

“It’s broken”
Doctors’
experiences
on the
frontline
of a failing
mental
healthcare
system

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Introduction

“Mental healthcare in this country is dysfunctional. It’s broken.”

Interviewee 5, General Practitioner

Mental healthcare in England is in crisis. More people than ever are coming forward for help, but NHS services do not have the resources they need to respond to such a growth in demand.

The BMA has carried out in-depth interviews with ten doctors across the mental health system, including those working in psychiatry, general practice, emergency medicine, and public health.² We wanted to explore their experiences of providing mental healthcare, including what helps and hinders them in providing good care to patients, how things have changed in the time they have worked in the NHS, and their thoughts on how the challenges identified are impacting on patient care and experience. Interviews with doctors were supplemented by discussions with key stakeholders, including charities and patients. A detailed explanation of the research methodology can be found in Annex 2.

We’ve heard how doctors are struggling to ensure patients can receive the care they need in the face of inadequate funding, insufficient workforce, and unsuitable infrastructure. Moreover, doctors’ work is compromised by a society that is not designed to support good mental health and wellbeing.

This is due to several factors:

1. **Funding** is insufficient and not always used in a way that allows doctors to provide the care they want for patients.
2. There are not enough trained **staff** in the health and social care system to treat and support people with mental illness.
3. The **different parts** of the health and social care system that provide treatment and support to people with mental illness find it difficult to **work together** to support patients.
4. Our society is not set up to **support** people’s mental health and to **prevent** the onset of mental illness.
5. All these pressures on the system are **damaging patient care** and particularly affecting certain groups, such as children or people with neurodevelopmental disorders.

At the same time, there have been some success stories. We heard about well-resourced gambling addictions clinics that are providing high quality care to a group previously often overlooked; we heard of assertive outreach in Early Intervention and Psychosis units, which can catch people experiencing or at high risk of psychosis, and provide psychological and medical support before their condition or symptoms worsen; and we heard that new ways of doing things, such as peer support, have created opportunities for better tailored care.

Good mental health is essential to a functioning society. Mental illness carries a [huge cost](#) to individuals, society, and the health and social care system. Without the appropriate treatment or support, mental illness can lead to lost productivity and the need for informal care; mental ill health has been estimated to cost around £118 billion annually to the UK economy, or nearly £101 billion in England alone, equivalent to roughly 5% of the UK’s GDP. Mental health problems and poor mental health can also influence all aspects of a person’s life and relationships, often causing huge anguish to individuals, families, and communities.

Many people experience mental health problems at some point in their lives. A recent wide ranging cross national review of over 150,000 people in 29 countries found that [around one in two people](#) will develop at least one mental health condition in their lifetime. Rates of mental illness also appear to be increasing, with the Covid-19 pandemic having a significant impact on people's mental health. Rates of mental health conditions amongst children and young people seem to be growing particularly quickly. Between 2017 and 2022, [rates of probable mental disorder](#) in England increased from around 1 in 8 young people aged 7-16 to more than 1 in 6.

Following decades of neglect (albeit with some periods of real drive for improvement), mental health has been a key focus for the NHS in recent years and specific commitments to improve and expand NHS-funded services have been made, with the introduction of waiting times and access standards for key services, as well as creating specific targets for investment (workforce and funding). Yet demand continues to outstrip investment, and many targets are not being met. Services are overwhelmed by demand and the system is under huge pressure. Government figures show that the number of people unable to access the treatment they need in a timely manner continues to increase.

This report proposes clear and actionable policy recommendations to ensure the system allows doctors ability to provide good quality mental illness care. If implemented, as a society we can start to tackle the huge cost of mental health to people's lives, the NHS, and the economy.

Whilst this report covers England only, and health is a devolved issue, as a UK-wide association, the BMA knows that many of these problems exist in health services across the UK.

1

Funding is insufficient and not always used in a way that allows doctors to provide the care they want for patients

All ten doctors we interviewed spoke of the mental health system as a system under extreme pressure. They highlighted how resource constraints are resulting in a system at or beyond its limit. Operating in an environment of scarcity means doctors do not have the resources they need, and a lack of funding has wide-ranging impacts including insufficient workforce and inadequate estates. It also makes it harder for different parts of the system to work together when there is competition for limited resources. Ultimately, doctors are having to make difficult choices to prioritise patients, meaning others do not get the support they need, and overall patient care is affected. Doctors spoke passionately of their distress at being unable to provide the care they would wish to, and the impact on their morale of feeling that they do not have the resources they need.

“Mental health services in this country are as poor as I have ever known them since I started to study psychiatry in 1988.”

Interviewee 5, General Practitioner

This section discusses the state of funding for mental health services in the NHS, highlighting how it does not match need for mental health services. It also focuses on a lack of investment in mental health estates. The later sections of the report highlight some of the other consequences of funding that is not keeping up with demand, including workforce (Section 2) and the challenges for different parts of the system working together (Section 3). Section 4 discusses how a wider lack of investment in public services, including public health, has impacted on mental healthcare. Section 5 examines the impact on patient care that a lack of investment is having (Section 5).

Funding and investment in mental healthcare is insufficient to meet demand and provide high quality care.

“The quality of the staff hasn’t changed, but the ability to deliver and give time and properly establish a relationship with a patient has really been impacted by lack of funding... I’ve been in the same trust for all these years ... So I’ve seen it change completely.”

Interviewee 8, Consultant Psychiatrist

Doctors told us how the lack of funding for mental health services had impacted their ability to provide good care. Funding is essential to ensure appropriate resourcing of existing services and the infrastructure needed to provide them. It is also needed for the expansion of services in key areas where people are falling through the gaps in service provision. Some doctors blamed a lack of funding for staff shortages, citing a lack of investment in staff recruitment and training, inadequately attractive remuneration to retain staff, and budgetary pressures leading to cuts to team sizes (see Section 2).

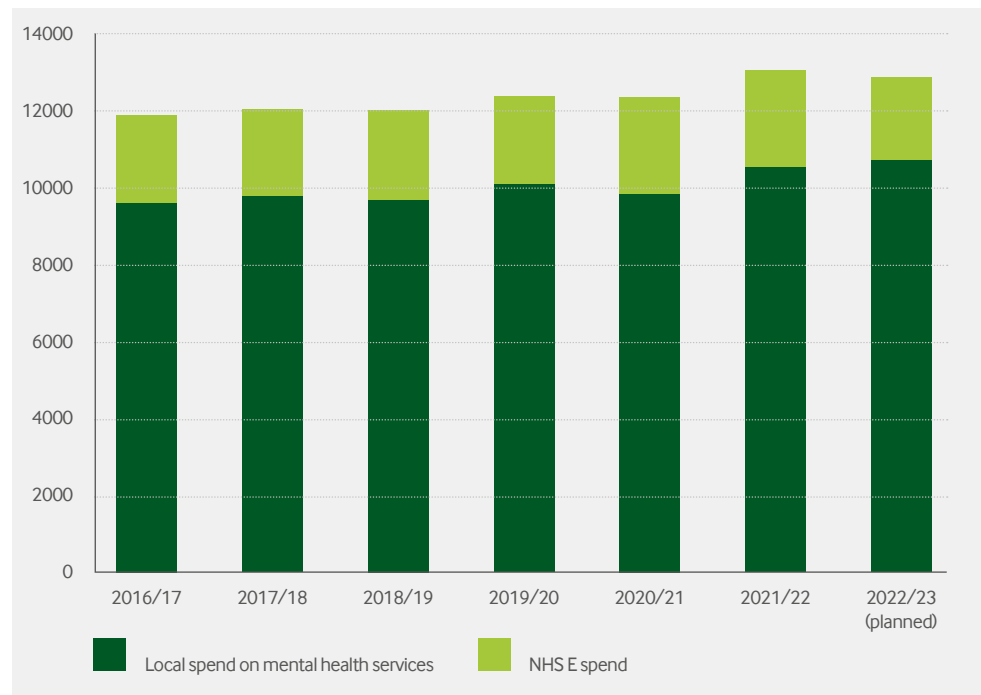
“When we [society] make people mentally unwell, we do not have the staffing, funding, physical space to enable them to become well again... Services and teams ... are all fighting for limited scraps of money.”

Interviewee 7, Psychiatrist

The NHS has clear targets for mental health investment and spending, set out most recently in the NHS Long Term Plan for Mental Health (2021). Most notably this included a commitment to increase mental health funding by £2.3bn a year in real terms by 2023/24 compared to 2018/19. The National Audit Office’s (NAO) analysis of available mental health funding data shows that, based on national and local spend, NHS England was on track to meet this target but suggests that recent rises in inflation may put the target in jeopardy (see Figure A).

Figure A: The NHS says it is on track to meet its target of additional spending in 2023/24 compared to 2019/20

NHS real-terms spending on mental health, £2023/24 prices, actual (2016/17 – 2021/22) and planned (2022/23)



Source: BMA analysis of [National Audit Office data](#) using OBR Economic and Fiscal Outlook March 2023 GDP deflators

The NHS also has targets for local healthcare bodies (Clinical Commissioning Groups (CCGs) and now ICB (Integrated Care Boards)) to increase their annual spend on mental health services at a faster rate than their overall allocation. This commitment is known as the Mental Health Investment Standard (MHIS). And from 2019, it has made a commitment that funding for children and young people’s mental health services would grow faster than both overall NHS funding and total mental health spend.

However, as one doctor highlighted, just because funding is increasing, it does not mean it is sufficient. Furthermore, the [MHIS commitment does not set any minimum increase](#) in spending and therefore the targets to increase overall mental health spend and children and young people’s mental health spend can be met with a very small proportional increase.

“[More funding] applies if it’s £1.00 more than last year... [There needs to be] capital investment, workforce planning, training and then obviously spending on those staff to keep them employed and on their development”
 Interviewee 7, Psychiatrist

These targets are unambitious and not based on an assessment of the level of funding needed to meet demand.¹ Despite modest funding increases, service usage has skyrocketed. Between 2016/17 (the first year comparative data is available and 2022/23, the number of referrals to NHS mental health services grew by 48%² - significantly more than the increase in funding. Also, these figures only capture those in contact with services – it is estimated that [millions more](#) would benefit from support but have not accessed services. As a result, several access targets are also being missed; for example, the target to increase the number of 0-17-year-olds treated was 3% below the goal; and targets for referrals for treatment for children and young people with an eating disorder have not been met since being introduced in 2016. The NHS is also below its target for people accessing talking therapy services, which was 22% below target in 2021/22.

A particular problem is that there is not high quality up to date data available on the level of need for mental health services. The prevalence of adult mental illness is determined by a significant survey conducted only every seven years; the Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population. The most recent survey was delayed due to COVID-19 and is not expected to be published until 2025, as a result, there is not recent data on the number of adults with mental health illnesses (the [most recent published](#) is from 2014.) Therefore, it is difficult to determine currently exactly how much resource is needed to ensure everyone with mental illness who would benefit from support could access it; what is clear is that the current level is insufficient. Similarly, the Mental Health of Children and Young People (MHCYP) [survey](#) follows an inconsistent reporting pattern. The recent waves to follow up on survey subjects has been helpful, but there needs to be a commitment to ongoing regular surveying of children and young people to allow for ongoing monitoring to inform funding need.

“I think lack of funding is a major issue. We haven’t had, well I can’t recall, any major investment for a while. Morale is low... I’m fed up. You know, I don’t enjoy my job as much as I used to.”

Interviewee 2, Consultant Psychiatrist

1 The NHS appears to be on track to meet the target set out in the NHS Long Term Plan of additional overall funding of an additional £2.3 billion funding (in real terms) by 2023/24. However, that target would only leave mental health funding in 2023/24 4.2% higher than it was in 2016/17, reflecting the relatively low ambition of the target.

2 Source: BMA analysis of NHS Digital data.



Good practice case study one.

Gambling services are a success story that shows sufficient resourcing can bring positive results.

A recent focus on those struggling with gambling addiction has shown how sufficient funding can bring positive results. Prior to 2022, there were only two gambling treatment clinics in England, and insufficient funding. But in 2022, the [NHS announced](#) it would be fully funding new gambling clinics as part of a new national programme to serve the increasing number of people seeking support for gambling addiction. The government has committed to open 15 clinics across England by the end of 23/24, with 12 already opened at the time of writing (end of January 2024). One doctor working in these clinics told us of how this has been successful:

“[Since] 2015 probably, I think I had seven years of a disastrous lack of funding and then it got very dangerous because I had long waiting lists. Gamblers are very suicidal and it was awful, but then things improved and yeah, I think that we provide good treatment everyday. We respond to risk. We have safeguarding meetings, we have enough staff.”

Interviewee 8, Consultant Psychiatrist

By the end of 2023/24, NHS gambling clinics [will have the capacity](#) to treat up to 3,000 patients per year. The latest data available, for the first two quarters of 23/24, show a total of 863 referrals into NHS Gambling Services, an increase 138% (501 additional referrals) compared to the equivalent period in 2020/21. The service is proving effective: outcomes data from 22/23 found that patients on average have a PGSI score (a metric measuring problem gambling, with a score of 8 or more representing problem gambling) of 20.4 at the start of treatment and 3.4 at the end of treatment. Patients also had an average CORE-10 score (a measure of psychological distress) indicating moderate psychological distress at initial assessment, reducing to only mild distress on average at the end of treatment.³

There is insufficient investment in the mental health estate, most notably in beds.

One of the main areas where doctors told us there was insufficient investment was in the NHS mental health estate (the physical buildings used to provide NHS mental healthcare). In too many instances, the mental health estate is not resourced to be able to provide a therapeutic environment. [18% of the mental health estate](#) was built before the NHS was formed, and urgently needs upgrading. Both the Independent [Review of the Mental Health Act](#), and the Care Quality [Commission's State of Care report 2023](#) reported poor quality buildings and facilities in mental health services, and safety issues arising from these, including those relating to ligature points, and sexual safety.

In 2020, ministers pledged that beds in mental health dormitory-style accommodation should be replaced with single, en-suite accommodation by 2025. However, it is being reported that several Trusts are due to miss this target due to “challenging economic conditions”.

³ The data is from privately shared correspondence with NHS England in February 2024.

“In my Trust and mental health wards they have bays rather than...single rooms. Which is not appropriate for mental healthcare”

Interviewee 7, Psychiatrist

In addition to inadequate facilities, there are not enough mental health beds available, leading to significant problems for doctors and patients.

“There have been patients who’ve waited up to five days for a bed...In the ED, which doesn’t go down very well and it’s quite difficult because if they become really, really agitated... on occasion, they have been admitted to things like places of safety [be]cause [there] have been no beds anywhere. So there’s always this massive bed juggling issue that goes on and that impacts both on them because they can’t start their treatment or their assessment properly.”

Interviewee 4, Consultant Psychiatrist working in A&E

Overall mental health bed stock has declined. The daily average number of available beds decreased from around 23,500 in September 2010 to just over 18,000 in June 2023 – a 23% decrease.⁴ At the same time, the population of England has grown, meaning the decline in the number of beds relative to the population is even sharper. The number of beds for mental health patients per 10,000 people in England has decreased from 4.4 in 2010 to 3.2 in 2022.⁵

This has been in part due to an effort by NHS England to prioritise community mental health services within mental health spending at the expense of inpatient care (with the important caveat that even core community services remain underfunded.) Whilst it is important that people are supported in the community where possible, this cannot be at the expense of provision for people for whom inpatient treatment is necessary.

“It’s actually quite expensive to put people in wards and it would be good to develop community services. But you can’t just develop community services by shutting down wards and shunting the money to them [community services]. You’ve got to have a bit of both.”

Interviewee 4, Consultant Psychiatrist working in A&E

As a result, safe occupancy rates for mental health beds are routinely breached. Occupancy rates for mental health beds fluctuated between 86% and 90% in the decade before the pandemic. Yet 85% occupancy is generally the level considered to be the point beyond which safety and efficiency are at risk. During the pandemic, mental health occupancy rates fell to 79%, but they have since risen again to 89%.

⁴ BMA analysis of [NHS Bed availability and occupancy data](#). Mental illness beds do not include learning disability beds.

⁵ BMA analysis of [NHS Bed availability and occupancy data](#) and ONS Population [Estimates](#) and [Projections](#). Mental illness beds do not include learning disability beds.

As a result of insufficient bed capacity, the NHS was unable to meet its target to eliminate inappropriate out of area mental health placements. The government set a national deadline to eliminate these placements for adults by the end of March 2021, but this target was not met. An out of area placement occurs when someone needing inpatient mental healthcare is admitted to a unit that is not part of the local service network. This can be very difficult for the patient, because they often cannot be visited, or visited regularly, by either their usual staff support team or friends and family.

One response to low bed capacity from the NHS is the reliance in some cases on private placements, using NHS resources to purchase spaces in private facilities. The vast majority of inappropriate OOA placements (96% from data captured by the BMA) are sent to private providers. However, these are not a good solution for patients or for the healthcare system. The CQC found that for out of area rehabilitation mental health placements, patients on private wards tend to stay twice as long, costing twice as much to the NHS, and extending the pain of separation for patients from their families and support networks.

Policy recommendations

- **The Government and DHSC should determine the level of funding/funding targets for mental health services based on a full assessment of unmet need to ensure everyone (children and adults) who need mental health support is able to access it.** DHSC should determine funding targets based on a full assessment of unmet need, rather than simply increasing funding compared to historical rates. The data and assumptions used to determine this should be published so it is clear and transparent how funding was determined. There also needs to be more regular and timely data collection of prevalence of mental illness to ascertain the level of need and inform how much funding is needed, including for specific subgroups and populations experiences significant inequalities in mental healthcare. The Adult Psychiatric Morbidity Survey (APMS) to establish levels of mental health need in England should happen with greater frequency (for example, it should be conducted every four years rather than every seven). There should also be a clear commitment to regular comprehensive surveys of children and young people's mental health.
- **Ringfenced funding should be provided for mental health infrastructure,** to ensure that the mental health estate is fit for purpose. Psychiatric inpatient care has been in a state of neglect in many areas from lack of resources. There are not enough NHS and local mental health beds in England, resulting in patients being admitted far from their homes and families. Currently, capital funding is provided for the NHS with no specific mental health ringfencing. Ringfencing is necessary to ensure funding is not allocated elsewhere in the NHS estate or to plug other gaps in the system. This should be based on assessment of need considering the current state of infrastructure, what is needed to make it fit for purpose, and how many additional beds are needed where to ensure that targets can be met.

2

There are not enough trained staff to meet the needs of people with mental illness.

A key issue arising from our interviews with doctors was the state of the mental healthcare workforce. Doctors spoke of their frustrations that their job is made harder, and their patients' care' made worse, by a lack of staff who can provide good quality mental healthcare.

It is, primarily, a case of insufficient numbers, with vacancies and rates of turnover too high, and levels of recruitment and retention too low. The problem is made worse by not having the right mix of staff to provide strong multidisciplinary care.

There is also the issue that not enough staff in the wider NHS workforce have sufficient training or experience in mental illness. Some doctors we spoke to believed that a lack of training across the workforce was compromising patient care in the NHS.

There are not enough trained staff with the right skills mix in the health and social care system to treat and support people with mental illness.

Mental healthcare does not have the numbers of staff it needs to provide good care for patients.

The experience of the doctors we spoke to was that there were not nearly enough staff in mental healthcare for them to provide, and for patients to receive, good quality care.

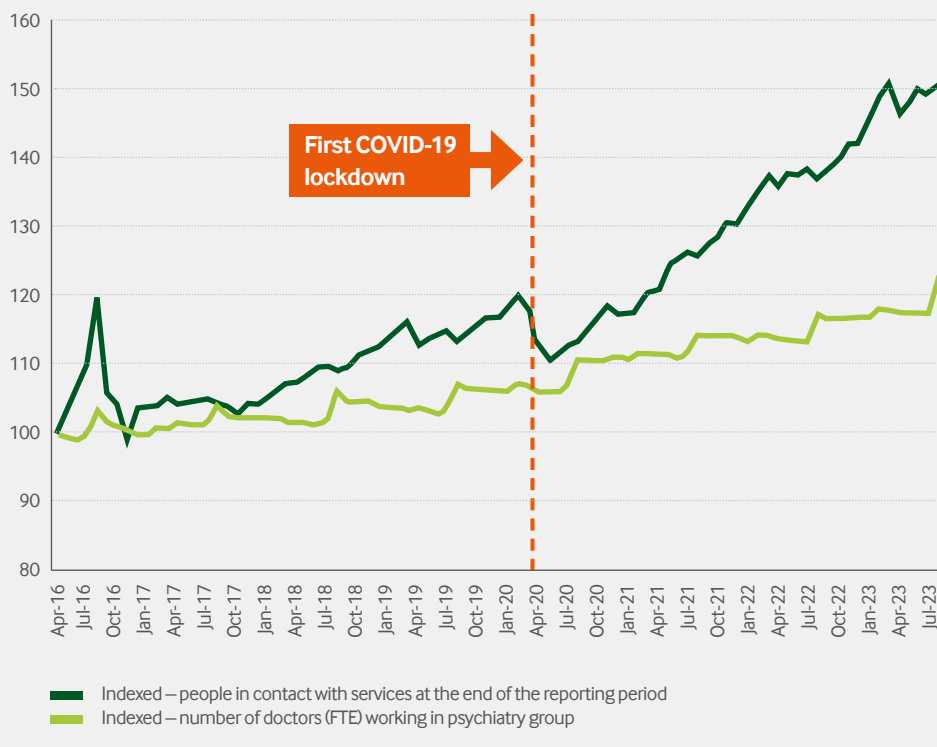
“If someone is meant to be on the two to one [observation ratio] but you’ve not got enough staff, naturally that’s not going to happen...Or if you decide that that needs to happen, it means that some of the other patients might not get the observation level they need. You have to make really difficult decisions. With the limited resources we have, who do we prioritise? Who do we look after?”

Interviewee 9, Psychiatrist

The data shows a story of high vacancy rates, and low levels of recruitment and retention. Despite overall growth in the mental healthcare workforce, it is not keeping up with demand. Overall, the mental health workforce increased by 22% between 2016/17 and 2021/22 (from 109,000 to 133,000 FTE staff). Over the same period, the number of medical staff has increased by 13%, and nursing staff by 9%. But whilst the workforce is increasing, the number of people in contact with services has increased at a much greater rate. The result is the growth in workforce is insufficient to meet demand.

Indexed number of FTE doctors working in psychiatry in comparison to the number of people in contact with services.

April 2016 - August 2023



Source: BMA analysis of [NHS Digital Workforce Statistics](#) and [NHS Digital Mental Health Services Monthly Statistics](#).⁶

In addition, the [average vacancy rate](#) across England in NHS mental health services is high. 12% of roles are vacant in mental health services, higher than the average vacancy rate across the whole of the NHS in England (8%). The average vacancy rate of doctors in mental healthcare is even higher, at nearly 15%. Within NHS mental health nursing, the vacancy rate is even higher, standing at 18.5% on average across England (June 2023).

“We don’t have any crisis workers after 9 o’clock at night. So if there’s a problem after 9, they’re basically on their own. There’s a telephone line you can call, or it’s the police.”

Interviewee 1, Consultant Psychiatrist

⁶ Services data shows the number of people in contact with services at the end of the month (MHS01) including: adult mental health, children and young people, and learning disabilities. This is a measure of the number of people with an open referral and does not indicate whether a person has received any treatment or where the person is on a care pathway. Workforce data shows the number of FTE doctors working in psychiatry including: child and adolescent psychiatry, forensic psychiatry, general psychiatry, old age psychiatry, psychiatry of learning disability and psychotherapy. These include the roles of: Consultant, Associate Specialist, Speciality Doctor, Staff Grade, Speciality Registrar, Core Training, Foundation Doctor Year 2, Foundation Doctor Year 1, Hospital Practitioner/Clinical Assistant, Other and Local HCHS Doctor Grades.

Trust leaders report that shortages in the mental health workforce are a major constraint to improving and expanding services. According to a survey by the National Audit Office (NAO), 26 out of 34 responding trusts, and 21 out of 29 responding ICBs, said workforce shortages were a very significant barrier to improving services (and a further five trusts and ICBs said a significant barrier). There were particular shortage concerns regarding medical staff, nursing staff, and psychologists.

“Historically what I’ve seen was...an issue around nursing recruitment and retention [and] medical recruitment and retention. But now I realise you’re having issues even with psychology and occupational therapy.”

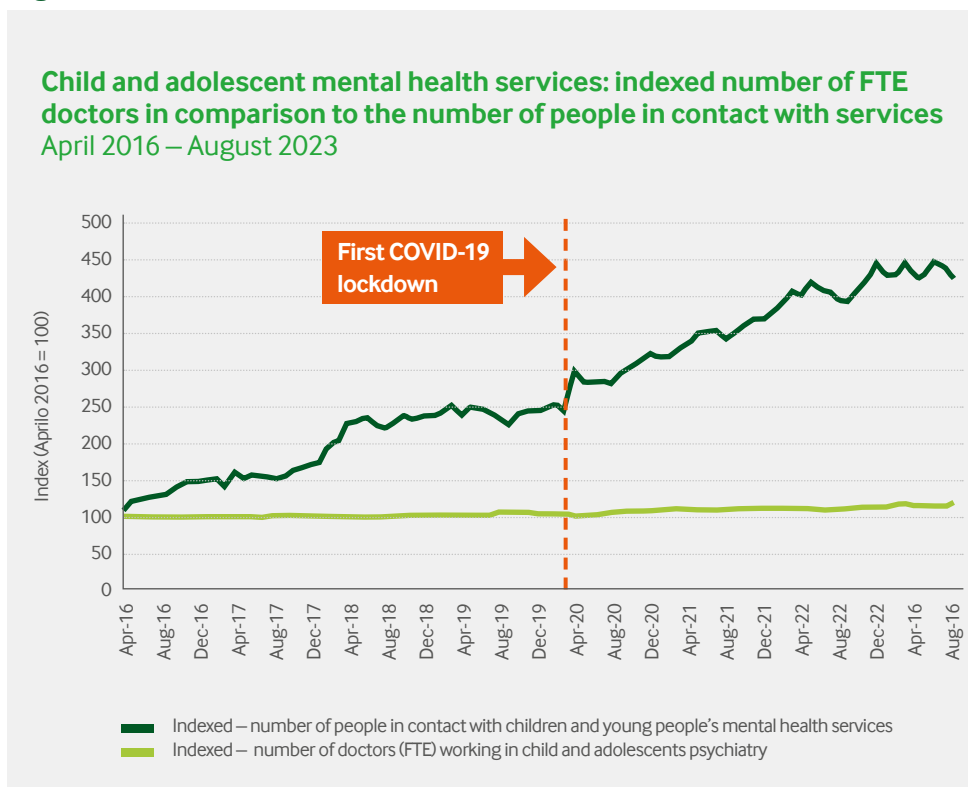
Interviewee 6, Consultant Psychiatrist

The main reason for shortages cited were problems recruiting and retaining staff in part due to competition in other sectors. 66% of mental health trusts surveyed by the NAO in the same survey reported that staff choosing to work in private practice was a reason for workforce shortages, where they may enjoy better pay, terms, and conditions. As NHS services become overwhelmed, private provision becomes more desirable for staff looking for a better workplace environment.

Turnover is also increasing in the mental health workforce. During 2021/22, 17,000 staff (12%) [left the NHS mental health workforce](#), up from 13,000 a year earlier. Turnover is a significant problem in the NHS. When a doctor leaves, even if their position is immediately covered, which is not always possible, health services lose their experience and expertise, to the detriment of their patients, colleagues, and the ability to train the next generation. As will be discussed in more detail later in this report, morale has been severely affected within mental healthcare, and this goes some way to explain high rates of turnover. The latest [NHS Staff Survey](#) from 2022 showed that overall, morale of the wider NHS workforce had declined for a second year, with nearly a third of respondents often thinking about leaving their organisation, an increase of 5.7 percentage points since 2020.

A lack of qualified staff is a particular problem for child and adolescent mental health services (CAMHS). More children and young people are asking for help than ever before, and there are not enough staff to respond to that demand. Since 2016 the number of children and young people in contact with these services has expanded at over 3 and a half times the pace of the psychiatry workforce (Figure 1).

Figure 1.



Source: BMA analysis of [NHS Digital Workforce Statistics](#) and [NHS Digital Mental Health Services](#) monthly statistics⁷

Meanwhile, GP practices across the country – often the first point of call for those seeking support with their mental health – are experiencing significant and growing strain. GP numbers are declining, demand rising, recruiting and retaining staff is becoming more challenging, with clear knock-on effects for patients. Between September 2022 and September 2023, in full time equivalent (FTE) terms of 37.5 hours per week, the NHS lost the equivalent of 254 fully qualified FTE GPs.

Primary care must not be forgotten in any efforts to expand the mental healthcare workforce. There have been recent attempts to expand the mental healthcare workforce within primary care, primarily with the inclusion of Mental Healthcare Practitioners within the Primary Care Network (PCN) Additional Roles Reimbursement Scheme (ARRS). However, these roles are currently limited to two FTE positions for a population up to 100,000 patients, must be agreed with the local community mental health services provider, and as of [October 23](#) there were only 155 FTE mental health practitioners working within the PCN ARRS. This is a concerningly low number considering there are around 1,250 PCNs in England. More on general practice can be found in Section 3.

⁷ Indexed analysis shows the percentage change over time. Services data shows the number of people in contact with children and young people's mental health services at the end of the month (CYP01). This is a measure of the number of people with an open referral and does not indicate whether a person has received any treatment or where the person is on a care pathway. Workforce data shows the number of FTE doctors working in child and adolescent psychiatry including roles of: Consultant, Associate Specialist, Speciality Doctor, Staff Grade, Speciality Registrar, Core Training, Foundation Doctor Year 2, Foundation Doctor Year 1, Hospital Practitioner/Clinical Assistant, Other and Local HCHS Doctor Grades. Due to a cyber incident affecting a number of mental health providers, data from August 2022 is estimated by NHS England.

Mental healthcare does not have the right skill mix amongst its staff to provide good care for patients.

Numbers alone are not enough; teams need the right mix of staff. A multi-disciplinary team is crucial for good patient mental healthcare. It allows for person-centred care in which a patient can access the different types of treatment and support they need for a better chance of holistic and sustainable recovery and a good quality of life. A patient on a psychiatric ward, for example, will need at the very least a psychiatrist for clinical overview and drug therapy, a clinical psychologist to advise on talking therapy, and a mental health nurse to provide care and support recovery including through support with medication and advising on social activities. Non-clinical roles such as the peer support network that has expanded in recent years can also provide a vital element to enhance someone's recovery and quality of life, as Good Practice Case Study Two will examine in more detail. Different settings will require a different mix of staff but, in all cases, a well-resourced multi-disciplinary team makes good care easier to provide.

“We have a big forensic service, but we don't have a drug worker and drug and alcohol is a big problem within our service. How can we run a forensic service without people addressing their drug and alcohol problem, which is one of the major contributors for [reoffending]?”

Interviewee 6, Consultant Psychiatrist

In our interviews with doctors, we heard that the multi-disciplinary staff they relied on to provide good care were increasingly hard to find and keep, often moving between different parts of the mental healthcare system. Secondary mental health services are unable to offer an attractive enough working life to recruit and retain the multi-disciplinary staff they need. One doctor told us that mental health nurses and clinical psychologists were moving from their psychiatry unit to general practice, employed by the Primary Care Network (PCN) because it was harder to progress in mental healthcare beyond Band 5/6, and general practice was able to pay more. While general practice also needs staff with expertise in mental health, staffing one service should not come at the expense of another, but rather all services must be staffed adequately. To achieve this, developing a comprehensive plan for the mental health workforce that considers the whole health and social care system is critical.

“...our ability to reward experience, reward good practice or reward people who have done additional training is just non-existent. So you know, really good people will leave and go and work for agency because they get paid appropriate to their experience.”

Interviewee 3, Public Health Consultant

Because of struggles to recruit people, we heard from doctors that positions are often offered to less experienced applicants, who are then leaving early because they are put into positions of too high responsibility with inadequate training and support, reinforcing the under-staffing cycle.

“So [one of the two] kind of big reasons that people are leaving is because they are put in charge of an acute inpatient ward when they’re two months out of their nursing training and they think Christ alive. Why? Why am I doing this? This is the scariest thing ever or they’re leaving and going on the bank.”

Interviewee 3, Public Health Consultant

There has been a change in the staff mix in mental health services over the past decade, with a decrease in the percentage of medical and nursing staff compared to therapists and non-clinical staff, as Figure 2 shows. There has been a particularly marked decrease in the proportion of nursing staff, who interviewees remarked they were most in need of in their services. In March 2013, nursing staff made up 39% of the mental health workforce, falling to 32% in March 2023. The proportion of doctors has also fallen, from 8% to 7% in the same period. Efforts to grow the mental health workforce have been particularly focussed on other professionally qualified clinical staff, primarily scientific, therapeutic, and technical staff.

There has been an increase in the proportion of [more junior roles](#) within the mental health workforce in all staff areas except nursing. In 2021/22, 8% of medical staff were core trainee doctors compared to 6% in 2011/12, and the percentage of support staff who are bands 1-5 (the lower end of seniority) has increased from 54% to 71%. This decline in more senior roles is a challenge for teams who may have less specialist expertise to draw on.

“Over the years, we’ve had cutbacks...we used to be a team of over 40 and I think we’re now a team of about 35. It’s not a huge number, but it’s enough...and a lot of those staff are not as qualified... [It’s] difficult to get people, [and] we’ve been creative in the posts we’ve created to allow more bodies, but they’re not necessarily as well qualified as they used to be.”

Interviewee 2, Consultant Psychiatrist

Our research found this is felt acutely in addiction psychiatry, which is a specialty that has been decimated since addictions services were moved out of the NHS into local authorities in 2012. This is discussed further in Section 5.

The [NHS Long term workforce plan](#) recognises that there is a particular need for more mental health nurses and more psychologists, and sets out key targets to be met for increasing their numbers over the next fifteen years. However, it did not include plans about how to meet these targets. Without clear incentives and a focus on encouraging people to train in these roles, as well as policies to recruit and retain staff, it is not clear how these will be met to secure the well-staffed multi-disciplinary teams patients and staff need (especially as [previous targets](#) for recruiting more mental health nurses have not been met).

Figure 2: Doctors and nurses make up a smaller fraction of the mental health workforce, compared to the overall Hospital and Community Health Service workforce.

	Mental health workforce, March 2013	Mental health workforce, March 2023	All HCHS workforce, March 2023
Doctors	8%	7%	10%
Nurses and health visitors	39%	32%	26%
Other professionally qualified clinical staff	13%	18%	16%
Support to clinical staff	38%	40%	31%
NHS infrastructure support	2%	2%	16%
Other/unclassified	0%	0%	0%

Source: BMA analysis of NHS HCHS Mental Health Workforce Statistics

Morale is affected by the challenges of working in mental healthcare.

The extent to which the challenges of working in mental healthcare affect morale cannot be underestimated. In addition to the pressure caused by high demand, staff shortages and a lack of funding, doctors are concerned about their ability to do a good job, which has a huge impact on morale and doctors' mental health, making workforce problems worse. [Research](#) from the BMA published in 2021 showed the significant prevalence of moral distress and injury amongst doctors.⁷ The report included testimony from a psychiatrist who said they recognised the concept from years of working in CAMHS.

The BMA have repeatedly expressed our concerns that funding of the [NHS Staff Mental Health and Wellbeing Hubs](#) has been withdrawn. Funding for the hubs, originally set up in the pandemic, has been cut to just £2.3 million, and there has been no clarity on where this funding has been diverted or how this money will be used for evidence based mental health wellbeing support for NHS Staff. In a workplace in which moral distress and moral injury may be occurring at higher rates, that is unacceptable.

We also heard from doctors that, even simple things that can help improve wellbeing and morale at a very basic level are missing from many workplaces. For example, we heard that doctors were unable to access nutritious, decent, hot food at work. Beyond the physical health benefits of decent food, the impact it has on how doctors feel they are valued, is significant.

“...provision of hot meals that are actually decent out of hours would go a long way...not like some rubbish chicken burger that only has, like, 2% chicken in it...cos staff morale is so important in work and especially the kind of work we do. If you're burned out and tired and don't want to be at work, with the best of intentions it's going to bleed into the service you're able to provide, and I think that has been ignored for so long in the NHS that nobody expects anything nice to be done for them anymore. I think it's a shame.”

Interviewee 9, Psychiatrist

Policy recommendations

- **The Department for Health and Social Care must plan for and incentivise the expansion of the professionally trained mental healthcare workforce, including within psychiatry and general practice, with a focus on nurses, care coordinators, and those providing psychological therapies.** Without the right numbers of staff, and without the right skill mix of staff, doctors will continue to struggle to provide the best care for their patients. This will also help expand the number of therapies on offer in the NHS. The NHS Long Term Workforce Plan goes some way towards this, by identifying clear targets for medical and nursing staff, and psychologists. However, this plan is based on ambitious productivity targets that may be unrealistic. Furthermore, these plans must be accompanied by funding to ensure high-quality staff are recruited.
- **NHS England must restore the number of training places for addiction psychiatry within the NHS to improve doctors' ability to treat someone with a substance abuse issue.** Record levels of substance abuse must be met with an effort to reverse the decimation of the addiction psychiatry workforce, and to embed skills in the wider medical profession. In addition, we support the Royal College of Psychiatrists' recommendation that NHS England should ensure that every ICS has NHS specialist addictions services led by appropriately trained and experienced addiction psychiatrists. In this way, addictions treatment services can be expanded in a similar vein to the gambling treatment clinics. This will make it easier for doctors to provide high quality care to the increasing number of people presenting with drug or alcohol poisoning.
- **The Department for Health and Social Care must provide clarification on where the funding withdrawn from NHS Staff Mental Health and Wellbeing hubs is being diverted to.** At a time of high need for staff working in mental health services, refusing to invest in mental health and wellbeing support in the NHS is dangerous. The NHS workforce deserve reassurance that money is being invested in evidence-based mental health and wellbeing support elsewhere.

3

The different parts of the health and care system, both within and outside of the NHS, find it difficult to work together to support patients.

For doctors to provide the most effective care for patients, all parts of the system need to be able to work together. Unfortunately, because so many parts of the system work under extreme pressure, this is often impossible.

Doctors told us of siloed services, and the challenge services face when working together. General practice, community mental health, and urgent and emergency care are overstretched, and there is often tension between different parts of the system. Social care capacity is also a particular problem, leading to issues for inpatients when it is time for them to be discharged.

Digital infrastructure in the NHS is also hindering doctors' ability to provide high quality joined-up mental health care. Where one part of the system cannot talk to another about the same patient, patient care is compromised, and doctors are unable to work as effectively.

General practice and community mental health services are too overstretched to work effectively together to support patients.

There is sometimes tension between primary and secondary care, caused by underlying stress that patients will not receive the care they need when neither service has the capacity to provide it. Some GPs feel frustrated that their referrals are being rejected, and some psychiatrists working in Community Mental Health Teams (CMHTs) can sense this frustration. The truth is both services are under extreme pressure, with neither at fault.

“...it does feel that it's bit of a them and us and it shouldn't be that way”

Interviewee 2, Consultant Psychiatrist

As section 5 examines in more detail, CMHTs are unable to accept the same number of referrals they once could, due to pressures in their services. Meanwhile, general practice in England is at breaking point, with GPs experiencing high levels of demand at a time of a declining GP workforce. General practices in England carried out 4.6 million (9%) [more appointments](#) in December 2022 and January 2023 than the same months three years before. At the same time, the NHS is [losing GPs at an alarming rate](#), as examined in section 2.

“When I was in psychiatry [training], I would sit in referral meetings, and those referral meetings were sometimes just about bouncing back...you know...oh they haven't done this...it's literally like, how can we stop people coming in because we haven't got the resource and the capacity to deal with the demand.”

Interviewee 10, General Practitioner

On top of this, GPs are seeing increasingly high numbers of patients with mental health problems. The most recent data from 2018 suggests that 40% of [GP appointments](#) involve mental health. This number is now likely much higher due to the impact of Covid-19, and growing levels of poverty impacting on mental health (examined in more detail in Section 5).

We heard from one GP that mental health cases can be the most challenging, because typically they are enduring and there is less evidence for the efficacy of mental health treatments compared to physical health treatment. In addition, the amount of time it requires to talk sensitively to someone about their mental health is often not possible in a system where GPs are often limited to standard 10-minute appointment times due to a lack of time and capacity given current workload demands.

Whilst GP training equips people to treat and support people with uncomplex common mental disorders, such as low-level anxiety and depression, it does not necessarily equip them for more complex cases. However, increasingly more complex cases are remaining in general practice due to the difficulties of referring them to secondary care.

“We are holding a lot more risk because unfortunately the mental health services are just not there. They’ve not been there for a long time, they’re in disarray...literally someone has to be about to jump off a building before there is an intervention. And the GP has to manage that.”

[Interviewee 10, General Practitioner](#)

Another problem we heard was that patients can become ‘lost’ when general practice is unable to perform assertive outreach on patients who have been discharged from Community Mental Health Teams (CMHTs) but do not report to general practice to receive generalised ongoing care in the community. This is something some patients can find challenging for many reasons, such as poor signposting, or suspicion of health services that they may feel have treated them unfairly in the past. Under-resourcing makes such assertive outreach difficult.

It is not just between general practice and CMHTs that a tension exists in working together to provide patient care. We were told by some psychiatrists we interviewed that misconceptions and misunderstandings about mental illness and psychiatry exist elsewhere in secondary care. We spoke to doctors who found that they were often sent patients other parts of the hospital could not support, but who did not have a mental health problem, thus taking up more of their already stretched time.

“There’s an expectation that psychiatry isn’t just for mental illness...it will mop up anything that other people don’t understand or like. There was this patient who...turned up at the emergency department refusing to say what her name was and that was the only symptom she had. She was sort of fine but she wouldn’t speak and she wouldn’t say what her name was. Sometimes she’d write something down on a pad. So she just got immediately referred to psych...there was absolutely nothing wrong with her. But all that was psychiatry for some reason.”

Interviewee 4, Consultant Psychiatrist working in A&E

Good patient care requires a good working relationship between all the parts of the system required to treat and support a patient. From our interviews and from the wider literature and data analysis, it’s clear that central government’s inability to resource mental healthcare, as well as physical healthcare, in England is impacting the ability of services to do this effectively, fuelling tensions, undermining trust between teams and ultimately risks compromising patient care.

A&E is struggling to respond to demand caused by poor resourcing of other areas of mental healthcare.

Accident and Emergency care provides a vital service for people who are in mental distress or crisis. The expansion of liaison psychiatry, which works at the interface between physical and mental health by providing psychiatric care to general medicine patients (often in emergency departments) has been a positive development, as has expanding the availability of 24/7 crisis lines.

However, as overstretched GP practices, CMHTs, and secondary psychiatric services struggle to meet demand, crisis care is becoming overwhelmed. Whilst other parts of mental healthcare are, to some extent, able to control who comes through their doors, emergency care is the door that is always open. It is always somewhere that someone can go when their mental health has reached crisis point, and they cannot access other services, or do not know how to.

“...patients always know that they can come into the emergency department...between spring this year and spring 2022 there was a doubling of Mental Health Act assessments in the emergency department. Which I think is fairly indicative of more systemic issues and obviously it impacts on our workload.”

Interviewee 4, Consultant Psychiatrist working in A&E

For a patient who needs to be admitted to hospital for treatment, a limited number of beds (as discussed in Section 1) makes this difficult. People with mental health needs are currently **twice as likely** to spend 12 hours or more in EDs from their time of arrival as other patients. From our interviews we heard one example of a patient who had been waiting in A&E for five days for an inpatient mental health bed.

Crisis services for mental health patients are at breaking point; the Royal College of Emergency Medicine [reported](#) in 2022 that A&E mental health attendances increased by 133% between 2009/10 and 2018/19, with 12% exceeding 12-hour waiting times, twice as frequently as non-mental health attendances. Higher rates of A&E attendance are associated with poor mental health and in recent years high service use by psychiatric patients is replicated across the wider urgent and acute care pathway.

For children and young people the picture is also bleak. In February 2024 it was [reported](#) that the number of children referred to emergency mental healthcare in England had soared by more than 50% in three years. The Royal College of Psychiatrists reported that this increase amounted to more than 600 mentally ill children a week deteriorating to such a state that they had reached crisis point.

“I think that the impacts [of system pressures] are on the patient group as a whole, not just mental health patients [be]cause obviously the services trying to see them are a bit more stretched, but also that impacts on other users of the emergency department as well. So I think in that way it’s become a poorer experience and it knocks on to things like, you know, the actual care environment but also things like the hours of waiting until you can be assessed and all that sort of stuff.”

[Interviewee 4, Consultant Psychiatrist working in A&E](#)

IT systems do not allow for doctors to look after their patients as they would wish.

“the relationship between secondary mental healthcare and secondary acute services is poor. It’s often made substantially worse by IT problems.”

[Interviewee 7, Psychiatrist](#)

There is little to no interoperability (the ability of computer systems to connect and communicate with each other) between services in the NHS. This means that crucial information shared by patients with health services does not follow a patient’s care pathway. While this is a cause for concern in any healthcare setting, it is particularly damaging in mental health services where patients can be forced to relive trauma related to their condition to provide their clinician with all the information to help treat them. It has become an accepted frustration in the NHS, and there has been little government intervention or regulation to force suppliers to make their systems interoperable. This wastes doctor and patient time and is a significant drain on productivity.

“[In our city] we have two mental health trusts. But we don’t share the same electronic medical records. And as you can imagine if a patient is coming from one part of the city to another part...it can be very difficult to piece together what’s been going on...I had this recently...a patient that had been previously known to the other trust had presented to us in a crisis, but we had no information about them and trying to obtain that information, it was a bit arduous.”

Interviewee 9, Psychiatrist

Historic and ongoing competition between IT suppliers mean that digital systems in the NHS seldom work well with each other. In mental healthcare, this carries additional stress for patients, and must be addressed urgently.

The social care system is collapsing, and people with mental illness are left behind.

“The biggest struggle for me is social services. I think because especially in our group of patients, it’s really, really hard to get the support that they need via social services.”

Interviewee 2, Consultant Psychiatrist

Mental health social care is a branch of social care which supports people who live with a severe mental illness to stay well in the community and is instrumental in improving people’s quality of life and reducing admissions to hospital. It is misunderstood and appears to be neglected by health and social care bodies alike. Doctors working in mental health services told us about the critical need for more social care support for their patients.

“I think there could be a lot more closer working with social services...I think the whole thing doesn’t work. So I think you either fully embed social services and the NHS together so that it is one, especially for older people it is so important to have effective social services, and that includes having you know, day centres and things like that locally as well. It’s not just purely about having carers coming into people’s homes, it’s about providing other things outside of the box, as it were.”

Interviewee 2, Consultant Psychiatrist

The social care system in England is in dire need of reform. Years of chronic underfunding, workforce issues, and system fragmentation have undermined the crucial role social care plays in the health and wellbeing of the population. Meanwhile, [demand for care is growing](#), driven by changes in demographics. [Demand from working-age adults](#) in 2021/22 had increased by 22 per cent since 2015/16 (it was a 9% increase across all ages). Meanwhile, [in 2021/22, local authority budgets](#) (which include social care) were 10.2% below 2009/10 levels. This means people are missing out on support: in 2021/22, [nearly one-third of requests](#) for local government funding for social care resulted in no support.

Mental health social care must be prioritised and better resourced to allow people to have a better quality of life and stay in the community. From a practical point of view, this would go some way to addressing significant problems for the NHS, such as delayed discharges due to a lack of social care to support someone after coming out of hospital.



Good practice case study two.

The growth of the voluntary sector in supporting people with their mental health has been a welcome development.

The voluntary sector can provide people with essential support with their housing, employment, financial assistance, and other areas that support people's mental health outside of a clinical remit. This is crucial where there is an absence of sufficient government investment in public services, as this report has examined in Section 1. We spoke to doctors for whom the voluntary sector provided vital support for their patients.

“Well, our crisis lines locally are all provided by the voluntary sector. And they are incredibly well received by our service users. They get really good feedback. Actually, the vast majority of our service users who call them are in some sort of emotional crisis. They're not acutely psychotic. I mean, if you were acutely psychotic, I very much doubt you would be ringing a helpline, and I very much doubt your families would either, they'd be bundling you in a car and taking you to A&E, which is where you should be.”

Interviewee 3, Public Health Consultant

Volunteer services are also crucial for the promotion and protection of good mental health and can be vital to prevent the onset of acute illness. Where NHS services cannot necessarily provide specific support for groups that are unfortunately often still less well served by mainstream services, such as LGBTQ+ groups, the voluntary sector can provide tailored support for people who would benefit from a more inclusive approach to mental health promotion and prevention.

The peer support workforce, meanwhile, can be a lifeline for patients and doctors. This is made up of people who have lived experience of the same illness or condition as someone for whom they are providing emotional support. Whilst it should not replace medical treatment, it can be an alternative or additional option for patients, particularly when it is hard to access specialist clinical care. Peer support can free up clinical time for doctors and provide patients with more appropriate care. We heard from one doctor who felt the move towards peer support was a positive development for the NHS. Whilst not exclusively voluntary, volunteers are sometimes recruited to perform this important role.

“[There’s been developments in] emotional support for people who are not so straight forward that they can just go into IAPT, but perhaps have long term personality or long-term emotional support needs. And they find it difficult to interact with standard psychiatry, which is probably inappropriate for them anyway. There’s now a burgeoning of a different source of alternatives for them, including peer led or people with lived experience interacting with them.”

Interviewee 4, Consultant Psychiatrist working in an Emergency Department

Even though some peer support services are staffed by volunteers it is not a free service and must also be adequately funded and resourced.

Care coordinators can bring different parts of the system together but there are not enough of them

The need to coordinate better across different parts of the system is recognised. One doctor told us that the most critical need for CMHTs is for more care coordinators.

“We haven’t got enough care coordinators- we’re constantly short of them.”

Interviewee 7, Psychiatrist

Care coordinators help to navigate and arrange care across the whole health and care system, bringing together multi-disciplinary teams. A care coordinator can arrange services such as occupational therapy, social care, and psychotherapy for a patient; all vital components of providing someone with a good quality of life and keeping them out of hospital for as long as possible. An expansion of care coordinators has the potential to be of particular use to support people with complex needs, particularly those with long term or multiple conditions – for example [NICE provides guidance](#) on the use of care coordinators for those with co-existing substance abuse and mental health problems. However, this is only possible where services exist, an issue discussed further in section 5.

Care coordinators could also be used to address the difficulties patients have in accessing the right care in a complicated and multi-faceted mental healthcare system. For many patients, it feels there is no right door. The BMA supports the ‘No Wrong Door’ vision for healthcare. The NHS Confederation and Centre for Mental Health define this vision as “People will be able to present at any point in the system – from pharmacies, advisory services and community groups to education, social services, the criminal justice system and primary care – and be guided to the right support without delay.” The vision is that by 2032, there will be no wrong door for anyone wanting support for their mental health or neurodiverse needs. The expansion of referral pathways in mental healthcare was a response to diversifying the ways in which people could access help. However, a lack of resources overall has meant services are in too many cases more thinly stretched, and triaging and referring is taking up more time than ever and taking away time for treatment. We heard from doctors working both in primary and secondary care that this was a problem. The more staff in the workforce who can coordinate care and help someone get the help they need more quickly and easily, the better.

Policy recommendations

- **The UK Government must regulate IT system suppliers to make their products interoperable by default.** Doctors are not given the technological infrastructure to allow them to work efficiently together. Making it mandatory for IT systems to work well together will help doctors to provide care more efficiently and avoids harm for mental health patients.
- **The UK Government must further embed mental health social care within the NHS, for example through in-house social workers.** The vision of both the *Five Year Forward View for Mental Health*, and the *NHS Long Term Plan* is for holistic mental health care that is personalised and community focused. For this to happen, care must be better coordinated and integrated between the NHS and the care sector – and this cannot happen without dedicated staff. Roles needed include social workers supporting the transition between inpatient care to home, as well as care coordinators to ensure the right support is provided at the right time. ICBs should be provided with guidance and supported to work with their partner ICPs to embed social care expertise within NHS services.
- **NHS employers in England should establish and adequately fund a peer support workforce, voluntary and paid, in mental healthcare settings where appropriate.** There are crucial elements of support and recovery that are more appropriately provided outside a clinical sphere. ICBs should help to facilitate such an expansion of services.

4

Our society is not set up to support people's mental health and to prevent the onset of mental illness.

The extent to which medical care can address rising rates of demand for mental healthcare is limited. Mental health, like all other aspects of health, [is significantly influenced by social determinants](#) (the conditions in which people live, grow, work and age.) If someone's mental illness is caused or exacerbated by the social determinants of health, a doctor's ability to provide care is compromised. There is a limit to what a doctor can do when someone's mental health is so affected by living in poor housing, unemployment, or difficult family lives. It was clear from many of our interviews that doctors feel they are working with patients for whom the odds are stacked against them.

There is a well-established body of evidence showing that prevention is better than cure and benefits us all. From a population health perspective, the chances of becoming ill are lower. For the doctor, there is less demand on over-stretched services. For the UK government, it is more cost-effective. The cost of mental illness is significant, and the aforementioned figure of nearly £101 billion in England alone is an [underestimation](#) as it does not include the costs associated with dementia, intellectual disabilities, alcohol or substance abuse, or deliberate self-harm or suicide.

Despite this, there appears little sign the UK government has grasped the significance of the issue and how failing to tackle these wider social issues is increasing demand for NHS mental healthcare. Doctors feel they are picking up the pieces of a government that is failing to protect the mental health of the population and mitigate demand on overstretched NHS services.

Doctors struggle to support patients' mental health in a society which has not addressed social determinants, including poverty and racism

Someone's socio-economic status is inextricably linked to their mental health. Maintaining good mental health is made more difficult without a decent standard of living and quality of life. The latest figures show that in 2021/22, around [one in five people in the UK](#) (22%) were living in poverty, which equates to around 14.4 million people. This had gone up by one million from the previous year. Across the UK men and women in the poorest fifth of the population are [twice as likely](#) to be at risk of developing mental health problems as those on the average income. Meanwhile, [the growing numbers of people](#) experiencing housing precarity and homelessness is having a detrimental impact on the population's mental health. Nearly two-thirds of renters in 2023 said [their mental health had worsened](#) due to housing worries in the past year.

Meanwhile, children whose parents report poverty in pregnancy are [nine times more likely](#) to face additional traumatic experiences compared to their wealthier peers. Adverse childhood experiences (ACEs) have a causal relationship with mental illness. When a child experiences trauma in their childhood, such as the death of a parent, substance abuse in the home, or physical neglect, they are more likely to develop a mental disorder at some stage in their life.

Despite everything that is known about the links between poverty and mental health, the UK government has not shown an understanding that to address poverty is to protect the country's health, the economy, and the NHS. The BMA has raised concerns that the [country is getting sicker](#), but still not enough is being done to stem the tide of poverty and ill health in the face of years of austerity and the cost-of living crisis.

“The entirety of society seems designed to make people mentally unwell...if we had less poverty, if we had nicer workplaces, if we had, you know, housing that wasn’t rubbish. If our social services system worked and supported families where there was abuse or neglect or indeed removed children from those environments and looked after them well. If we didn’t have a society that very heavily promoted body dysmorphia, we wouldn’t have as many eating disorders.”

Interviewee 7, Psychiatrist

The government’s failure to address rates of poverty impacts doctors’ ability to provide mental healthcare in two ways.

Firstly, doctors are treating patients for whom only the symptom can be treated rather than the cause. A doctor can prescribe anti-depressants for someone who has developed acute anxiety because of a precarious living situation, and that person’s symptoms may be alleviated. If the person remains in poverty, however, drug therapy is unlikely to be a long-term solution for the patient.

Secondly, high rates of poverty are creating more demand on mental healthcare, and so the opportunity is being missed to reduce the rates of mental illness in England.

Meanwhile, black people are overrepresented as patients in many parts of the mental health services. They are four times more likely to be detained under the Mental Health Act than white people and are more likely to have a serious mental illness. Black people still experience racism at high rates in England and are more likely to be living in poverty than their white peers. The evidence shows us that structural racism leads to people from ethnic minority backgrounds having poorer health outcomes. Both racism and poverty are causal [factors for mental illness](#). Structural inequalities and institutional racism in England must be dismantled if we are to address such stark inequalities. The failure of the UK Government to commit to the reform of the Mental Health Act in November 2023, which included approaches to reduce the disproportionate number of black people detained (for example by strengthening patient voice), has been a devastating blow to hopes of progress.

Doctors remain in a situation in which demand for their care is high, but they are often unable to treat the cause of the problem, instead having to focus on the symptoms. That is unsustainable and must be addressed to secure a mentally healthy population and a mental healthcare system that is able to effectively treat those with a mental illness.

Public mental health is not funded adequately, and this is compromising prevention of ill health

“Everybody wants to do the right thing. Everybody’s trying really hard, but we’re just not putting our money where our mouth is when it comes to saying we need to invest in prevention and early intervention.”

Interviewee 3, Public Health Consultant

Public mental health has been an area that has received scant attention by the health and social care system. A decade since the release of a [report](#) by the previous Chief Medical Officer, Professor Dame Sally Davies, on the topic there has been very little progress on its recommendations.

However, some NHS mental health care, as previously discussed in Section 1, has received more attention in recent years in terms of funding targets. Within that, acute care is prioritised, whilst an upstream, public health approach is largely ignored. This is only increasing pressure on the NHS.

Public mental health refers to the promotion of mental health and wellbeing and prevention of mental illness. Public mental health interventions are wide ranging but include things such as population-level suicide awareness training and interventions, health visiting services which include support to prevent or support the treatment of post-natal depression, or tackling loneliness in older people.

Local authority funding for public health that funds specific preventative services including smoking cessation, some weight management support, and suicide prevention has been slashed in recent years. Since 2015/16, the local authority public health grant has been cut by [20% per person](#) in real terms once additional drug and alcohol funding is taken into account, according to the Health Foundation. And within dwindling budgets, local authorities are not prioritising mental health: in 2022/23, only [2% of total local authority spend](#) on public health was on mental health.

In addition to cuts to the targeted public mental health budget, other public services such as open spaces, recreation and sport, and libraries which have also been found to have an impact on public mental health, have also suffered serious funding cuts.

In both cases, services which prevent mental ill health are being deprioritised. Government must invest in prevention, through public health budgets and beyond, to ensure that doctors are able to provide mental healthcare for their patients that is sustainable.

Policy recommendations

- **The UK Government must protect budgets for the public services that contribute to mental wellbeing. This must be alongside the restoration of the public health grant to 2015/16 levels, which [the Health Foundation](#) has calculated would require an additional £1bn in 2023/24 price terms for 2024/25.** NHS mental healthcare in England is overstretched, and doctors are unable to provide care to all who need it. The public mental health budget should be increased, and cuts to public services such as open spaces and libraries that support mental wellbeing, should be reversed. The BMA supports a suggestion by Demos that all departments should have [specific budgets](#) for prevention set aside to aid these goals.
- **The UK Government must ensure financial security for all.** Mental illness is strongly associated with poverty. Mental health demand on services can and should be stemmed by providing everyone with the means to live a healthy life. Doctors can no longer pick up the pieces of government's failure to provide this. As a first step, the basic level of the main working age benefit, Universal Credit, should be raised to cover essential living costs in light of the [ending of cost of living payments](#), and the hourly minimum wage should be set at the level of the Real Living Wage for all age groups. Over the long term, the Government should explore reforms to ensure that both social security and wages guarantee everyone can access the income they need to stay healthy and well.

5

Pressures on the system are damaging patient care and particularly affecting certain groups, such as children or people with neurodevelopmental disorders.

The consequences of a failure of the UK Government to tackle the social determinants that are leading to poor mental health, and to alleviate pressures on the healthcare system are that not all patients are receiving adequate care, and some may not receive any care at all. Doctors in specialist mental health services, which are mostly located in secondary care, are increasingly unable to see as many patients as need their help, or they are not able to see patients as often as they were able to in the past.

Some patients fall through the gaps and are left without any support. One particular concern discussed by multiple interviewees is that there are limited opportunities for psychological therapies for those with more complex needs, leaving a significant group of patients with nowhere to turn.

Even where patients can access support, waiting lists are very long and people's mental health may deteriorate whilst they are waiting. Meanwhile, certain groups of patients are more adversely affected, creating or exacerbating inequalities.

Doctors are unable to see as many patients as need help, or as often as they once did.

Access to mental healthcare has become more difficult.

“[Support for people with mental health conditions] is shocking. We would not accept this in any other area of medicine.”

Interviewee 7, Psychiatrist

Demand for mental healthcare in England is higher than services are resourced to respond to. One consequence of this increased demand is that mental health services have been forced to be more selective about the referrals they accept. Thresholds for accessing care have gone up as spaces for treatment have become harder to come by. [In 2021, NHS Providers and NHS England produced estimates](#) which suggested that an estimated 8 million people with a mental health need were not in contact with the NHS. One significant driver of this is that many people are not meeting the threshold to access the services they need, even if they would benefit from treatment.

“What we are seeing is that our triaging is much more rigorous. So, patients that we would have seen, we aren't seeing now as much.”

Interviewee 2, Consultant Psychiatrist

This is reflected in the data. [In a 2022 NAO survey of NHS mental health trusts](#), most reported that waiting times and lists had increased in response to demand and service pressures, while nearly half had raised treatment thresholds (15 out of 33) and reduced provision in some service areas (six out of 33).

“Something that I’ve noticed is [that] sometimes patients fall through the...gaps. So...it might be determined that they’re not ill enough to have secondary care input but they’re too ill to have primary care input. It’s like OK...who looks after those patients then?”

Interviewee 9, Psychiatrist

Another symptom of under-resourced services is that patients who need mental healthcare face long waiting times, which can cause their mental health to decline further. [One survey](#) from 2022 found that nearly a quarter of mental health patients (23%) wait more than 12 weeks to start treatment. Over two fifths (43%) said that the wait between initial referral and second appointment (the point when treatment usually starts) had caused their mental health to worsen.

“There’s nothing [in mental healthcare] that you can get at speed.”

Interviewee 7, Psychiatrist

The transition from CAMHS to adult mental health services is another area in which people with a mental illness are falling through the gaps. The problem is exacerbated by strict criteria, which as discussed is deemed necessary due to limited resourcing.

“...another thing that I’ve noticed needs a bit more work is the transition from adolescent services into adult services. CMHTs just tend to have quite strict criteria for taking people on...[in CAMHS] we don’t always like to give people a diagnosis because we know that these things can be a bit of a label that you then sort of can’t get rid of. So we tend to work more with a problem list of difficulties...I think that can also be a reason why the adult team might struggle to say well...they’ve not technically got a diagnosis of what would we be supporting them with...”

Interviewee 9, Psychiatrist

Doctors are increasingly unable to see their patients as often, affecting continuity of care

The doctor-patient relationship is crucial in mental healthcare to promote recovery. For people who have suffered trauma, who are experiencing feelings of acute anxiety, or who are in emotional distress, it can be hard to trust someone enough to share details of difficult life experiences with them. To establish a trusting relationship takes time, and to maintain that trust requires [continuity of care](#). Unfortunately, doctors are increasingly unable to see their patients as often or for as long as they might like, both in primary and secondary care.

“...we, you know, used to see...patients, you know, on a regular basis, they felt really supported and I felt I was, you know, I got to know them really well. But now I have one such patient and it’s very, very different...from the patient point of view they felt so well supported and I think they were better in themselves because they knew that they’re gonna go come and see [the doctor] in a few weeks, whatever. Whereas now I just don’t get that opportunity. Which is sad...”

Interviewee 2, Consultant Psychiatrist

There are not enough opportunities for doctors to refer patients to psychological therapies beyond the NHS Talking Therapies Programme

In mental healthcare, there are two main types of clinical care, psychological and pharmaceutical. Both can be effective for patients, especially when used together. However, the provision of psychological therapies requires more staff and is therefore more impacted by the disparity between demand and supply in the NHS.

“Fundamentally, we don’t have the resources for patients that we did 10 or 15 years ago. So thresholds for seeing us are much higher than they were, thresholds for having talking therapy are completely in a different league to what they were 10 or 15 years ago, and waits for stuff like that are much longer.”

Interviewee 1, Consultant Psychiatrist

Psychological therapies deployed by psychologists, psychotherapists, family therapists, and medical psychotherapists are crucial in the treatment of mental illness. The most common, publicly available talking therapy service available for people with a mental illness in England is the NHS Talking Therapies Programme, formerly known as Improving Access to Psychological Therapies (IAPT). This is a short-term primary care talking therapy service for people with a common mental disorder (such as anxiety, depression, or obsessive-compulsive disorder), with most treatments based on cognitive behavioural therapy (CBT). This programme is a centrepiece of the NHS’ recent focus on mental health, with over 1 million people using the service annually. NHS England continues to expand it, with the aim of reaching a significant proportion of people with a common mental disorder. Recovery

rates for the service are getting better (though still only just above 50%), and targets for people to be seen within six weeks are [consistently](#) met. Latest data shows that in August 2023, 89.7% of referrals waited less than six weeks to access NHS Talking Therapies services, and 50.3% moved to recovery (slightly above the target of 50%).

However, there are limitations to NHS Talking Therapies. Firstly, the types of therapy available for people within the programme are limited. CBT is an effective therapy for some, but it is short-term and highly structured which may not suit everyone. For people whose illness is not complex or severe enough for specialist services, but for whom CBT is not useful, there are limited options within the NHS. With no other therapy treatment options available in primary care and higher thresholds for referrals to specialist mental health services, this is leaving a significant gap for access to other psychological therapies.

“So if you’ve got quite a low level mental health problem like anxiety or depression, you can actually access [NHS Talking Therapies.] But then as soon as that person feels suicidal, that becomes like an exclusion for that. And then you wonder who’s gonna see them. And if you become repeatedly or have long-term suicidal ideas, you seem to be excluded from a lot of things. And then if you look at, say, the specialists in the complex needs services, they’ve got massive waits to go in there.”

[Interviewee 4, Consultant Psychiatrist working in A&E](#)

Secondly, people with active suicidal ideation, or more complex mental illness (or severe mental illness known as SMIs), such as bipolar disorder, personality disorder, or a primary diagnosis of an eating disorder are excluded. For example, for someone with a personality disorder, a different type of therapy, Dialectic Behavioural Therapy (DBT), may be more useful, but it is much harder to access than CBT. People with an SMI are therefore more adversely affected by poor access to psychological therapies.

“So you get, you know, a little bit of CBT or whatever when really you need...psychodynamic therapy or interpersonal therapy or DBT...Access to non-drug therapy is shockingly poor.”

[Interviewee 7, Psychiatrist](#)

Meanwhile, there are inequalities in outcomes for people from black and other ethnic minority communities within the NHS’s largest talking therapies programme. This should be of deep concern. In addition to this, the most recent [Adult Psychiatric Morbidity Survey](#) found that 14.5% of white British people aged 16 and over were receiving treatment for mental health compared with only 6.5% of people from black and minority ethnic backgrounds. Improving access to Talking Therapies must be a crucial part of addressing this disparity. [The NHS Race and Health Observatory report](#) noted poor outcomes can be tackled and even disappear when access is improved, and culturally sensitive therapy is provided. This is discussed more in Section 5.

Although the expansion of NHS Talking Therapies has largely been a success, there needs to be a wider range of psychological therapies available, with more consideration of how to close the gap for people from black and minority ethnic groups. This will ensure people are not unnecessarily excluded from better mental health and a better quality of life.

Specialised and targeted care is particularly poor for certain groups

“...people who have got any level of complexity or inequality, just the potential for them to fall through the gaps is just massive.”

Interviewee 3, Public Health Consultant

Too many patients are being let down by mental healthcare, and some groups are worse affected than others. This includes children and young people, patients with a neurodevelopmental disorder, people with an addiction, and those from black and minority ethnic backgrounds.

Children and young people are not getting the help they need.

For children and young people, [the latest evidence](#) suggests that rates of mental illness may be growing at a faster rate than amongst adults. Between 2017 and 2022, rates of probable mental disorder increased from around 1 in 8 young people aged 7-16 to more than 1 in 6. For those aged 17-19, rates increased even faster, from 1 in 10 to 1 in 4.

The importance of intervening early in someone’s life to prevent or manage mental illness cannot be overstated. Over half of all mental health disorders start [before the age of 14](#), with 75 per cent by 24 years of age. Early intervention is therefore key. Despite this, many are not able to access the help they need when they need it. In 2022, [a major study](#) conducted by Young Minds of nearly 14,000 young people under 25 found that over 40% waited over a month for mental health support after seeking it.

“The most heart breaking for us is seeing how many children we deal with, who, be they at school or university, are left waiting and waiting for years even to be seen once you know, and then they’re given a leaflet or, you know, an online programme, I mean it’s just horrendous.”

Interviewee 8, Consultant Psychiatrist

It is no surprise, then, that in August 2023, it was [revealed](#) that the number of children in mental health crisis had reached record levels in England. For the first time, urgent referrals of under-18s to mental health crisis teams reached more than 3,500 in May, three times higher than in May 2019. Just over a quarter (26%) of young people said they had tried to take their own life because of having to wait for mental health support.

In 2018, the government [committed to introducing piloted waiting time targets](#) for children and young people’s community mental health services. These have been piloted but not yet implemented across the system.

Furthermore, government targets for children and young people’s mental health services are insufficiently ambitious. An NAO report into Progress in Improving Mental Health Services in England from February 2023 found that even if the NHS achieves its access targets for children and young people 2023/24 as set out in the Long Term Plan, only two fifths of 0-17 year olds with diagnosable need will be accessing services.

Waiting lists for neurodevelopmental disorders are growing, and doctors are not resourced to see as many people who need support

We heard from doctors about their concerns for people with a neurodevelopmental disorder. Though autism and attention deficit hyperactivity disorder (ADHD) are not considered by some to be mental health disorders, they are diagnosed and treated within mental healthcare.

“Care for people with autism and ADHD, that’s really, really poor at the moment. The waiting lists are just absolutely through the roof.”

Interviewee 3, Public Health Consultant

The growth in people asking for treatment for attention deficit hyperactive disorder (ADHD) has grown exponentially in recent years. [One major study](#) found that between 2000 and 2018, there was approximately a twenty-fold increase in ADHD diagnoses and nearly fifty-fold in ADHD prescriptions in men between the ages of 18-29. The rise in demand for services has resulted in some adults in the UK facing [a four year wait](#) for an assessment on the NHS. However, understanding the scale of the problem is difficult as there is no official national data on waiting times for autism and ADHD services.

People with autism often also have very significant anxiety, low mood, and symptoms of obsessive-compulsive disorder, and stand to benefit from a well-resourced mental healthcare system. Access to diagnosis and support is challenging for patients; a record 190,000 patients are [expected to be waiting](#) for an autism diagnosis by 2024.

In both cases, private provision is increasingly seen as the only way to get an assessment more quickly. Some private clinics have been exposed as providing assessments that do not meet the standard of quality set out in guidance from the National Institute for Health and Care and Excellence (NICE). Patients are therefore paying money for a sub-standard assessment which may incorrectly diagnose them. Aside from the emotional implications this may have for someone, patients who then go to the NHS for treatment are turned away because their diagnosis does not meet the NICE guidelines. This should not be an acceptable experience for anyone, and is only exacerbated by the lack of resourcing provided to NHS services.

People with a substance addiction are often falling through the gaps

There was particular concern amongst our interviewees about the barriers to care for people with substance abuse.

“The world of addictions is a disaster...it breaks my heart.”

Interviewee 8, Consultant Psychiatrist

There are very few NHS services for people struggling with addiction, particularly when mental illness is also a factor, and doctors do not receive the training they need to treat people. Despite [NICE guidelines](#) that clearly state people with a separate mental illness can be treated for an addiction, we heard in interviews with doctors that patients are sometimes told different things by services. Some patients are told to seek treatment for their mental health before getting treatment for their addiction, but are then told they have to seek treatment for their addiction before getting treatment for their mental health. Many are therefore left without any help at all.

There is a considerable lack of expertise in the NHS in the treatment of people with addictions, which is particularly concerning at a time of rising substance abuse deaths. [Drug related deaths](#) are at a record high in England and Wales, with the mortality rate having increased every year since 2012. Since Covid-19, meanwhile, [alcohol specific deaths](#) have risen sharply; rates seen in England and Wales in 2021 are also at a record high. Despite a high need in the population, doctors find themselves severely limited in their ability to help people with a substance abuse problem, due to the severe pressures and lack of funding across mental healthcare more widely.

The most significant reason for higher levels of substance abuse and an inability to treat people with a substance addiction can be traced back to the Health and Social Care Act of 2012, which transferred addictions services in England from the NHS to local authorities. This has since had a disastrous effect on addictions services. Funding was cut for these services, as local authorities found themselves unable to afford to commission them with their ever-decreasing budgets. Drug and alcohol services have been one of the biggest victims of these cuts, experiencing a 17% cut between 2015/16 and 2023/24. The [2021 Black review of drugs](#) called for additional reinvestment, which the government granted with £780 million to rebuild the drug treatment system, however the level of underinvestment over the prior decade has had a devastating effect not just on the services themselves but on addiction psychiatry as a medical specialty. In February 2020, the Royal College of Psychiatrists [published a report](#) that warned that addiction psychiatry could be wiped out in the next 10 years, such was the extent of the cuts. It found that the number of higher training posts across England had fallen by 58%, from 64 in 2011 to just 27 in 2019, leaving some regions without a single trainee. Not only does this affect the availability of consultant addiction psychiatrists to run those services which have survived the cuts, but it means there are fewer specialists in the NHS who can pass on their expertise and experience to junior colleagues. Furthermore, with fewer addictions services in the NHS, there are fewer training opportunities for doctors and other health professionals to build knowledge and experience in a serious health issue that is affecting increasingly large numbers of people.

“There’s nobody [where I work] really with addictions expertise, so it falls to the ED staff, the GP, and possibly me. We’re not commissioned to provide addiction services [be] cause they’re all local authority now. But we sort of do... You can get some [addictions expertise] in ED, you can get some in a ward, but that’s just by accident.”

[Interviewee 4, Consultant Psychiatrist working in A&E](#)

There are solutions and examples of services that could help those with addictions. Yet they will not be possible without specifically targeting resources at this issue. In our interviews, one doctor noted that the funding and workforce attention that Early Intervention in Psychosis (EIP) services had received had made a difference. EIP services are specialised services that aim to provide prompt assessment and evidence-based treatments to people with first-episode psychosis. A key principle of EIP services is assertive outreach. Dedicated resourcing has allowed for assertive outreach to a population who may not have capacity or agency to seek help. The [most recent audit report](#) of EIP services from 2022 reported that 66% of teams had an increase in staff posts in the last year and had shown improvement in key outcome measures such as physical health checks for their patients. The nature of substance abuse means proactively seeking help is extremely challenging, and so assertive outreach in this service would help enormously. Services, however, are not currently resourced even to support everyone who does manage to seek courage to ask for help.

There are racial inequalities in mental healthcare

Across prevalence, access to support, and outcomes from treatment, people from black and ethnic minority backgrounds fare worse in mental healthcare than white people. Black people are more likely to be diagnosed with a mental illness than white people and have worse

mental health outcomes. As we have outlined already in this report, structural inequalities and institutional racism that exists in society, and within the NHS, must be acknowledged and addressed to improve the mental health care of black people.

A recent [major study](#) by the NHS Race and Health Observatory into IAPT (or the NHS Talking Therapies Programme as it is now known), found that in comparison with White British people, with the exception of Chinese people, people from minority ethnic groups (including non-British White people) experience worse outcomes (although this has narrowed in recent years), wait longer for assessment, and are less likely to receive a course of treatment following assessment. One [recent study](#) also found that black people were less likely to refer themselves to NHS Talking Therapies (known as IAPT at the time of the study).

The Patient and Carer Race Equality Framework (PCREF), published by NHS England in October 2023, seeks to hold providers accountable to hold data on racial communities, co-designing plans, competencies that need to be attained, and require providers to evidence collecting patient and carer feedback and then using that feedback. Such accountability is essential to securing meaningful and sustainable change.

Another practical step that can be taken to address poorer rates of access and outcomes is to address the overwhelmingly white Talking Therapies practitioner workforce. The ethnicity of the Talking Therapies programme workforce is broadly consistent with population demographics across England, with 80% of staff reporting their ethnicity as 'White or White British' compared with 83% of the wider England adult population. However, the fact that black people have higher rates of mental illness suggests a significant disparity. In a survey for the [Race and Health Observatory](#) report just over one-third of clinical leads (34%) and commissioners (36%) 'disagreed' or 'strongly disagreed' that in their Talking Therapies programme, the clinical workforce reflected the population served. A [2016 qualitative study](#) found that black and minority ethnic service users felt that therapists may not understand their presenting problem within their psycho-social context. The importance of representation cannot be overstated when working with a population who have little faith that their culturally specific needs will be accounted for in treatment.

Policy recommendations

- **NHSE must expand NHS-funded talking therapy training across the full range of evidence-based therapies to address the gap in provision between services for common mental health problems and high threshold specialist provision.** There are too few opportunities for people to access psychological therapies for whom NHS Talking Therapies is considered inappropriate, either because they are too ill, or because CBT won't suit their needs. Exclusion criteria cut people off from accessing help when there is little alternative provision. Furthermore, psychological therapies must ensure there is better access for ethnic minorities, and outcomes are more equal to their white peers.
- In line with the Black Mental Health and Wellbeing Alliance's manifesto, **the UK Government must support and resource the national adoption of the Patient and Carer Race Equality Framework (PCREF).** This framework will go some way to address the unacceptable racial inequalities experienced by black and minority ethnic patients in healthcare. Support must be provided for as long as it is needed, particularly until all mental health service providers have adopted the PCREF in full. This must be resourced with staff and funding to ensure a significant improvement in access, experience, and outcomes.
- We support [Healthwatch's recommendation](#) that **NHS England must collect and publish national data on ADHD referrals and waiting times.** Without available data with which to hold decision makers to account, we are not able to fully understand how people with neurodevelopmental disorders can be better served. In addition, until mental health services are better funded and resourced to reduce waiting lists, NHS teams should be provided with updated guidance for supporting patients waiting for a diagnosis. In the long-term, mental health services should be funded and resourced to reduce waiting lists for people with neurodevelopmental disorders.

Conclusion

Doctors who provide mental healthcare in England are struggling to provide the care they want to for patients. The doctors we interviewed who worked across the NHS impressed upon us the considerable difficulties of treating patients in the current system. What we heard in our interviews is that doctors are working in an environment that is not conducive to supporting people with their mental health and with a wider society that does not support mental health and wellbeing. This is strongly supported in the data and literature.

Whilst in recent years we have seen a welcome focus on mental healthcare, with accompanying policies, promises and targets, there has been no overall improvement in services and services are facing ever increasing demands this is incredibly frustrating and often distressing for doctors who want to deliver the best care possible to their patients.

From our interviews, and accompanying data analysis, we can conclude a key reason for this is because mental healthcare has not been provided with the funding or staff necessary to achieve such an improvement for patients and the doctors who work within it. Targets are often unambitious, and it is difficult to ascertain how much funding and staff is needed because of a lack of consistent data on the prevalence of mental illness in England.

Just like all staff in the NHS, doctors in mental healthcare working extraordinarily hard for patients. We can see with amazing clarity what can be achieved when those efforts are supported with workforce and adequate funding; the success of gambling addiction clinics is one such example. Without a concerted effort from central government to resource mental healthcare based on demand (which continues to grow beyond what the NHS can respond to) as well as changes to society to promote good mental health, the future looks bleak. The NHS will continue to haemorrhage staff, patients will receive worse care, and we will be a poorer society for it. The case for change is evident; the UK government must respond urgently.

Annex 1: An overview of the mental health system in England

The mental health system is complex. NHS-funded mental health services are provided by a combination of NHS trusts, GPs, and non-NHS providers. Services can be in community, primary care, inpatient, and A&E settings, or accessed digitally. There are separate services for adults, older adults, and children and young people. (In 2021/22, services for children and young people made up 8% of [mental health service spend](#).)

How mental healthcare is provided and by whom varies at a local level. Most NHS services are now commissioned locally by the 42 [Integrated Care Boards \(ICBs\)](#) across England, which took over responsibility for NHS services, funding, and commissioning in their local areas from CCGs (Clinical Commissioning Groups) in 2022. Each ICB allocates funding and responsibilities for services to NHS providers, such as NHS trusts, primary care providers, and GPs. How this money is allocated is largely determined by each ICB individually and based on their own assessment of their local population's needs, meaning that NHS services can and do vary across the country.

Once commissioned by an ICB, NHS providers may directly provide these services themselves, but can also in turn commission other NHS or non-NHS providers (such as the voluntary and community sector) to provide them on their behalf.

In addition, although most services are commissioned locally by ICBs, some specialist NHS services, such as adult secure care, are commissioned at a national level.

Local authorities also commission and provide some health and care services for specific groups and areas where they have statutory duties and powers. This includes some mental healthcare for children and young people in schools, for adults with an addiction, and for adults who need care after being held under the Mental Health Act. Local authorities receive some funding from the Department of Health and Social Care to do this, as well as supplementing with local tax revenue.

ICBs and local authorities can also pool their resources and jointly commission certain mental health services, with the intention of providing more co-ordinated care. These arrangements are typically pursued under so-called 'section 75 agreements' which, under the NHS Act 2006, allow NHS bodies and local authorities to contribute to a common fund that can then be used to commission health or social care services. The UK Government has signalled its intention to expand the use of pooled budgets, meaning that they may become an increasingly common feature of the commissioning and provision of mental health services.

Annex 2: Research methodology

The report is based primarily on research undertaken by the BMA between July and September 2023. The BMA carried out semi structured interviews with ten doctors working in mental healthcare. We spoke to doctors working in psychiatry, general practice, emergency medicine, and public health.

Participants were identified after we sent out messages to BMA member networks asking for volunteers happy to be interviewed anonymously for a report examining the experience of doctors working in mental healthcare. We made a concerted effort to speak to a diverse group of doctors along ethnicity, age, grade, geographical location, and gender lines. We also wanted to speak to doctors both close and not close to BMA policy making.

The standard questions we asked, not including follow up questions or points of clarification were as follows.

Experience of supporting patients

1. What does a typical day look like for you?
2. In your view, how well does the mental healthcare system currently support patients?
3. Can you provide an example of when you or your place of work was able to provide mental healthcare which made you feel satisfied the patient was well supported?
4. Can you provide an example of when you or your place of work was not able to provide mental healthcare which made you feel satisfied the patient was well supported?
5. What do you see as the major issues with the system affecting your ability to provide mental healthcare?
6. How well do you think the different parts of the mental healthcare system work together to identify and treat patients with mental illness?

How the system could work

1. What changes within the NHS are needed to make you better able to provide the care you wish to?
2. Are you aware of better models of care elsewhere you would like the NHS, or where you work, to adopt?

Changes and trends

1. Have you seen any changes in how patients receive mental healthcare during your time working in the profession?
2. Have you any experience in trying to change how a service provides care? What worked well, or less well?

Final summary

1. Is there anything else you would like to briefly mention that we haven't covered today?

The qualitative research was supplemented by stakeholder interviews. These did not follow the interview questions exactly but were based on the semi-structured interview questions. We interviewed The Royal College of Psychiatrists, Mind, and Rethink Mental Illness. We also canvassed views from patients and carers, and their feedback has helped shape the report.

Thank you to everyone who gave their time to speak to us and share their views, which have been invaluable in shaping this report.

BMA

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