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Breaking down barriers —
the challenge of improving
mental health outcomes

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Summary

— Mental health problems are the largest source of burden of disease in the UK, and there is a vast amount of unmet need among people of all ages with mental health problems. A range of barriers limit the mental health sector in providing the same quality of care as physical health services.

Inadequate funding at a time of increasing demand
— Spending on mental health care equates to only 11% of the UK NHS budget, despite accounting for 23% of the burden of disease in the UK. There is also increasing demand for mental health care with patient numbers increasing across a range of conditions.

Access problems and a lack of integration and prevention
— Patients are often unable to access the care they need in a timely manner or close to home, including long waiting times for psychological therapies; a lack of 24/7 crisis care; and too high a threshold for receiving specialised mental health support.
— There is often poor integration of mental health services with other services locally, making the patient's experience of care more difficult, and causing some patients to 'fall through the gaps' in the system. This costs the NHS in England approximately £8-13 billion a year.
— There is a lack of focus on prevention and early intervention, including insufficient focus on groups typically more vulnerable to mental health problems. In England, less than 0.1% of the total annual NHS mental health budget is spent on prevention, and early intervention services in many areas of the UK are suffering funding constraints.

Inadequate provision and quality of services
— Despite the vast majority of adults with mental health problems being managed in primary care, GPs are limited in their ability to provide optimal mental health care because of pressure on consultation times and high workload levels. Many vulnerable groups with a need for mental health care (eg homeless people) have low registration rates with GP practices. When patients are referred to psychological therapies, there are inconsistent rates of recovery.
— Within secondary care, there is inadequate provision of community services meaning that many people do not receive the crisis care they need. Access and waiting times for CAMHS (child and adolescent mental health services) are inadequate across the UK, predominantly because of funding cuts. In the worst cases, this has caused children and young people to access services in different areas away from homes. For example, in 2014, the average distance travelled in England for a mental health bed was 22km, compared to only 10km for 70% of patients accessing physical health care. There are also concerns that some CAMHS clinics may not be child-friendly, and that children are being turned away because they do not meet the high clinical threshold.
— Despite one in five mothers suffering a mental health problem during pregnancy or in the first year after childbirth, the provision of perinatal mental health services is poor across the UK, with an ongoing shortage of beds in specialist mother and baby units in England and Scotland, and no specialist mother and baby units at all in parts of England, Northern Ireland and Wales. Health visitors, who carry out mental health assessments with new mothers, are also under resourced.

— Older people's mental health has often been neglected; for example, only 6% of older people with depression are referred to mental health services (compared to 50% of younger people), and older people typically have to wait longer for mental health treatment and are less likely to have access to the most effective therapies.
— Significant reductions to acute inpatient mental health beds across the UK have led to the over occupancy of wards and many vulnerable patients having to be cared for far from their homes ('out-of-area' placements). For example, in England, the rate of out-of-area placements more than doubled between 2011 and 2014.

An understaffed workforce and insufficient training
— There is insufficient recruitment of psychiatry trainees across the UK, and a high percentage do not complete training in this specialty. This may be caused by common misconceptions about psychiatry, such as it being considered "less scientific" than other branches of medicine, and the stigma around mental health. There is also understaffing of other parts of the mental health workforce, including reductions in the number of mental health nurses across the UK between 2010 and 2013.
— Many trainee GPs have limited exposure to mental health issues in training, and mental health is not a routine component of CPD (continuing professional development) or specialist interest training. Many GPs lack knowledge about specialist mental health services. There is also a lack of universal mental health training across the health workforce; for example, many practice nurses feeling ill-equipped to deal with aspects of mental health they are responsible for.

Introduction

Mental health problems are the single largest source of burden of disease in the UK, affecting one in four people.[1,2] Poor mental health carries an economic and social cost of £105.2 billion a year in England, £8.6 billion a year in Scotland, £2.8 billion in Northern Ireland and £7.2 billion in Wales.[3] Improving the outcomes for people with mental health problems therefore represents a core public health issue.

Doctors see first-hand the impact that poor mental health has on people's wellbeing, physical health and lives; and on the wider health system. Despite the ambition to provide the best care possible, there are a number of barriers which limit doctors' ability, and that of the mental health sector, to do so. As a result, there is a vast amount of unmet need among people with mental health problems, and caring for these patients can represent a substantial challenge for doctors and other health professionals.

This briefing sets out the key barriers to providing good mental health care. In line with the BMA's vision for mental health, recognising these barriers provides a platform to identify what action is needed to ensure people with mental health problems receive optimal care, such that they are able to recover or improve their condition and have a better quality of life.

Terminology and data
There is no set definition of a mental health problem, and the terminology used to describe a mental health condition can vary. Diagnostic criteria have been developed, and continue to evolve over time, to help identify mental health problems such as the WHO (World Health Organization) 'ICD-10 Classification of Mental and Behavioural Disorders' and the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders.[4]

There are a range of mental health conditions – from common problems such as mild depression and anxiety disorders, to more severe mental health problems, such as schizophrenia and bipolar affective disorder – which require different levels of care. For the purposes of this briefing, the term 'mental health problem' is used in a broad sense to refer collectively to the range of conditions that can affect a person's mental health. Reference is made to specific mental health conditions where appropriate.

The amount of data available on mental health care is relatively limited compared to physical health care.[5] Comparative data are included in this briefing where possible to illustrate the disparity between mental and physical health. It is also worth noting that there are varying levels of data available across the UK, with data in England most readily available. Where possible, data is included for Northern Ireland, Scotland and Wales.

Barriers to providing optimal mental health care

The mental health sector is often unable to deliver the same standard of care as physical health. For example, three in four people with a mental health problem in England receive little or no treatment for their condition.[6] A 2016 CQC (Care Quality Commission) survey found one in three NHS patients with depression and other mental health problems in England receives poor treatment.[7]

There is also a significant disparity in life expectancy for people with mental health problems compared to those without a mental health problem. The Five Year Forward View for Mental Health found that people with a severe and prolonged mental health problem are at risk of dying on average 15 to 20 years earlier than other people.[8] One in three of the 100,000 people who die prematurely each year in England has a mental health problem.[4]

There are multifactorial and complex reasons why there is vast unmet need among people with mental health problems, which include:
— inadequate funding at a time of increasing demand
— access problems and a lack of integration and prevention
— inadequate provision and quality of services
— an understaffed workforce and insufficient training.

Inadequate funding at a time of increasing demand
Historically, mental health has been chronically underfunded as it has not had the same level of political prioritisation as physical health care. Mental health problems affect a quarter of the population, and account for 23% of the burden of disease in the UK, yet spending on mental health services equates to only 11% of the UK NHS budget.[6] Specifically, the RCPsych (Royal College of Psychiatrists) estimated that 9% of the NHS and social services spending in Northern Ireland, 11% in Scotland, 12% in England, and 12% in Wales, is allocated to mental health services.[9]

At the same time, the demand for mental health care is increasing.
— Data from QOF (Quality and Outcomes Framework) show that, in England, the number of people with severe mental health problems accessing secondary and tertiary care increased from 0.8% in 2012/13 to 0.9% in 2013/14.[10] Data from QOF show that, in Wales, this rate increased from 0.6% in 2005 to 0.9% in 2016.[11]
— The prevalence rate of depression in England increased from 5.8% in 2012/13 to 6.5% in 2013/14,[10] and to 7.3% in 2015.[12] In Scotland, this rate increased from 5.2% in 2012/13 to 6.8% in 2014/15.[13]
— In England, a FOI (Freedom of Information) request found that between 2010/11 and 2014/15 average referrals to community mental health teams increased by 19%, and to CRHTs (Crisis Resolution and Home Treatment team) by 18%.[14]
— In Wales, the total number of referrals to CAMHS doubled between 2010 and 2014.[15] In Scotland, this rate increased by 49% between 2008 and 2013.[16]
— In Northern Ireland, between 2012/13 and 2014/15 the overall rate of self-harm increased by 12%, with the rate among 15-19 year-olds increasing by 30%.[17] In England, the number of girls aged under 18 admitted to hospital for self-harm has risen by 285% in the last decade.[18]
— In Northern Ireland, suicide rates have increased substantially over the past 20 years, particularly for men.[19]
— In England, prescriptions for antidepressants (used to treat depression and anxiety disorders) doubled (from 29.4 million to 61 million) between 2005 and 2015.[20] They increased by 54% in Scotland between 2001 and 2010, by 88% in Wales between 2000 and 2009, and by 60% in Northern Ireland between 2000 and 2008.[21]

This increase in demand may be due to an increased level of people reporting their mental health problems, although there are still many mental health problems which go unreported.[22]

Access problems and a lack of integration and prevention
Problems with waiting times and access

Waiting times for psychological therapies are commonly too long for people with mental health problems. In 2013 in England, 54% of 1,600 surveyed patients had to wait over three months, and 12% waited over a year.[23] In 2015, 85% of Welsh patients had to wait eight weeks,[24] and for more specialist care, some had waiting times of up to 50 months.[25] In 2014, less than 50% of Scottish patients were treated within 18 weeks,[26] and in 2016, one in three Northern Irish patients had to wait over 13 weeks.[27]

Long waiting times for psychological therapies has led to an increased use of and overreliance on antidepressants.[28] In response to the delay in accessing these services, in 2016, waiting time standards for psychological therapies were introduced in England for the first time; for 75% of people to begin treatment within six weeks of referral, and 95% to begin treatment within 18 weeks of referral.[29] In Scotland, there has been an 18 week waiting time target since 2014.[30] In 2016, Wales cut their target from 56 to 28 days[31] and Northern Ireland set a target of 13 weeks.[27]

A lack of 24/7 access to services for patients facing a crisis results in some patients becoming acutely unwell and relying on higher-cost care. A 2015 review of crisis care in England by the CQC found that only half of community teams surveyed were evaluated as 'good' for providing 24/7 crisis care.[32] The review also found that only 30% (of 37 organisations) had 24/7 provision of liaison psychiatry despite the fact that the peak hours for mental health crises are between 11pm and 7am.[32]

A further access issue is the high threshold for receiving specialised mental health support from secondary care, causing many patients to feel 'stuck' in primary care, not able to access the care they need.[28]

Due to a lack of available inpatient beds, many patients across the UK have to travel far from their usual local network of services to access acute care. In 2014, the average distance travelled in England to access a mental health bed was 22km, but some patients travelled as far as 128km.[33] In 2012/13, up to 5% of emergency mental health care in England was also out-of-area.[5] Comparatively, in 70% of cases in England in 2014, the average distance travelled to A&E hospitals for physical health care was only 10km.[34]

The Five Year Forward View for Mental Health found that 75% of people in England experiencing mental health problems receive no treatment at all.[8] Data from the OECD (Organisation for Economic Co-operation and Development) show that, between 2002 and 2012 in England, 72% of people who died from suicide had not been in contact with their GP or any other health professional a year before their death.[35] Between 2004 and 2014, this rate was 77% in Wales, 73% in Northern Ireland and 69% in Scotland.[36]

Poor integration and coordination of care

Despite some examples of good practice around the UK,[a] there is often poor integration locally between mental and physical health services, between primary and secondary mental health services, and between health and social care services. Good integration might involve, for example, liaison psychiatry teams in acute hospitals, enhanced support in primary care, integrated multidisciplinary teams in the community or physical health liaison within mental health settings.

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a   Such as a physical health liaison service in Highgate, an integrated perinatal and mental health care team in Devon & Torbay, and a Wellbeing 'Hub' in Sandwell, which are all examples of organisations working together to create joined-up care, centred around the patients' needs (source: www.kingsfund.org.uk/topics/integrated-care/integrated-care-map).

A lack of integrated and coordinated services makes the patient's experience of care more difficult; for example, by having to repeat their medical history several times.[37] Some of the most vulnerable patients may 'fall through the gaps' in the system and not access the right care.[38] A lack of integration makes it particularly difficult for patients who require urgent care, and for those with complex needs such as comorbid physical health or substance misuse problems. Some are bounced between services with neither team communicating to each other, leading to patients not receiving the holistic care they need.[37] The King's Fund and the Centre for Mental Health estimated that poor integration between mental and physical health services costs the NHS in England approximately £8-13 billion a year.[39]

A lack of focus on prevention and early intervention
Mental health problems tend to develop at an early age; half of all lifetime cases begin by age 14, and three-quarters by age 24.[40] Despite this, there is little emphasis on preventing mental health conditions developing, or intervening at an early stage when they do occur. This includes a limited focus on preventive measures targeted at groups typically more vulnerable to mental health problems, such as the homeless or those with a particular physical illness (such as HIV). Through financial mapping data collected on behalf of the Department of Health, it was estimated that overall spending on the prevention of mental health problems represented less than 0.1% of the total annual NHS mental health budget in England.[41]

The Health Select Committee in 2014 found that early intervention services in many areas in England are suffering from budget cuts and insecure funding.[42] Between 2010/11 and 2014/15, spending on children's centres, young people's and family support services fell by 24% in England.[43] In Scotland there is a lack of early intervention and prevention services for children and young people.[44]

In England, local authorities are responsible for promoting public mental health as part of their wider public health budget. A 2014 FOI request found that local authorities in England spend an average of just 1.36% (less than £40 million) of their total public health budget on preventing mental health problems.[45] This can be compared with £671 million on sexual health services and £160 million on smoking cessation services, for example. It was found that some local areas were not planning to spend any money at all on mental health prevention in 2014; and many were confused about their responsibility to prevent mental ill health.[45] A FOI request in Wales found that only 5% of their total PHW (Public Health Wales) budget was spent on preventing mental health problems in 2014/15.[46] Comparative data for Scotland and Northern Ireland are not available.

A report by the LSE (London School of Economics and Political Science) found that £45 million a year could be saved until 2019 in England by investing in early detection services for people with schizophrenia or psychosis.[47]

Inadequate provision and quality of services
Primary care
— General practice
Ninety per cent of adults with mental health problems are managed in primary care,[8] yet GPs are limited in delivering optimal mental health care because of pressure on consultation times. A 2015 BMA survey found that of nearly 16,000 GPs, 67% felt that there should be longer consultations for certain groups of patients, including those with long-term conditions.[48] In 2014, the RGCP (Royal College of General Practitioners) and RCPsych proposed that GPs should have more time for consultations with patients with mental health problems,[49] and in 2016 the BMA called for an extra five minutes for GP consultations.[50]

Workload pressures also represent a substantial challenge to GPs in providing optimal mental health care. The King's Fund found that in a study of 177 GP practices in England, the number of consultations rose by more than 15% between 2010/11 and 2014/15.[51] Seventy per cent of GPs in an RCGP Wales study said their workload was 'difficult' or 'very difficult' to manage.[52] Findings from the BMA omnibus tracker survey in 2016 support this, with 51.5% of GPs saying they had worked outside their regular hours.[53] In a 2015 BMA survey on primary care

in Northern Ireland, 76% of respondents said their workload affected their work-life balance.[54] This increase in workload is linked to the underfunding of primary care, which as a proportion of NHS funding fell from 10.4% in 2005/06 to 8.1% in 2014/15.[55]

Managing patients' mental health problems in primary care can be time consuming; over 50% of GPs in the RGCP Wales study said they were spending more time working on mental health than any other issue.[52]

There are also certain vulnerable communities known to have a high need for mental health care — including migrants, homeless people and sex workers — who have low registration rates with GP practices.[56]

— Psychological therapies
Within primary care, patients with common mental health problems (such as depression and anxiety) are referred to psychological therapy services. In England, this service is called IAPT (Increasing Access to Psychological Therapies). This service has vastly improved overall access to psychological therapies, but there is an inconsistency in the percentage of patients recovering. Data for 2015 show that 20 CCGs (clinical commissioning groups) in England had a recovery rate of at least 60%, whereas 14 CCGs had less than 30% of people recovering after completing the therapy.[57] The data show an overall recovery rate of 45.4%, which is under the IAPT target of 50% recovery.[57] Comparative data from Wales, Scotland and Northern Ireland are not available.

Secondary care (specialist services)
— Community services
Support is provided by CMHTs (Community Mental Health Teams) to people living in the community with more complex mental health problems. This includes a range of specific services such as CRHTs, Assertive Outreach services and EIP (Early Intervention in Psychosis) services. The CQC Review of Crisis Care in 2015 found that only 14% of people in England felt the care they received provided the right response.[32] It found that for people using CRHTs in England, a lack of frequent visits, inconsistency of staff and lack of support was a major frustration of people surveyed.[32] In Northern Ireland, this survey found a capacity problem for CRHTs and unacceptably long waiting times.[58]

— Services for children and young people
Children and young people are particularly vulnerable to mental health problems as many conditions typically manifest in childhood. Despite this, a 2014 report by the Health Select Committee concluded that there were "serious and deeply ingrained" problems with the commissioning and provision of CAMHS in England.[42] This is partly due to CCGs having frozen or cut their CAMHS budgets as a result of the wider mental health funding problems. A FOI request found that 34 out of 51 local authorities in England who responded had reduced their CAMHS budget between 2010 and 2013[59] (although 101 local authorities did not respond.) In Northern Ireland in 2013/14, just 7.8% of the total planned mental health expenditure was allocated to CAMHS.[60] In Wales in 2012/13, this figure was 6.9%[15] and in Scotland in 2015, it was only 5.5%.[61]

Underfunding has led to significant inpatient bed closures in CAMHS clinics, forcing many children and young people to wait or move to different parts of the country for available beds. It has also given rise to the unacceptable practice of children and young people being detained under section 136 of the Mental Health Act[b] in police cells, which was examined in the BMA's 2016 report *Young Lives Behind Bars*.[62]

b   The Mental Health Act is the law which can be used to take people to a place of safety using section 136 to assess them for a mental illness.

As a result waiting times for CAMHS are too long. In Northern Ireland, children wait up to nine weeks,[63] while data from ISD (Information Services Division) Scotland show that only three-quarters of children referred to CAMHS services are seen within 18 weeks.[64] There are also increased waiting times for community CAMHS services, and increased referral thresholds. Early intervention services within CAMHS are being cut, despite the fact that most mental health problems begin in youth.

Patients accessing CAMHS in England (who were interviewed in discussion groups) stressed the importance of these services being provided in a non-clinical building,[65] suggesting that clinics may not be the most child-friendly. There is also an increasing concern about children and young people being referred to CAMHS and subsequently turned away because they do not meet the high clinical threshold. A 2016 FOI request to 15 mental health trusts in England found that 61% of children and young people referred to CAMHS in 2015 received no treatment.[66]

— Perinatal services
One in five mothers suffer from depression, anxiety disorder or psychosis during pregnancy or in the first year after childbirth.[8] Not only do perinatal mental health problems affect the mother's health, but it can be very damaging for the emotional, social and cognitive development of the child.[67] Despite this, there is an ongoing shortage of specialist mother and baby units[c] across the UK; in Northern Ireland and Wales, there are currently no specialist units at all, as well as in parts of the North East, South and East of England.[68] Fifty per cent of mental health trusts in England do not have a perinatal mental health service with a specialist psychiatrist.[69] Health visitors, who carry out mental health assessments with new mothers, are also under resourced.[70] This lack of perinatal services can, to some extent, be attributed to funding constraints. However, a 2015 scoping study by NHS Improving Quality found that improving perinatal mental health did not appear to be a priority within many English CCG's business plans, which may be due to a lack of understanding amongst commissioners of perinatal mental health problems.[71]

— Older people's mental health services
Older people's[d] mental health has often been neglected.[8] Only 6% of older people with depression are referred to mental health services, compared to 50% of younger people.[72] Many older people are led to believe that depression is a normal part of ageing.[8]

On average, older people wait slightly longer for mental health treatment, in particular for old age psychiatry.[73] Older people are six times as likely to be on medication as younger people, and are only a fifth as likely to access talking therapies,[72] despite evidence that talking therapies can be highly effective in older people.[73]

Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60% of older people who suffer from a long-term illness.[74] Despite this, out of the 51 mental health trusts in England in 2016, 40% had no overarching strategies for supporting people with such comorbidities.[73]

A 2016 Alzheimer's UK report found that poor dementia care is still widespread and the quality of care varies widely between hospitals.[75] The BMA's 2016 report *Growing older in the UK* notes that people admitted to hospital with dementia are more likely to die, are at risk of longer hospital stays and more likely to decline functionally during their stay.[76]

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c   These units provide specialist care for mothers suffering with mental ill health, so that they do not have to be separated from their babies.

d   There are many different ways of defining 'older people'. For example, the ONS (Office for National Statistics) commonly quote data on individuals aged over 65, and those aged over 85 have been described as the 'oldest old'. The WHO define an 'older person' as someone 'whose age has passed the median life expectancy at birth', which in the UK is currently 81.2 for men and women combined.

— Acute inpatient care

Due to funding shortages, there have been significant reductions in inpatient mental health beds across the UK. In England, between 2010/11 and 2016/17 the average number of available beds during the first quarter (between April and June) decreased by 20%. The equivalent for general acute beds was much less (7%.) During the same time period in Scotland the average number decreased by 21%. Annually, the number of beds decreased by 33% in Northern Ireland and by 16% in Wales between 2010 and 2017.[77]

A 2015 survey by the Commission on Acute Adult Psychiatric Care in England found that 91% of 56 mental health trusts were operating above the RCPsych recommended bed occupancy rate of 85%.[78] In Northern Ireland, this survey found the average bed occupancy to be at 100%.[58]

Trusts and health boards across the UK are using beds in out-of-area placements when their own inpatient units are full, or when a patient might need longer-term support. Data from 30 out of 58 of England's mental health trusts show that the rate of out-of-area placements more than doubled between 2011 and 2014. In 2016, one in seven patients in England and Northern Ireland respectively, is in an out-of-area placement.[79,58] Out-of-area placements are detrimental to already vulnerable patients and their families, and are associated with an increased risk of suicide.[80] On average, out-of-area placements cost 65% more than local placements;[81] data from 30 trusts show that the cost of out-of-area placements in 2015 was £65.1 million.[82]

An understaffed workforce and insufficient training
Understaffing
— Psychiatry

The psychiatric profession is understaffed throughout the UK. In England and Wales, at the end of the first recruitment round for core training in psychiatry in July 2016, only 83% of the 439 vacancies had been filled.[83] In Scotland in 2013, only 12 out of 37 of these vacancies were filled.[84] In 2015 and 2016 in England, psychiatry had the lowest fill rate of all the medical specialties.[85]

There is also a high percentage of trainee psychiatrists that begin their core training, but do not continue. In England in 2014, nearly one in five doctors undertaking core psychiatry training did not progress into the final part of their training.[86] Comparatively, each year in England there are roughly 1,800 applicants for the 450 available posts in surgery.[87]
A 2013 RCPsych survey found that there were common misconceptions held by medical students and members of the public about the role of a psychiatrist,[88] such as it being considered "less scientific" than other branches of medicine.[89] This stigmatisation may deter junior doctors from choosing psychiatry as a career. In 2015, foundation posts in psychiatry were below the targets set by HEE (Health Education England)[e], which shows some junior doctors may not have the necessary exposure to psychiatry before choosing their specialty.[90]

— Other parts of the workforce

There is understaffing across other parts of the mental health workforce too. Only slightly more than half of the 75 CRHT teams surveyed by a 2013 UCL study across the UK had adequate staffing levels.[91] Between 2010 and 2013 in England, the reduction in bed numbers has resulted in a 10% decrease in nursing staff in psychiatric hospitals, with only partial re-deployment of nurses into community teams.[92] During the same time period, there was a loss of 16, 39 and 64 mental health nurses in Northern Ireland, Wales and Scotland respectively, despite recruiting extra nurses.[93] An understaffed mental health workforce has led to a decrease in patients' safety and has been linked to patient deaths.[36]

e   The target was to have 22.5% of all foundation year 1 and 22.5% of all foundation year 2 placements in England in psychiatry.

Training of the mental health workforce
— Medical school training
The overall framework of the medical curriculum in the UK is set out by the GMC (General Medical Council), and there is a suggested psychiatry curriculum by the RCPsych. The limited existing research on the teaching of psychiatry and mental health suggests there is variation in the structure, content, length and assessment methods used in UK medical schools.[94] Such variation is to be expected given individual medical schools develop their own course based on curricula objectives. That being said, our medical students have anecdotally reported being broadly positive about the mental health teaching they receive.

— GP training
General practitioners have a broad and demanding role to play in looking after patients with mental health problems, but are not as prepared as they could be in this role. Research by Mind in 2016 showed that on average, only 46% of trainee GPs undertook a training placement in a mental health setting.[95] The research also pointed out that none of the hours GPs spend on CPD training need to have a mental health component.[95] The provision of special interest training in mental health for GPs is also variable across the UK.[96] A 2015 survey by RCGP Wales found that GPs in Wales felt less confident in managing complexity in mental health, and had a low level of confidence in promoting mental wellbeing.[97] In a 2010 survey of 500 GPs in the UK, 42% said they lacked knowledge about specialist mental health services.[98]

— Insufficient training of other health professionals
There is no universal mental health training for all health professionals across the NHS. The 2016 Mind research found that 82% of practice nurses said they felt ill-equipped to deal with aspects of mental health they are responsible for, and 42% said they had no mental health training at all.[95] Twenty-nine per cent of midwives in an English survey said they had received no content on mental health in their pre-registration training.[69] A 2015 scoping study by NHS Improving Quality found that health care professionals often lack confidence and training in the recognition, treatment and support for women with perinatal mental health problems.[71]

A focus on intellectual disabilities

People with intellectual disabilities face similar challenges to those with mental health problems. They have a shorter life expectancy and increased risk of early death compared to the general population.[99] As highlighted in the BMA's 2014 report, *Recognising the importance of physical health in mental health and intellectual disability*, people with intellectual disabilities continue to suffer unnecessarily with untreated, or poorly managed, conditions.[4] A 2015 report, *Transforming Care for People with Learning Disabilities – Next Steps,* claimed that too many people with intellectual disabilities are admitted to hospital when it could have been avoided and remain there for too long.[100]

Due to recent funding cuts, hospitals are making significant reductions to the number of specialist beds for those with an intellectual disability. Between 2010/11 and 2016/17 the average number of available beds during the first quarter (between April and June) decreased by 49% in England, and by 59% in Northern Ireland between 2010/11 and 2015/16. 'Learning Disability Voices' – who represent 20% of all intellectual disability support services in the UK – predict that there will be a £926 million funding shortage for these services by 2020.[101] In 2016, the Western Health and Social Care Trust in Northern Ireland alone confirmed that services have been underfunded by up to £8 million in the last couple of years.[102] Community-based services for people with intellectual disability vary widely across England and Wales.[103]

There is also a higher prevalence of mental health problems in people with intellectual disabilities; population-based estimates suggest that 40% of adults with learning disabilities experience mental health problems.[104] People with intellectual disabilities have particular needs that have not always been considered by commissioners of mental health services, and these services have not always worked well together to provide appropriate support.[105]

Conclusion

This briefing sets out the range of barriers that limit the mental health sector in providing consistent high-quality care, leading to vast unmet need among people with mental health problems. Despite an increased and welcome focus on improving outcomes for patients with mental health conditions, there remain a number of system-wide challenges. These include inadequate funding for mental health services, at a time of increasing demand, problems with service delivery and access to services, a lack of integration between services and insufficient focus on preventing mental health problems. This is compounded by an understaffed workforce with insufficient levels of training. These barriers represent considerable challenges for the mental health sector, and improving the care delivered to mental health patients will require joined-up change from organisations, policymakers, doctors and health professionals.

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