.¹⁸ Furthermore, suicide is the leading cause of death for women during this period.¹⁹ Despite the high prevalence rate of perinatal mental health problems, perinatal mental health services have, until very recently, received little attention.

In 2014, around 40% of CCGs provided no perinatal service at all. The remaining CCGs had mixed provision of services, for example with one specialist psychiatrist or nurse in the locality. Fewer than 15%²⁰ of CCGs provided specialist perinatal mental health services at the full level recommended in NICE guidance,²¹ which requires having sufficient specialised perinatal community teams and the provision of MBUs (mother and baby units). In 2015, there were 15 MBUs across England, with a maximum of 12 beds each.²² Without an MBU, mothers requiring inpatient mental health care may have to be admitted to adult psychiatric wards where they risk being separated from their babies. This can be further damaging to the mother's mental health, and can have serious effects on the mother-infant relationship.²³

In response to this poor provision, some significant commitments were made to improving perinatal mental health care.

Box 3 – Funding commitments to perinatal mental health services in England

March 2015 – as part of the £1.25 billion promised in the 2015 Spring Budget (see **box 1**), the Chancellor announced that perinatal mental health services would receive £75 million by 2020.

August 2016 – as part of the funding to deliver the Five Year Forward View for Mental Health, NHS England announced a total of £290 million additional funding to perinatal mental health services to be released over a five-year period until 2020/21. With this extra funding NHS England committed to providing treatment to 30,000 more women each year.

August 2016 – NHS England launched a £5 million Perinatal Community Services Development Fund, increasing to £15 million in 2017 and to £40 million in 2018. CCGs, NHS trusts, foundation trusts and STP (sustainability and transformation plan) footprints were all invited to apply for this funding.²⁴

^g It is unclear whether this is in real or nominal terms.

As a result of these commitments, tangible improvements to the provision of perinatal mental health services in England have been realised, compared to pre-2015.

- Since March 2017, work has begun on building four new MBUs in the North West, South East, South West and East Anglia, each with 8 specialist beds.²⁵
- Perinatal mental health bed numbers are increasing within the pre-existing 15 MBUs, to increase capacity by 49%.
- There are 20 new or expanded specialist perinatal mental health teams.²⁶
- A total of 20 proposals have been selected for Wave 1 of the Perinatal Community Services Development Fund, covering 90 CCGs, six STP footprints and the four NHS England regions. With £40 million allocated, these areas are widening the reach of their services and improving their resources to treat more women.²⁷

This success can be largely explained by the funding being ring-fenced. This is one of the only examples of mental health funding being ring-fenced for a specific purpose within a specific time-frame.

Despite the visible improvements to perinatal mental health coverage, provision is still far from optimal. This is due to the very low baseline from which the expansion started, as a result of historic under-resourcing. For example, a 2017 survey²⁸ by RCOG (Royal College of Obstetricians and Gynaecologists) and the MMHA (Maternal Mental Health Alliance) found:

- Only 7% of the women who reported experiencing a perinatal mental health problem were referred to specialist care.
- For 38% of the women who were referred, it took over four weeks to be seen, with some waiting up to a year for treatment.
- Perinatal care across the country is still inconsistent, with a 20% difference in referral rates in some areas.
- The type of care received also varies, with only 8% of women being referred to specialist care in one area, compared to 50% in another.

The survey did however report some improvement in the number of women being asked about their mental wellbeing in the last five years. Only 8% of women who had given birth in the last year were not asked about their mental wellbeing by any healthcare professional, compared with 24% of women who gave birth 4-5 years ago.

The planned release of funding for perinatal mental health in 2020/21 should result in further improvements in provision. According to *Implementing the Five Year Forward View for Mental Health*, perinatal mental health will receive investments of £73.5 million and £98 million in 2019/20 and 2020/21 respectively.²⁹ However, this funding will form part of CCG baseline allocations, and as such will not be ring-fenced as previously. This raises the concern that the extra investment may not be used entirely for expanding perinatal provision and improving frontline services. It will therefore be important to closely monitor the progress of the expansion of perinatal provision throughout this period.

CAMHS

CAMHS has been made a priority in recent years, with substantial commitments to funding. In the 2015 Spring Budget, the Chancellor pledged an extra £1.4 billion over a five-year period. This amounts to an extra £250 million a year over the next five years, a 35% increase on the £700 million which was previously spent each year on these services.³⁰

As shown in **box 1**, in 2014, a PoE funding commitment was made by NHS England for CCGs to increase their mental health spending in real terms by at least the same proportion as their overall budget increase. An FOI request³¹ carried out by the charity YoungMinds investigated whether CCGs were meeting this commitment with regards to spending on CAMHS (to which 199 of 211 CCGs responded).

- In the first year of extra funding (2015/16), 36% of CCGs increased their CAMHS spending by as much as their overall budget increase. This increased to half in the second year of funding (2016/17).
- Between 2015/16 and 2016/17, 35% of the CCGs that responded either spent the same amount or decreased their CAMHS spending.

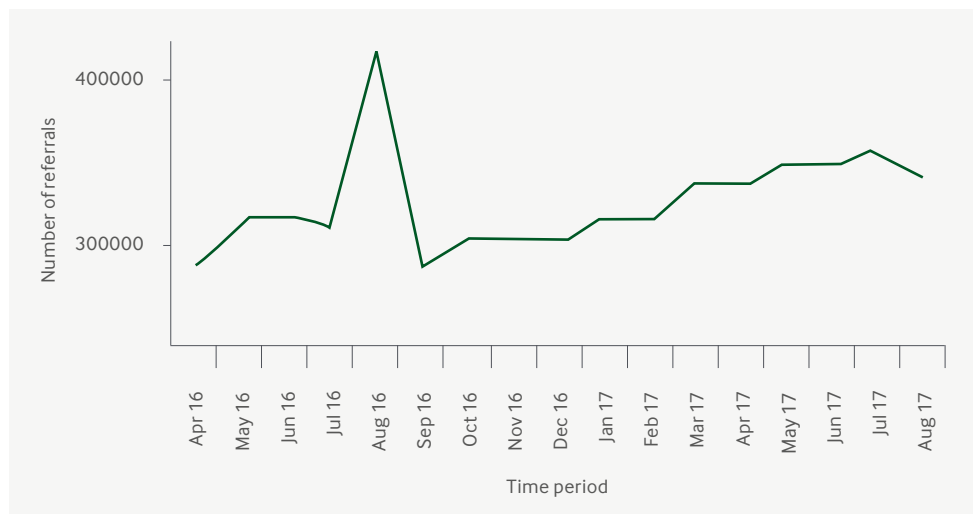
These data show a positive increase between 2015 and 2017, in the number of CCGs meeting the PoE funding commitment (from 36% to 50%). However, many CCGs are still not meeting the commitment, or increasing their spending at all. These CCGs may be using some or all the extra CAMHS funding to spend on other priorities, as discussed in **box 2**.

CAMHS struggling to meet demand

Data on referrals and admissions provide insight into how well resourced CAMHS is, in meeting demand for its services.

- Between 2012/13 and 2014/15, NHS Benchmarking Review data for CAMHS show a 64% increase in referrals (comparable data for 2016/17 are not available.) The same data indicate that the average maximum waiting time for a routine appointment in 2014/15 was 26 weeks, which had more than doubled since 2011/12. The data also show the number of children being admitted to A&E for a mental health problem more than doubled during this period.³²
- Between April 2016 and August 2017, NHS Digital data show an 18% increase in active CAMHS referrals.³³

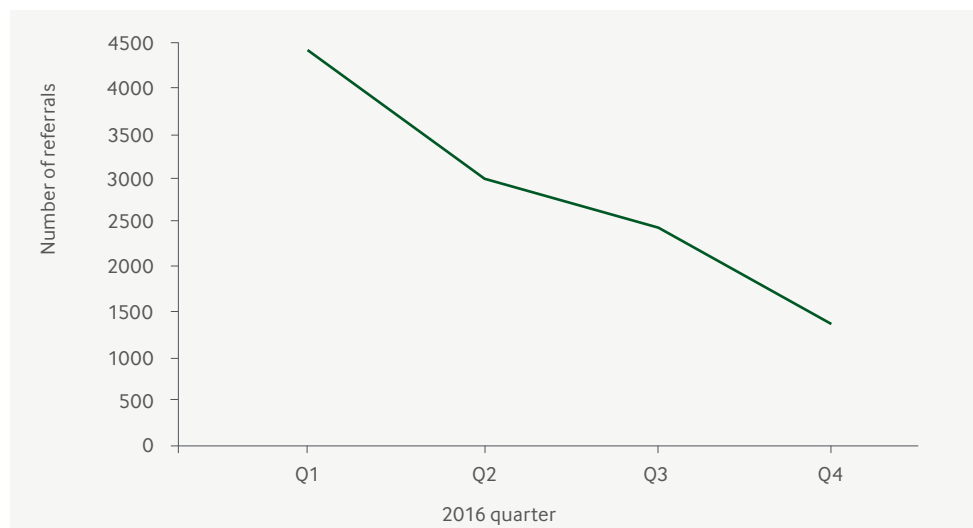
Figure 2 – Active referrals to CAMHS in 2016/17



The number of referrals to CAMHS services, according to NHS Digital data for April 2016 to August 2017.

- During the same time period, the Mental Health Dashboard shows a sharp decrease in admissions to tier 4 CAMHS,¹⁴ which are inpatient placements for children and young people requiring highly specialised care (see **figure 3**).

Figure 3 – CAMHS admissions in 2016



Number of admissions of children and young people into tier 4 CAMHS, during the four quarters of 2016. Based on data from the Mental Health Dashboard.

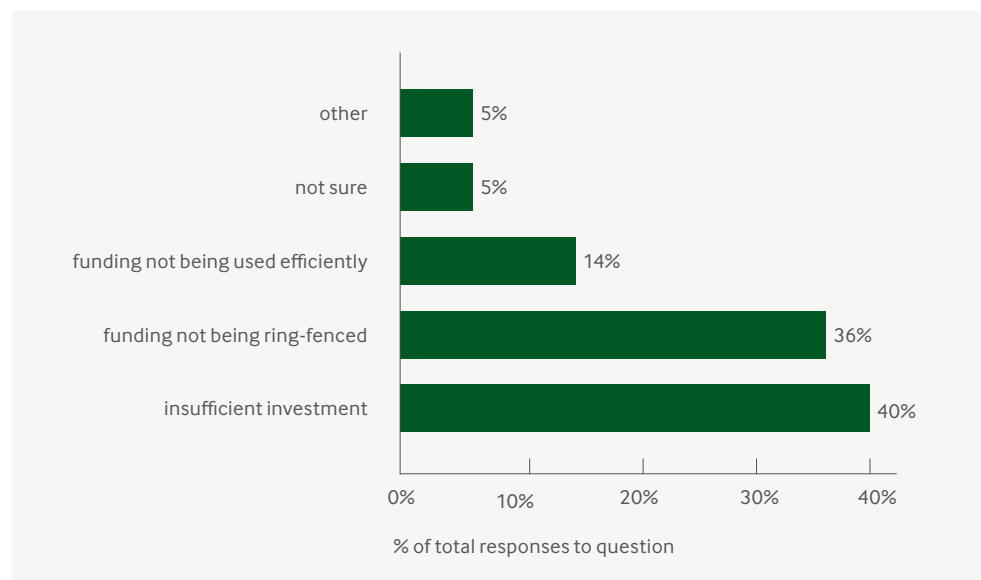
These data show a steady increase in referrals between 2011/12 and 2014/15, and between 2016 and 2017. Increased waiting times and A&E admissions are indicators of the service being under significant pressure, struggling to meet demand. The decrease in CAMHS tier 4 admissions suggests that more children and young people are receiving specialist treatment in the community. This may be because there are not enough specialist beds, and also because treating people in the community is less expensive than in hospital. It may also indicate an increase in referral thresholds, with CCGs prioritising those with the highest levels of need.

Survey of CAMHS professionals

A 2017 BMA survey of CAMHS professionals investigated how well they felt their place of work is funded, and how the recent funding commitments are impacting service provision. The survey had 243 responses.

- 91% felt that CAMHS is currently poorly funded, with the main reasons being insufficient investment, funding not being ring-fenced, and funding not being used efficiently.

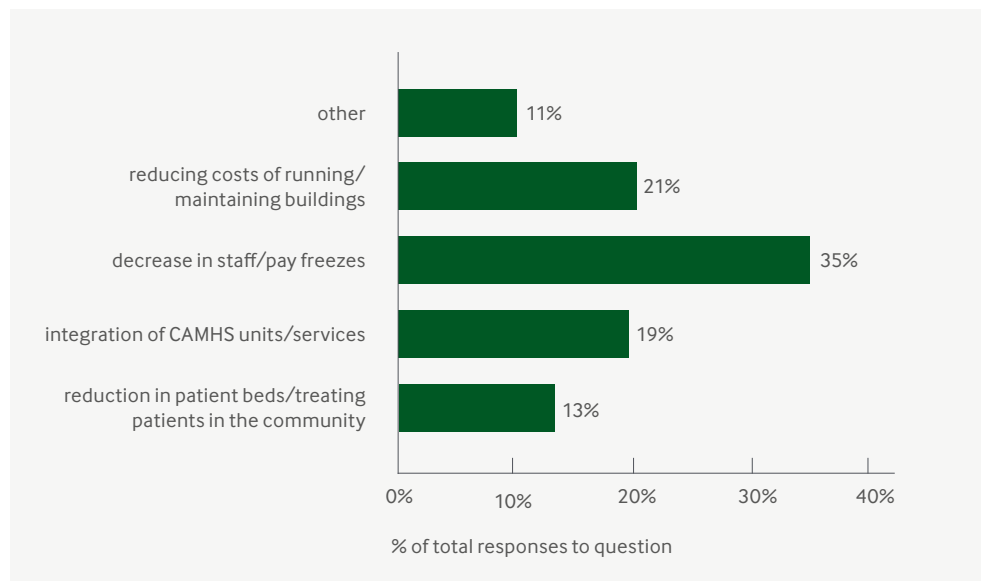
Figure 4 – Reasons why CAMHS is poorly funded



Results of a survey of CAMHS professionals, when asked about why CAMHS is poorly funded. Participants were able to select multiple options, the graph is expressed as a percentage of the total responses received.

- The majority felt that the lack of funding was caused by CCG's underinvestment.
- Just over a third of respondents felt that the new funding in 2015/16 was having **no impact** on frontline services. Just under a third felt it was having a **slightly positive impact**.
- 31% of respondents felt that the level of CAMHS funding had **substantially decreased** since 2015/16. In contrast, 28% felt it had **slightly increased**, showing some geographical variation, but no perceived major uplift in funding.
- 58% of respondents felt that changes to CAMHS funding levels had made them **less able** to do their job. The main reasons stated for this were: having insufficient capacity and resource, major staff shortages and an inability to cope with an increased number of referrals.
- Respondents felt that a decrease in staff/pay freezes was the main way in which costs had been cut.

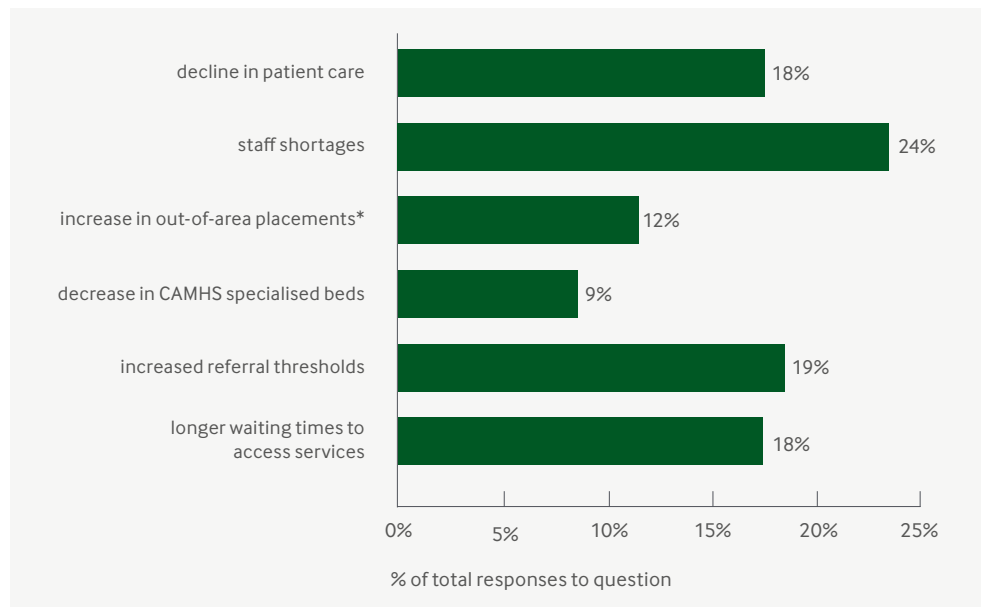
Figure 5 – Mechanisms of cutting costs across CAMHS



Results of a survey of CAMHS professionals, when asked about any ways their place of work had cut costs. Participants were able to select multiple options, the graph is expressed as a percentage of the total responses received.

- 45% of respondents thought cutting costs had caused a **decline in service provision**. 31% thought it had resulted in **improved service provision in some areas/a decline in others**.
- They reported the main reasons for a decline in service provision being staff shortages, increased referral thresholds and a decline in patient care^h.

Figure 6 – Reasons for decline in CAMHS service provision



*including placements in adult psychiatric wards/in general paediatric wards.

Results of a survey of CAMHS professionals, when asked about why there had been a decline a service provision, due to changes in funding levels. Participants were able to select multiple options, and the graph is expressed as a percentage of the total responses received.

^h ie not having quick access to a range of evidence-based services, including VCS (voluntary and community sector) services, not having holistic care, feeling stigmatised.

These survey results reflect concerns that CAMHS is underfunded, and that the new funding commitments in 2015/16 are not having the intended positive impact on frontline services. The findings support the notion that despite the new funding commitments, cuts are being made across the service, with many respondents reporting a decline in service provision.

Psychological therapies

Psychological therapies form a fundamental part of mental health services in England. There are a range of NICE-approved therapies provided by the NHS, delivered in primary, secondary and tertiary care settings. In 2017, the BMA conducted a series of FOI requests to investigate spending on psychological therapies across England. We received 197 responses out of a possible 208 CCGs, and 45 responses out of a possible 53 trusts. After analysis of the responses we had usable data from 175 CCGs and 37 trusts.

- 63% of CCGs and 81% of trusts that responded could provide data on overall spending on all psychological therapies. Of these, 28% of CCGs and 50% of trusts increased their spending in real terms,ⁱ on all psychological therapies between 2015/16 (when new mental health funding came in) and 2017/18 (their agreed budgets).
- 31% of CCGs and 17% of trusts decreased their spending on all psychological therapies, in real terms, between 2015/16 and 2017/18.
- 37% of CCGs and 19% of trusts were unable to provide data on their overall spending on all psychological therapies.

Figure 7 – CCGs' spending all psychological therapies

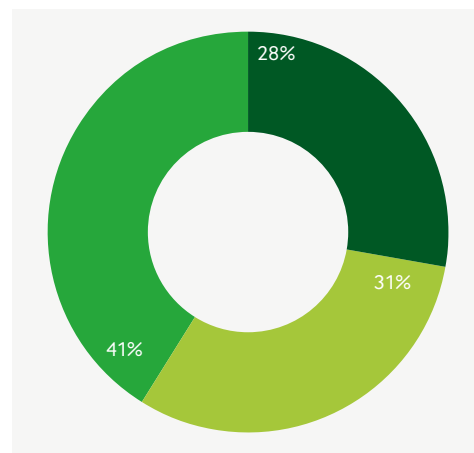
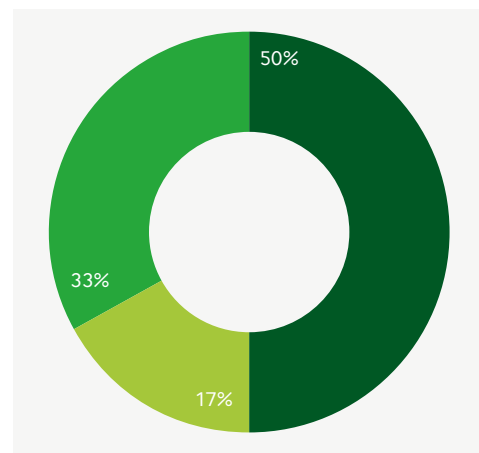


Figure 8 – Trusts' spending on all psychological therapies



■ increased spending ■ decreased spending ■ increased one year, decreased one year

Spending on all psychological therapies between the financial years of 2015/16 and 2017/18, based on data from FOI requests.

These data show that despite new funding announced in recent years, just over a quarter of CCGs, and only half of trusts, are increasing their real-terms spending on psychological therapies. A significant proportion of CCGs and trusts have increased their spending in one year, but have decreased it in the other, between the financial years of 2015/16 and 2017/18.

ⁱ These data were converted to real terms using the Consumer Price Index (CPI), which is the UK's key measure for inflation. CPI is the rate at which the prices of goods and services bought by UK households rise or fall.

IAPT and psychological therapies in secondary care

The IAPT programme was initiated in 2007, and has been supported by continued investment.^j These services are delivered in primary care, and consist mainly (but not exclusively) of CBT (cognitive behaviour therapy) to treat common, less severe mental health problems such as mild depression, anxiety and phobias.

Patients receiving psychological therapies in secondary care settings are likely to have more complex or severe mental health problems, and these services involve a range of therapies. Since the introduction of IAPT, there have been concerns that CCGs have prioritised commissioning these services over existing psychological therapies in secondary care. For example, the We Need to Talk Coalition, in its report *We still need to talk: A report on access to talking therapies*, claimed that 14% of new IAPT services have ‘replaced’ existing (secondary care) services; and that these services have seen their funding cut by over 5%.³⁴

The BMA’s FOI request asked CCGs and trusts what they spent on IAPT and psychological therapies in secondary care, between 2012/13 and 2017/18 (their agreed budget).

- The vast majority of those that responded (92% of CCGs and 81% of trusts) could provide a breakdown of their spending on IAPT. In contrast, only 35% of CCGs and 59% of trusts could provide a breakdown of their spending on therapies in secondary care.
- Of those that could provide this information, 83% of CCGs and 64% of trusts spent more per year on IAPT than on therapies in secondary care. This does not appear to be related to demand, as NHS Digital data^k show that in 2016/17 there were 2.6 million referrals to secondary mental health services,⁴ compared to 1.4 million referrals to IAPT.³⁵

Figure 9 – CCGs spending on IAPT vs therapies in secondary care

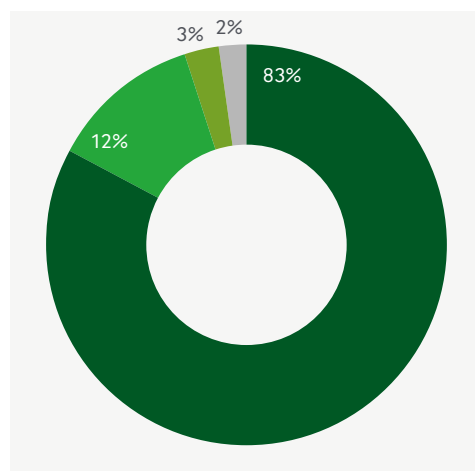
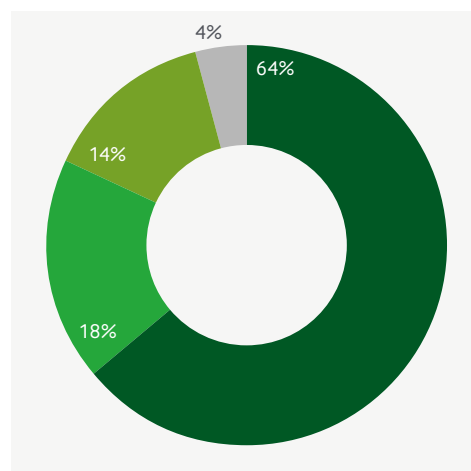


Figure 10 – Trusts’ spending on IAPT vs therapies in secondary care



spent more on IAPT
 spent more on secondary care
 spent the same
 no direct comparison

CCG and trusts spending on IAPT and psychological therapies in secondary care year between 2012/13 and 2017/18, based on a series of FOI requests.

These data indicate that many CCGs and trusts have prioritised the commissioning of IAPT over psychological therapies in secondary care. The fact that a large proportion of CCGs record their spending on IAPT, but not on psychological therapies in secondary care, also indicates that less priority has been given to these therapies.

^j When it began in 2007, there was a pledge for the NHS to be spending at least £170 million a year by 2010/11 on expanding IAPT services.

^k It is difficult to directly compare demand for psychological therapies in secondary care to IAPT, as available NHS Digital data are for secondary mental health services more widely, including learning disability services.

One explanation for IAPT being prioritised is that it is commissioned as its own separate service, whereas funding for secondary care services forms part of CCG baseline allocations. IAPT funding was also ring-fenced in the past (particularly pre-2010/11), which may have encouraged commissioners to be more inclined to fund it in the future. Our FOI requests demonstrate that many CCGs have also received central government funding earmarked for IAPT, particularly over the last three years.

The fact that from the outset there has been significant political interest in IAPT may also underlie its prioritisation³⁶⁻³⁷, – it was introduced alongside arguments that it would be cost effective, by reducing medical costs and increasing revenues from keeping people in work.³⁸ IAPT was also implemented alongside certain targets around access, recovery rates, and more recently, waiting times;¹ giving commissioners incentives to spend more on these services. In contrast, targets for psychological therapies for patients with more complex mental health problems have been limited with only one specific target for EIP (early intervention in psychosis) services.³⁹

This de-prioritisation of psychological therapies in secondary care is concerning, as NHS Digital data show a 63% increase in the amount of people accessing secondary mental health services between 2012/13 and 2016/17⁴⁰. A joint survey of 650 NHS therapists by the British Psychoanalytic Council and the UK Council for Psychotherapy reported that 77% said that they are seeing people with more complex needs.⁴¹

Implications for policy and practice

Research on the funding of mental health services in this briefing shows a mixed picture across different local areas and types of service. Some areas are increasing their spending in line with recent Government commitments to funding, and some services are seeing improvements. However, a significant number of areas are decreasing their spending or spending the same amount, or not meeting their funding commitments - despite the introduction of new funding in 2014. In addition, there are various indications that the mental health sector is under pressure and struggling to meet demand. To improve the resourcing of mental health services, there are two main elements to consider.

Increasing funding for mental health

Despite the renewed focus on mental health and commitment to parity of esteem, there remains a lack of parity in funding for to physical health care, compared to their relative burden of disease. Mental health is the single largest burden of disease in the UK (28%),⁴² but according to the Mental Health Dashboard, funding in England equates to approximately 13% of its total CCG budget. Although this proportion does not take into account the management of mental health problems by GPs, it is clear the mental health sector needs increased investment to more closely match the large burden of disease of mental health problems.

Without increased funding allocated from central government, CCGs will continue having difficulty increasing their spending on mental health services. This increased investment in mental health must take place in the context of increased funding for the NHS as a whole, which the BMA **continues to call for**. The BMA has consistently highlighted that the NHS is under unprecedented pressure, with insufficient funding to meet increasing demand. Putting the NHS in a stronger financial position overall would reduce the risk of mental health funding being diverted to balance NHS finances.

As well as funding commitments, other commitments to mental health have been made in recent years. For example, the 2017 HEE Mental Health Workforce plan, *Stepping forward to 2020/21: The mental health workforce plan for England*, outlines plans to increase

¹ In 2010 a target was made to treat 15% of people with common mental health problems annually by 2015, and to achieve a recovery rate of 50%. In 2016 a target was made 75% of people referred to begin treatment with 6 weeks, and for 95% to begin treatment within 18 weeks.

the mental health workforce by 19,000 additional members of staff.⁴³ Increased funding is required to expand the workforce to this level. According to our CAMHS survey, 'staff shortages' was the most popular reason given for how costs had been cut (alongside 'pay freezes'), as well as for why there had been a decline in service provision. Without a fully staffed mental health workforce, the sector will be unable to deliver high-quality mental health care. Plus, mental health services will be more appealing places to work, if they are fully-resourced.

Ensuring mental health funding reaches the frontline

An important way of ensuring that all the funding allocated to mental health reaches frontline services is having proper transparency and accountability for how the funding is spent. One way of doing this is by continuing to change the payment systems used to pay providers for mental health services. Historically block contracts have been mainly used to pay for mental health services, but these do not enable transparency about what is being spent. As part of delivering the Five Year Forward View for Mental Health, commissioners and providers are encouraged to start using capitated and episodic payment systems. These payment systems are designed specifically to promote transparency when paying for mental health services, and better support the delivery of holistic, integrated services.⁴⁴ NHS England and NHS Improvement should continue to support commissioners and providers to implement these new payment approaches and assess their effectiveness on a timely basis.

The Mental Health Dashboard is vastly improving transparency and accountability, by publishing key data in one central location. Using the Mental Health Dashboard, it is now possible to view total mental health spending on a range of services at CCG and STP-level. Despite this significant improvement, there are opportunities to expand the data provided on the Mental Health Dashboard. Our research on psychological therapies showed significant variation in whether CCGs and trusts recorded their spending on psychological therapies in secondary care. The Mental Health Dashboard should therefore be expanded to include spending metrics on other important services such as this, and perinatal services. Local authorities also commission mental health services, as part of their responsibility to promote public mental health and the prevention of mental health problems. This data should also be published in a transparent and easily accessible form.

Our research on psychological therapies shows that when adjusting spending figures for inflation, significantly fewer CCGs increased their spending over the last few years, than before adjusting for inflation. Therefore, as part of accountability, planning and analysis of mental health spending should aim to reflect real-terms spending changes. This would provide a more accurate picture of whether investment in mental health has increased, and by how much.

Having tools in place to improve transparency and accountability will enable greater scrutiny to ensure CCGs are meeting their responsibilities to increase spending on mental health, including their funding commitment. NHS England has recently committed to ensuring each CCG meets the Mental Health Investment Standard, and that this will be validated by auditing.⁴⁵ CCGs that are not meeting this spending target should be required to produce robust spending plans on how they will meet it, and there should be more support to help them to do so. Data on whether individual CCGs are meeting the standard should be published in an accessible and transparent format.

Even with improved accountability, the precarious financial position of the NHS means that funding may still be diverted elsewhere, to fill deficits. Measures must be taken to ensure that this does not happen, particularly for services where provision is poor. This includes services which may have been deprioritised at the expense of others - such as psychological therapies in secondary care. This also includes CAMHS, where despite recent funding commitments, doctors report a decline in service provision and being less able to do their job. Where there is a time-specific need to improve a particular service, ring-fencing funding can be an effective way of doing so, as demonstrated in the provision of perinatal mental health services. Therefore, where appropriate, ring-fencing should be considered, to ensure improvements are made to specific services within a fixed time-frame.

Areas for action

- The Government should increase funding for mental health services to more closely match the burden of disease of mental health problems in England.
- The Government should increase NHS funding as a whole, reducing the risk that mental health funding is diverted elsewhere, such as to fill deficits. This would also help to fulfil commitments to mental health, such as expanding the mental health workforce, as outlined in the HEE mental health workforce plan.
- NHS England should continue to support CCGs to use the new capitated and episodic payment systems to pay for mental health services, and should assess their effectiveness on a timely basis.
- The Mental Health Dashboard should be expanded to include spending on crucial services such as perinatal mental health and psychological therapies in secondary care.
- Local authorities should publish their spending on the promotion of public mental health, in an easily accessible location, similar to the Mental Health Dashboard.
- Planning and analysis of mental health spending should aim to reflect real-terms spending changes.
- CCGs must meet the PoE funding commitment/Mental Health Investment Standard set by NHS England and NHS Improvement. Those that are failing to should be required to produce robust spending plans on how they will meet this target. More support should be put in place for those who are failing to meet it.
- CCGs should ensure adequate funding for psychological therapies in secondary care, so that they are not de-commissioned at the expense of other psychological services, such as IAPT.
- Measures should be taken to ensure that mental health funding is only spent on mental health services, particularly where provision is poor (such as CAMHS and psychological therapies in secondary care), by ring-fencing funding where necessary. Where funding is no longer ring-fenced, such as future perinatal funding, development of these services should be closely monitored.

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