Health and Social Care Committee Inquiry into Community Mental Health Services.

**Joint submission: Local Government Association (LGA) and the Association of Adult social services (ADASS)**

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## Introduction: Local Government Role in Mental health

1. Local authorities have significant statutory and non-statutory responsibilities for community mental health. They employ the majority of Approved Mental Health Professionals (AMHP)[[1]](#footnote-1) who are responsible for undertaking duties[[2]](#footnote-2) under the Mental Health Act. They also have a shared responsibility with health partners for Section117 aftercare support for people discharged from mental health hospitals having been on s3 of the Mental Health Act. They commission a range of community mental health services, often jointly with the NHS and from a range of local providers - both Voluntary, Community, Faith and Social Enterprise (VCFSE) and independent sector. Such services support people with mental health issues in the community and leaving NHS hospitals.

2. Local authorities, as ‘leaders of place’ also have a wide range of roles, duties, and functions significant to nurturing communities that support wellbeing, including cultivating joint working between housing, public health, leisure, learning, community safety, the police and criminal justice system.

## 1. What does high-quality care look like for adults with severe mental illness and their families/carers?

3. In 2022, the Centre for Mental Health published research funded by the Department of Health and Social Care and jointly developed by the LGA and ADASS. The research focused on two core questions relating to the role of local authorities that commission and provide adult social services in assessing and meeting people’s mental health needs, these were:

* What does it look and feel like when support effectively considers people’s social and psychological wellbeing as part of mainstream assessments and care planning?
* What does it look and feel like when there is good collaboration in the commissioning and planning of mental health services and support?

4. Ten key themes were identified in the [published briefing](https://www.centreformentalhealth.org.uk/wp-content/uploads/2023/04/CentreforMentalHealth_ItFeelsLikeBeingSeen_Briefing60.pdf) as follows:

* **People who need mental health support say it feels good.** Service users give feedback such as “It feels like being understood as a whole person.”
* **Assessments are holistic, culturally competent and strength based.** Service users are routinely asked not just about their loss of functioning but also about their social and psychological needs and they recognise the strengths and resources they have.
* **Care plans are built around what service users want.** Care plans demonstrate that professionals have worked in partnership with service users to design care packages around the outcomes the service user wants.
* **Coproduction is meaningfully embedded at all levels.**
* **The local population and service users are well-informed and empowered to assert their rights.** The public understand what services they are entitled to; know their rights under the law; and understand how to access services locally.
* **Working conditions enable professionals to care with compassion.** Terms and conditions ensure that professionals are safe and supported in their roles.
* **Leaders have access to robust and valid monitoring data.** Metrics are available which enable leaders to measure whether their statutory duties are fulfilled; the extent of unmet needs; and whether the outcomes that service users want are being achieved. Performance data captures how service users feel about their care. Data systems between local authorities, NHS and other partners are inter-operable.
* **Directors of Adult Social Services demonstrate strong knowledge and expertise about mental health.** Senior leaders can clearly articulate the role of mental health in the context of social care, and how their services are experienced by service users (including racialised and marginalised communities).
* **There is a rounded service offer which includes public health and community work.** Service users can access care packages that are broad in scope and include offers on public health, community-level, and prevention work.
* **Senior leaders and social workers take an asset- based approach to their own skills and institutional capacity.** Social care professionals can articulate the added value of their skills in a mental health context and confidently challenge clinicians whilst maintaining good working relationships.

5. In addition to the above research, the Community Mental Health framework[[3]](#footnote-3) has identified what is needed - locally based, co-located services that are accessible to all at a point in their journey that is right for them. However, more join up and access to social work support is needed, as is better join up with local authority leaders so that the social determinants and the structures that support of good mental health are considered throughout the process.

**6. Joint Recommendation:** Local Government should be seen as an equal partner in the planning and delivery of Community Mental Health services, to ensure provision is appropriate to the place and well-integrated into local services.

## 1 a. How could the service user journey be improved both within community mental health services and in accessing support provided by other services/agencies?

7. Whilst the policy priorities have focused on creating more humane, seamless and supportive services, the reality at ground level is often that the need for savings in different organisations is exacerbating problems, making it more difficult for Directors of Adult Social Care and their Health partners to create the environments where such practice can flourish.

8. The following is taken from the Age UK study on NHS continuing healthcare[[4]](#footnote-4)

*’NHS Continuing Health Care (CHC) can be a lifeline for people. At a moment of highest need, often towards the end of life, it can provide the care and support someone needs to sustain their health and wellbeing. For many, it can take a huge amount of pressure off friends and family, themselves having to compromise their own health and wellbeing to support a loved one.*

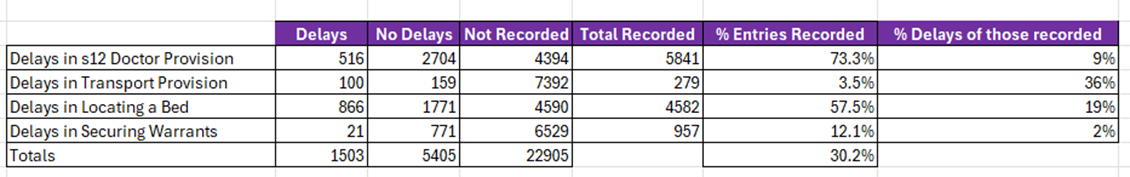
*However, getting CHC has long been one of the most pernicious postcode lotteries. For those that bypass some of these stages through the Fast Track process, they can hit another set of challenges when they’re reviewed, risking losing their care when their needs haven’t changed.*

*Even the NHS with that larger budget sees CHC as a significant cost. The last time it was estimated, NHS England projected CHC spend to hit £5.1 billion a year by 2020/21, prompting them to encourage local NHS bodies to reduce spending by £855 million by that time. The decline in Standard CHC eligibility since 2017/18 suggests that they may have had some success in that regard’*.

9. The above quote illustrates how the need to cut costs can adversely affect the experience of people - particularly as these cuts mean passing people over to the social care system which itself is under constant pressure to reduce costs.

10. Whilst we know what good looks like, we also know that is not always the experience of many people with severe and enduring mental health problems. Current structures within NHS mental health services can bounce people between different specialist teams leaving them without appropriate support when they most need it. People in acute crisis too often wait too long to access beds after they have been assessed as needing admission to hospital by AMHPs, waiting either in the community or Health Based Places of Safety (HBPoS) or A&E whilst the necessary resources are located.

*Figure 1: Early results from a proof of concept project on AMHP data set on care and treatment delays.* [[5]](#footnote-5)



**11. Joint Recommendation.** Develop local leadership structures to enable Local Authorities to become key leaders in partnership with NHS colleagues, as opposed to being seen as ‘stakeholders’. This could be achieved with a better use of Health and Wellbeing Boards / Safeguarding Partnership boards which bring together key local leaders and can feed data and intelligence of how effective and impactful current services are for those needing access to support.

## 1 b. How could this be measured/monitored locally and nationally?

12. There are two areas that are helpful in this regard. The first is the guide recently published by Partners in Care and Health and the ADASS Mental Health Network [Mental health performance, data and insight: Guidance for directors of adult social services](https://www.local.gov.uk/publications/mental-health-performance-data-and-insight-guidance-directors-adult-social-services#laying-the-foundations-for-good-mental-health-performance-reporting-)

This identified six key foundations for good mental health performance reporting:

* **Vision and understanding**: a shared vision for what good looks like and understanding of duties across the system.
* **Governance processes** to enable data sharing, reporting and escalation of risks and issues.
* **Understanding of ASC statutory duties** to ascertain whether duties are being met, especially when services are delivered via section 75 (s75) agreement with a health trust.
* **Practice**: understanding of whether social workers (and health staff if in s75) are delivering Care Act and MHA compliant assessments and support to understand whether data reporting issues are due to practice or data recording.
* **Information recording**: how effectively information is recorded on systems and whether system users understand what needs to be reported from systems.
* **Recording systems** that allow visibility or interoperability for partners and enable effective performance reporting.

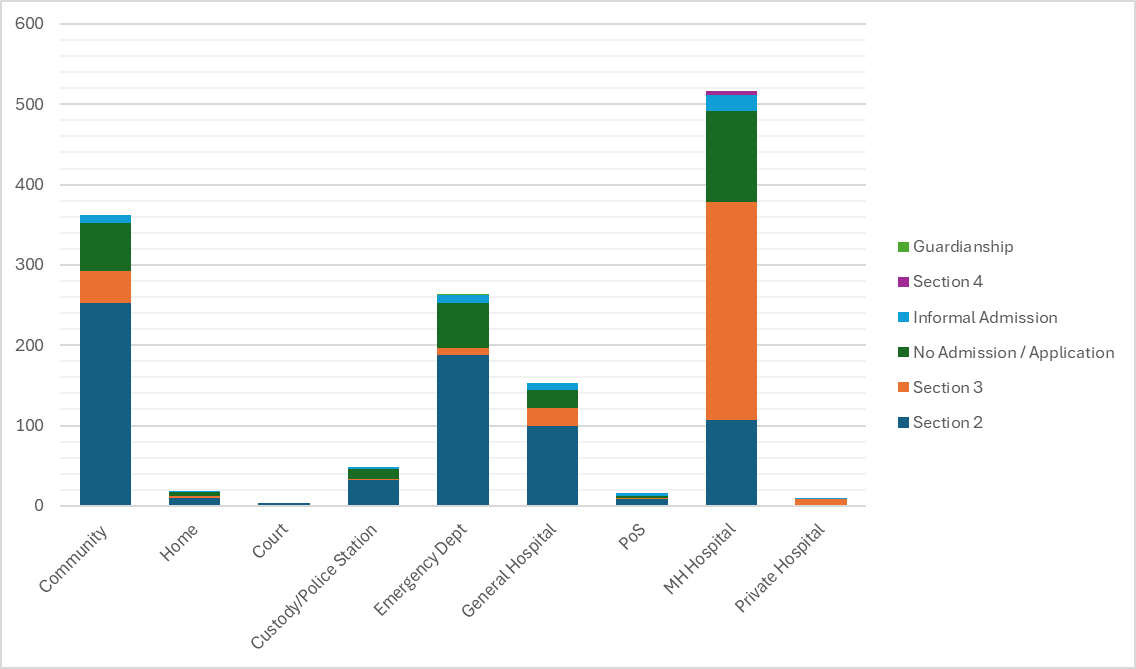
13. The second is establishing a National Data Set for AMHP practice[[6]](#footnote-6). This was recommended by the independent Wessley review on Mental Health Act reform in 2018, which recognised that the current data available at a national level on use of the Mental Health Act focuses solely on those who get admitted to hospital. Data on people’s journeys into the system (how long people are waiting in the community for beds to become available, where they are assessed, what happens to those with mental health needs who don’t need to be detained but do need support) is currently missing at a national level, even though it may be available locally.

14. Currently, Partners in Care and Health, ADASS and the LGA are working together on a ‘Proof of Concept’ project to develop a national AMHP data set against which all areas could then collect data. This would enable better scrutiny and more informed policy and service development at a local and national level.

15. For example, early results from the proof-of-concept collection (see footnote 5) show that on average of 54% of requests for assessment resulted in admissions – another way of thinking about this is that AMHP involvement prevented detention in 46% of referrals.

16. Additionally, assessment happen in a variety of places, with mental health hospitals accounting for the largest number of assessments:

*Figure 2: Early results from a proof of concept project on AMHP data set on where assessments take place*



**17. Joint Recommendation.** That Government continue to support the AMHP dataset project, enabling it to become a statutory requirement to collect such data, and exploring recommendations around how local systems such as Safeguarding and Health and Wellbeing Boards (and other relevant structures) should scrutinise such data and use it with health partners in their service and workforce planning.

## 2 a. What progress has been made in implementing waiting time and access standards for community mental health services?

18. Adult community mental health services provided by local authorities are commissioned by adult social care and generally delivered by private providers of the voluntary, community, faith and social enterprise (VCFSE) sector. There are currently no set waiting times for local authority adult social care services.

19. There are currently only two access and waiting time national standards that apply to community NHS adult mental health services. These standards apply to NHS Talking Therapies (formerly Improving Access to Psychological Therapies, or IAPT) and a standard that applies to access to early Intervention in psychosis. The waiting times for these two services are currently in the main being met. Source: [NHS England » NHS mental health dashboard](https://www.england.nhs.uk/publication/nhs-mental-health-dashboard/)

20. There have been [proposals to further expand access and waiting time standards](https://www.england.nhs.uk/publication/mental-health-clinically-led-review-of-standards/) to community-based mental health crisis services, mental health needs in an emergency department, and non-urgent community mental health care. NHS England has undertaken [wider consultation](https://www.england.nhs.uk/publication/mental-health-clinically-led-review-of-standards/) on a set of new standards that are currently being piloted, including national data collection, but a timeframe for setting the standard is yet to be announced. [Published data](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-august-provisional-september-2023) on non-urgent access to adult community mental health services shows that the current average (median) waiting time from referral to the second contact (when treatment is deemed to have started) is 47 days. However, 10% of people have waited at least 238 days. The [recommended target](https://www.england.nhs.uk/publication/mental-health-clinically-led-review-of-standards-models-of-care-and-measurement/) is four weeks (Source: [Kings Fund 2024](https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-access#access-in-other-areas-of-mental-health-care-is-variable)).

21. People waiting for mental health support do not do so in a vacuum. They wait whilst supported by family carers, by schools, by community services. In essence by the services and networks supported by local authorities' day in, day out. It is also important to recognise that looking after a family member with a mental health problem can significantly affect carers' own mental health. According to Carers UK, a significant number of carers in the UK are experiencing mental health issues[[7]](#footnote-7).

22. The following results from the ADASS Spring Survey of 2024[[8]](#footnote-8) illustrate the areas of concern with financial pressures on Adult Social Care Budgets in relation to support to those with serious mental health conditions.

*Figure 3 Financial Pressures on Budgets- Area of Greatest Concern*

|  |  |  |
| --- | --- | --- |
|  | **2023/24** | **2024/25** |
| Older People (People Aged 65+) | 2% | 4% |
| People aged 18-64 with disabilities or mental health needs | 33% | 34% |
| Both Equally | 65% | 62% |

23. There is particular concern about the numbers of young people with Mental Health needs being transferred from Children’s Social Care.

*‘The ADASS Spring Survey looked in detail at some of the drivers of social care budgets, which broadly relate to rising costs, increasing needs and increasing complexity of needs. Respondents to the Autumn Survey provided additional insights into some of these pressures.* ***Several reported that they were seeing a particular rise in the number of young people with complex needs, including complex mental health needs.’[[9]](#footnote-9)***

24. We know from other sources, such as the Nuffield Family Justice Observatory Research[[10]](#footnote-10) into those young people whose detention is being authorised by the Community Deprivation of Liberty Order (DoLO) section of the Family Courts, that they are needing support and containment because of their experiences of trauma, adversity (such as abuse and neglect), and neurodiversity and that these experiences are resulting in mental health problems, behavioural problems and issues such as self-harm. We also know that the rising numbers of such orders are thought to be related to a decrease in the numbers of inpatient tier 4 Child and Adolescent Mental Health Services (CAMHS) beds (down 20% since 2017, according to the Nuffield Report) and a greater reluctance to use youth custody routes for some young people at a time when we also know that demand from this cohort is growing.

25. Whilst agreeing with the principle that trauma should not be medicalised unnecessarily, and that those who are neurodiverse and need additional support to navigate the adult world successfully should receive it, removing access to CAMHS inpatient support without a parallel development of more appropriate community resources and interventions has been counterproductive.

26. Within the DfE, concern about this cohort has resulted in proposals to change the law and to fund better alternatives to the unregulated placement currently available. More thought also needs to be given to how to support (and fund) the right care between the ages of 18 and 25yrs to support their progression to adulthood.

27. As pointed out by the IMPOWER/ADASS report on Progression to Adulthood,[[11]](#footnote-11)

urgent action is needed by Government to address the challenges and improve the life chances of young people in this cohort. For example, for many experiencing mental health challenges, the ‘cliff edge’ of 18yrs (when support moves from child to adult services in both health and social care) causes them and their families great stress and anxiety.

**28. Joint Recommendation:** Government urgently considers the recommendations on progression to adulthood contained in the IMPOWER report [[12]](#footnote-12) and reports back on actions that can be taken as part of the upcoming 10-year plans for health and social care to meet the needs of the 18-25yr old cohort who are experiencing mental health challenges.

## 2 b. How could access be improved across the country?

29. We need to recognise and build upon the benefits of the connectivity between the NHS, local government, and other partners in health prevention, preventing deterioration for those with acute problems and promoting recovery, such as integrated NHS/local government community mental health teams and hubs.

30. A focus on community integration will strengthen links between NHS services and other council services and help to embed a ‘whole person’ approach that seeks to address the often-multiple factors that affect mental wellbeing.

31. Councils deliver or commission services that help people in vulnerable circumstances and at crisis points, such as social support in crisis, supported housing, public health, domestic abuse, homelessness support, substance and alcohol abuse and money advice, as well as services such as libraries, parks, rights of way and leisure centres that help to improve people’s general mental wellbeing.

32. We welcome the shift towards **neighbourhood working** and are interested in seeing the learning and outcomes from the neighbourhood mental health centres that are currently being piloted. However, neighbourhood working must be about more than co-locating services and buildings and about working with natural geographies to understand local strengths and needs. Joining services at a hyper-local level to achieve a shared goal has been a feature of good integrated services and strong communities for many years. There is no ‘one size that fits all’ model for what good looks like - indeed the whole ethos of neighbourhood is what works in one area, might not work for others.

33. The LGA and ADASS are keen to work with trailblazer local authorities and health partners to understand the shared approaches of areas that are already working in this way and better understand the blockages that may be preventing scaling and sustaining neighbourhood working. A permissive approach built on good practice and sustained through regular evaluation and sharing of best practice will be key to achieving the outcomes that we all know neighbourhood working can deliver. We look forward to continuing to work with government to facilitate learning from the range of neighbourhood work underway.

**LGA Recommendations.**

34. At a recent LGA hosted roundtable of local government leaders, the following themes emerged regarding neighbourhood working:

* + A strong recognition that any neighbourhood model must be couched in the context of strong relationships between local government, health, and voluntary and community sector leaders. They are so pivotal to delivering change that organisations and systems should be challenged when relationships are not delivering the changes needed
  + Outcomes - A relentless focus on outcomes and people is needed rather than settings and services.
  + Changing the narrative – the narrative around social care, especially in integrated neighbourhood teams, needs to shift away from hospital discharge, and recognise the far greater role that it plays in helping people to pursue the things that matter to them most.
  + Learning– both from what is currently happening, but also from other change activity e.g., Sure Start.
  + The importance of creating safe spaces for local partners to try new things and understand the impact.
  + Data is important, but insight is essential to developing hyper local approaches that reflect need.
  + Further recommendation, when considering future funding, consider how to ensure early help is available by funding effective commissioning with partners in the VCFSE sector.

## 3. Has the Community Mental Health Framework been an effective tool for driving the delivery of more integrated, person-centred community mental health services?

35. The Framework highlighted the importance of the contribution of all partners to supporting good mental health in the community. However, to achieve a more person-centred service, long-term investment needs to be prioritised. Although improved joint-working or different ways of working may be effective, the core of developing a system that provides effective treatment of mental health in the community is sufficient investment.

**36. Joint recommendation.** We are calling for funding for local government statutory and non-statutory mental health services to put them on an equal footing with NHS clinical mental health services. Such investment is essential if the big shift from hospital to community is going to be achieved in the arena of mental health. The focus needs to be on early intervention and preventing people needing to access acute mental health care where possible and appropriate. However, as previously stated, this would be enhanced were local government seen as structurally a leading partner with health.

## 4. How can community mental health services work with social care, the third sector and local government to better address service users’ health and wider social needs that are wider determinants of mental health outcomes?

37. In February 2024, the LGA with partners in Care and Health published ‘[Top Tips and Key Actions for Successful Collaborative Partnership Working Across Mental Health Services’](https://www.local.gov.uk/publications/top-tips-and-key-actions-successful-collaborative-partnership-working-across-mental). This report recognises that every heath and care system will experience challenges in relation to partnership working given the statutory and cultural differences of organisations working across the mental health pathways and that there will be different arrangements to frame local partnership working, including for example a Section 75 agreement.

38. It also provides an example of Tools to support a partnership outcomes framework including the [Tower Hamlets Shared Outcomes Framework](https://www.towerhamletstogether.com/the-challenge/shared-outcomes-framework#:~:text=The%20purpose%20of%20the%20Outcomes,what%20improvement%20work%20to%20prioritise). Although their shared outcome framework is across the adult social care and health system, it provides a good example of what can be achieved when partner organisations, people with lived experience and carers, the VCFSE and providers come together to develop outcomes that matter to local people.

39. However, the key issue as mentioned earlier is that the planning and leading of community mental health needs to be embedded within the local government, with health and social care working as equal partners and informed by the needs of the local population.

## 4 a. How could the funding system be reformed to more effectively drive transformation in the delivery of integrated and person-centred community mental health services?

40. Pooled budgets, use of the Better Care Fund in Mental Health, agreements on the effective use of Section 117 and CHC funding have been demonstrated as offering effective ways in which available money can be best used to focus on people and the outcomes they want and need to be able to live their best lives.

41. However, these advances are being undermined due to budgetary pressures on both local authorities and ICBs. Where additional financial investment has been given for mental health, the risk is that without ring fencing this funding (understandably) can go to meeting the financial pressures of the current system, rather than investing in the future preventative system we want to see. For example, whilst information on the use of the Better Care Fund on mental health has been estimated by NHSE as accounting for 4% of the spend, it is much more difficult to see whether this relates to supporting the current system rather than better alternatives. Evidence suggests that using out of area hospital placements results in longer stays and is more expensive – but in a system where people are regularly waiting long periods after assessment for mental health beds to be available, it is understandable that local managers need to make sure these people are safe now ahead of developing future services.

42. The Mental Health Investment Standard is a positive commitment, but more evidence is needed to demonstrate how this money is spent.

**43. ADASS recommendation:** Community Mental Health funding pathways need to be reviewed, with a particular focus on ensuring that additional investment funding to build up new services is ring fenced to ensure that it does not get redirected to cover day to day costs. When doing this work, creating systems of equal partnerships in the leadership of community mental health provision is essential.

44. Oneoption worth considering would be for a ring-fenced grant to be located within local government rather than health. Under the direction of local Health and Wellbeing Boards, new developments can be influenced by all that is known across the local system about mental health need, and reporting on spend can be more clearly delineated.

## 5. What blockers or enablers should policy interventions prioritise addressing to improve the integration of person-centred community mental health care?

45. Rising need for mental health services continues to outstrip service provision. Adult Social Services budget’s ability to meet demand are under severe pressure. NHS staff shortages also remain a threat to further improvement and expansion and integration of community mental health. These pressures mean people may not be getting the mental health treatment they need when they need it.

**46. What we do know - Increased Need**

There is significant increased need for mental health care and support and evidence of unmet need. The number of people accessing mental health services in England has increased over time. The number of people in contact with NHS-funded secondary mental health, learning disability or autism services in England was 24% higher in 2023/24 than in 2019/20 (pre-pandemic). <https://commonslibrary.parliament.uk/research-briefings/sn06988/>

47. The following comes from the [Darzi Independent Review of the NHS](https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf):

*‘At the start of 2024, 2.8m people were economically inactive due to long-term sickness. That is an 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions. Being in work is good for wellbeing. Having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work. ‘*

48. There are an increasing number of people in contact with NHS-funded mental health, learning disability and autism services. Since April 2016, the number of people in contact with secondary mental health services has increased by 59%, and the number of referrals to NHS Talking Therapies has increased by 44%.

49. There is also an increase in the use of the Mental Health Act. In 2023-24,52,458 new detentions under the Mental Health Act were recorded, but the overall national totals will be higher. NHS Digital estimate there was an increase in detentions of 2.5 per cent from last year.

[Mental Health Act Statistics, Annual Figures, 2023-24 - NHS England Digital](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures)

50. Additionally, the Darzi review’[[13]](#footnote-13) findings provide a key indicator of the challenges that exist:

‘7. *Waiting lists for community services and mental health have surged. As of June 2024, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people. By April 2024, about 1 million people were waiting for mental health services. Long waits have become normalised: there were 345,000 referrals where people are waiting more than a year for first contact with mental health services—more than the entire population of Leicester—and 109,000 of those were for children and young people under the age of 18.’*

*And*

*‘20. ....It was the choice of successive governments to exclude primary care, mental health and community services waiting times from NHS constitutional standards, which are instead focus on hospital care. This has been reinforced by the failure to invest in the measurement of primary, community and mental health services, which has obscured the real consequences of cuts to block budgets’*

60. It is, however, important to understand that the impact of this increase in demand is experienced more widely than in the health system. Local Authorities have been reporting increasing pressure from referrals where mental ill-health is a key component since the pandemic. For example, the [Kings Fund 2024 report on access to mental health services](https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-access#access-in-other-areas-of-mental-health-care-is-variable) whilst focusing on the NHS, also refers to Community Services and unmet need that fall more within the remit of local government.

61. Many who draw on adult social care services are younger, working-age adults with disabilities or serious mental health issues. While their aspirations—fulfilling independent lives, relationships, and employment—may align with those of older generations, supporting them effectively requires a distinct approach.

62. Recently published research from the County Councils Network, [‘The Forgotten Story of Social Care’](https://www.countycouncilsnetwork.org.uk/wp-content/uploads/The-Forgotten-Story-of-Social-Care.pdf) brings to life the scale of the challenge ahead. 40 per cent of people drawing on adult social care support in England are working age individuals aged 18–64 with a disabled condition (a learning disability, a physical disability or a mental health condition) who make up the working age adult population, or individuals aged 65+ with a lifelong disabled condition (a learning disability or long-term mental health condition).

63. National expenditure on social care support for working age and lifelong disabled adults has risen by over a third between 2020 and 2023 in England, with forecasts for the 2024 financial year even higher, despite the total volume of individuals in this population supported not having risen over this period. Whole system changes for working age and lifelong disabled adults based on their specific needs, not based on an older adults’ model, is needed. It is also important to recognise that the 18-25year old cohort are of particular concern, and as the [IMPOWER/ADASS report on Preparing for Adulthood suggests](https://www.adass.org.uk/wp-content/uploads/2025/01/IMPOWER-ADASS-Preparing-for-Adulthood-Report-2024.pdf) action here is needed to ensure young people get the support they need to make the most of their adult lives.

64. It is important to note that Local Government spending on adult mental health comes from the adult social care budget. The [Adult Social Care Activity and Finance Report 2023/24](https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2023-24) shows that mental health was identified as the ‘Primary Support Reason’ for people who needed care - a total of 12% of spend. Increasing costs and demand in adult social care means budgeted net spend on adult social care increased by £3.7 billion (18.1 per cent) in real terms from 2019/20 to 2024/25. Despite the rate of inflation falling from its peak there is little sign of these cost pressures tailing off. Of the additional £3.7 billion in budgeted spend since 2019/20, £1.9 billion of this increase was from 2023/24 to 2024/25.

65. The [ADASS Spring Survey 2024](https://www.adass.org.uk/wp-content/uploads/2024/07/ADASS-Spring-Survey-2024-FINAL-1.pdf) of Directors of Adult Social Services concluded that the financial situation facing the service “is as bad as it has been in recent history.” Budget overspends in 2023/24 were the highest for a decade, savings required in 2024/25 are at their highest for eight years and there is an “increasing reliance on one-off reserves to prop up budgets”.

**66. Joint recommendation:** There is an urgent need to rebalance spending in favour of community based mental health services, in preference to paying the higher financial and other costs associated with providing inpatient care in response to emergencies, which might have been avoidable had investments in prevention and early intervention been made. Although this has been the ambition of successive governments’ policies, not least since it should increase system-wide efficiency, it is likely to require an extended period during which net spending increases enable the ‘double-running’ of inpatient beds, whilst new investment in community services ensures their effectiveness is fully established.

**67. LGA Recommendations**

* The LGA believe that all options for raising revenue and the approach to allocations should be on the table. In the LGA [Autumn Budget and Spending Review Submission 2024](https://www.local.gov.uk/publications/autumn-budget-and-spending-review-submission-2024), we have recommended the following:

* All disparate funding streams for adult social care to be brought together into a single pot, allocated directly to councils and with no (or only limited) conditions, and put into the funding base to provide certainty and the ability to plan for the long-term.
* Funding to be more outcomes-focused, linking back to the duties, intent, and ambition of the Care Act.
* End the reliance on council tax and the social care precept as a key means for funding adult social care and instead look to national taxation. Formalise national funding for adult social care but with delivery remaining local and frame this positively (for instance fulfilling the ambitions of the legislation) rather than negatively (for instance ‘bailing out councils’).

* Explore the potential for better alignment between adult social care and the benefits system, including for instance Attendance Allowance.

* Commit to a review of NHS Continuing Healthcare.

* Consider a different funding model for younger adults and older people to reflect the different life situations faced by people aged 18-64 and those aged 65 and over.

* Investing in earlier preventative support in social care would improve people’s lives and save £3.17 for every pound spent. The LGA’s [joint publication](https://www.local.gov.uk/publications/earlier-action-and-support-case-prevention-adult-social-care-and-beyond) with ADASS, Social Care Institute for Excellence, Mencap, Skills for Care, Think Local Act Personal, The Care Provider Alliance and Social Care Future makes the case for a shift towards taking action and offering support earlier, so that more people can live the lives they want.

**68. ADASS recommendation:** DHSC to instigate a national review of higher cost support delivered across CHC, joint funded and adult social care provision (so the most complex/specialist end) in the independent sector, to better understand and plan for the cross-sector rising costs. This would be to determine a long term financially sustainable model for provision of this sort, given costs appear to be increasing for all sectors. This would help there to be a better national understanding of the drivers and future trends expected for highest-cost care at the interface of CHC and social care.

**69. Supported Housing**

Availability of supported Housing is key to good community mental health. Supported housing provides vital accommodation and tailored support for individuals with complex needs, including those at risk of homelessness, individuals with mental health conditions and disabilities, older adults, and those transitioning from care or hospital settings. It prevents crises by offering stable environments that reduce reliance on costly services such as hospitals, care homes, and emergency accommodation. However, the sector faces significant challenges, including unsustainable funding structures, workforce pressures, and regulatory gaps.

70. The delayed implementation of the Supported Housing (Regulatory Oversight) Act 2023 exacerbates these issues, leaving councils with limited tools to tackle poor-quality provision.

71. A lack of supported housing was responsible for a fifth (20%) of all delayed discharges, and nearly three-quarters (73%) of all housing-related delayed discharges, from mental health hospitals. Recently published [National Housing Federation research](https://www.housing.org.uk/resources/finding-a-safe-home-after-hospital/) reveals that hospital patients, ready to be discharged, spent 109,029 days stuck in mental health hospitals in England last year (2023/24) impacting their health outcomes and preventing new admissions, due to a severe shortage of supported housing.

**72. Joint recommendation.** A sustainable funding regime and urgent government support is needed to secure the future of supported housing and ensure it continues to deliver social and economic benefits.

## 6. What are the examples of good or innovative practice in community mental health services?

**73. Local information and support.** The charity Together for Mental Wellbeing, in collaboration with Southwark Council and other health and social care partners in the area, provides a variety of integrated community mental health services through the [Southwark Wellbeing Hub](https://www.together-uk.org/southwark-wellbeing-hub/), including crisis support and a new service working with Black carers and their families.

**74. Employment.** There are several new interventions and 'accelerators' in this space but it not clear that different interventions/approaches are joined up at place or that appropriate adaptions are being made so that people with a learning disability and autistic people benefit from additional support. Examples include; [Health and work accelerators](https://www.england.nhs.uk/2024/12/world-leading-nhs-trial-to-boost-health-and-support-people-in-work/). In work support with a focus on musculoskeletal, diabetes and mental health. Individual placement and support (IPS) is a model of supported employment for those experiencing severe mental illness. NHS has [published guidance on IPS models](https://www.england.nhs.uk/long-read/individual-placement-and-support-for-severe-mental-illness/) that states this should be part of local community mental health provision but, unfortunately, these are not being provided in all places.

75. Some councils are working together through combined authorities to ensure that economic growth and employment strategies are inclusive of people with a learning disability, autistic people, and people with mental health conditions.For example, the [South Yorkshire Mayoral authority has commissioned Individual Placement and Support in Primary Care (IPSPC)](https://www.southyorkshire-ca.gov.uk/Explore_Working-Win) This project support people who have a health condition to find and stay in employment.

Also [York and North Yorkshire Combined Authority has been chosen as a trailblazer](https://yorknorthyorks-ca.gov.uk/york-and-north-yorkshire-trailblazer-to-unlock-barriers-to-work/) to trial ways of getting people in ill health back into work.

**76. Northumberland Council’s** [**‘North East mental health trailblazer’**](https://northern-insight.co.uk/business/integrating-mental-health-and-employment-support-has-helped-hundreds-into-work/) on behalf of seven councils piloted integrated employment support and talking therapies to unemployed people with anxiety and/or depression, to improve their mental wellbeing and help them find work. Over 1,450 people were supported, with more than 270 moving into work, showing these services could work together, but funding ended, so the work discontinued.

**77. Greater Manchester Combined Authority’s** (GMCA) [**‘Working Well’**](https://www.greatermanchester-ca.gov.uk/what-we-do/work-and-skills/working-well/) suite of devolved and test-and-learn employment and health related programmes, take a whole-population approach to health, skills, and employment. To date, these programmes have supported more than 60,000 people, helping more than 15,500 into work - a success rate of 26 per cent. Crucially provision also supports inactive groups. GMCA recognised from the start that to turn Greater Manchester into a ‘northern powerhouse,’ it had to tackle the very high level of economic inactivity, and particularly health-related economic inactivity. It was also a key element of the health and social care devolution deal.

**78. Enabling Assessment Service London** (EASL)[[14]](#footnote-14) EASL is a mental health team supporting homeless people across London and the agencies that work with them. They are a Community Interest Company and employ experienced Social Workers and Occupational Therapists (who are all AMHP qualified) as well as CPNs, Psychologists and Psychiatrists and provide an expert support and assessment and support service across the Capital. They are commissioned by local authorities, charities and the mayor of London.

**79. NHS Community Mental Health Services commissioned by councils under s75 arrangements or commissioned from councils.**

**80. Integrated community learning disability teams** are an effective way of ensuring that people get support in a timely way and resources are used more effectively by providing a joined-up approach to health and social care. Unfortunately, these types of integrated services are not available in all places.

**81. Crisis Houses and Women's Crisis Houses**- these combine community clinical and social care support to provide an effective way for people to stabilise and return home. In North Central London, these schemes are open to everyone experiencing a mental health crisis.

**Housing**

**82. Helping people to keep their homes** when they are experiencing distress/periods of mental illness and during their time as inpatients. Examples of councils' doing this well include Wirral council having an Occupational Therapist that works with homeless people/people at risk of homelessness to ensure that the right support is in place to help them obtain and keep their home.

**83. In-reach intensive support** that can work with families and providers to provide additional support in the family's home/supported living/residential care to help carers and individuals navigate a crisis and ensure that even when someone goes into hospital that relationships are maintained, and people can go back home. An example of this type of approach is [Reach housing advice and support service in Bath and North East Somerset.](https://www.dhi-online.org.uk/get-help/housing-advice-support)

## 6a. What needs to happen to scale up the adoption of these practices across the country?

**84. ADASS** **Recommendation:** The Darzi Review recommended that we ‘Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population ages. Financial flows must lock-in this change irreversibly or it will not happen.’

85. This quote summarises the challenge of community mental health care. Unless the funding flows change, so that community provision can prioritise its needs ahead of acute hospital pressures, the change that we need to see in community mental health will not happen.

86. In addition, perceptions of responsibility for mental health services need to change. NHS doctors and nurses provide unparallelled expertise in the treatment of care of those with mental health problems. However, in a community setting mental health care and support must be seen as a partnership activity between health and social care. Services must be developed and delivered at a local level, taking account of the needs and challenges of different local areas and those working within those services (whether employed in public or VCFSC sector)

**Workforce**   
87. The AMHP workforce is crucial to the operation of the Act, but their role extends beyond undertaking Mental Health Act assessment and deciding whether to accept the recommendations of doctors and detain someone. They are also a crucial resource for working with people before an assessment takes place to try and avoid detention becoming necessary. Working within multidisciplinary & multiagency settings, they can bring their specialist skills and authority to bear across a range of situations from working with teenagers to supporting older adults with cognitive challenges.

88. This wider application of their role is only possible where they have sufficient capacity and support to make these preventative interventions happen.

89. The annual AMHP workforce survey suggests that there are 3800 AMHPs nationally (this compares to approximately 140,000 s12 doctors ) a third of which are over 50yrs old. If we are to make best use of the AMHP’S ability to prevent admission, significant investment is needed in both the number of roles available and understanding how best to support and deploy AMHPs.

**90. Joint Recommendation**: The government invest in research to establish how best to deploy AMHPs to make effective use of their skills in preventing admission, including numbers needed and models best suited to different settings . Cost benefit analysis should also be included in this work. Based on the outcome of that research, appropriate funding be made available to train and employ any additional AMHPs needed.

**90. Joint Recommendation**: The Mental Health Bill currently going through Parliament has four principles that need to inform all policy – ensuring choice and autonomy, promoting least restriction, ensuring care and support is provided in the least restrictive way and promoting the rights of the individual.

When the Act is introduced, it will have significant resource implications for councils which need to be fully funded on a long-term basis. The Act needs to reflect the operational needs and resource pressures on local government, and partners, who will need to be resourced to support effective implementation. For many years mental health services at all levels have been reduced despite rising demand.

91. We support investment into expanding and transforming mental health services to ensure more people can access the support they need. Investment must also include mental health support delivered by councils, as well as NHS services.

**92. Joint Recommendation:** The Bill Impact Assessment currently does not identify any increase in demand of community mental health services, aside from advocacy. To achieve this reform successfully, it will require investment in both Voluntary Community, Faith and Social enterprise (VCFSE) and council commissioned community mental health services. This is particularly important as statutory local authority adult mental health services and much VCFSE mental health provision is funded from the social care budget.

The LGA is the national membership body for local authorities, and we work on behalf of our member councils to support, promote and improve local government.

ADASS is the Association of Directors of Adult Social Services in England. We are a membership charity, a leading, independent voice of adult social care.

**This is a joint LGA and ADASS submission to the Inquiry, but we highlight where a specific recommendation is made by just one organisation. This generally reflects where one or the other organisation has yet to reach a settled position.**

1. [Approved Mental Health Professional (AMHP) workforce](https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Social-work/Approved-Mental-Health-Professional-workforce.aspx) 79% are directly employed by local authorities, the majority of the remainder are NHS employed but under partnership agreements. (s75) [↑](#footnote-ref-1)
2. AMHPs assess people for detention with psychiatrist, applying a social perspective & balancing different rights in their decision making.. [↑](#footnote-ref-2)
3. [NHS England » The community mental health framework for adults and older adults](https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/) [↑](#footnote-ref-3)
4. Age UK- Continuing to care? Older people let down by NHS Continuing Healthcare [↑](#footnote-ref-4)
5. Taken from early results of the proof of concept project on AMHP data. Over the course of three months (13 weeks), over 30 LA areas submitted their AMHP activity data. This included representation across all regional areas. [↑](#footnote-ref-5)
6. Modernising the Mental Health Act (2018) p210 ‘The DHSC should work with local government stakeholders......to establish a new official national dataset of AMHP activity. [↑](#footnote-ref-6)
7. State of Caring, Carers UK 2023. [↑](#footnote-ref-7)
8. ADASS conducts two major surveys per year - the Spring Survey focuses on finances and has highlighted the growing challenge of providing the right care and support to people, and its costs. [↑](#footnote-ref-8)
9. ADASS Autumn Survey, 2024 p8 [↑](#footnote-ref-9)
10. [Children subject to deprivation of liberty orders - Nuffield Family Justice Observatory](https://www.nuffieldfjo.org.uk/resource/children-subject-to-deprivation-of-liberty-orders) [↑](#footnote-ref-10)
11. [Preparing for Adulthood Report ADASS – IMPOWER](https://impower.co.uk/publications/preparing-for-adulthood-report-adass/) [↑](#footnote-ref-11)
12. Ibid [↑](#footnote-ref-12)
13. [Independent Investigation of the National Health Service in England](https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf) [↑](#footnote-ref-13)
14. [Enabling Assessment Service London](https://easl.org.uk/) [↑](#footnote-ref-14)