A MENTALLY HEALTHIER NATION

Towards a ten-year, cross-government plan for better prevention, equality and support

CENTRE FOR MENTAL HEALTH

Rethink Mental Illness.

mind

Mental Health Foundation

Mental Health Network
NHS Confederation

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Association of Mental Health Providers

student minds

Anna Freud

In support of
THE MIX
Essential support for young people

NSUN National Survivor User Network

MindForward Alliance

Place2Be
IMPROVING CHILDREN'S MENTAL HEALTH

SAMARITANS

YOUNGMiNDS

MQ
Mental health research

MHFA England

bacp | counselling changes lives

NATIONAL CHILDREN'S BUREAU

SCHOOLS WELLBEING PARTNERSHIP

CHILDHOOD BEREAVEMENT NETWORK

National Bereavement Alliance

Children & Young People's Mental Health Coalition

UK YOUTH

ash.
action on smoking and health

ALCOHOL HEALTH ALLIANCE UK

ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH

The Children's Society

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

Race Equality Foundation

Stonewall

MONEY AND MENTAL HEALTH
POLICY INSTITUTE

TURNING POINT
inspired by possibility

AGENDA alliance

THINK AHEAD

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Dozens of organisations representing millions of people with an interest in mental health have been involved in the creation of this document. Writing was led by Ed Davie, Chair of the Mental Health Policy Group, made up of Centre for Mental Health, Mental Health Foundation, Mind, NHS Confederation's Mental Health Network, Rethink Mental Illness and the Royal College of Psychiatrists. The Mental Health Leaders Group, made up of 15 organisations including service user-led charities and the Children and Young People's Mental Health Coalition, were heavily consulted through workshops and written contributions. Where subject expertise (on smoking, alcohol, housing and suicide prevention, for example) was needed, recognised experts were consulted including Action on Smoking and Health, the Alcohol Health Alliance, Shelter and the Samaritans. Organisations and people from racialised communities, including those involved in the writing of the Black Mental Health Manifesto, also contributed.

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EXECUTIVE SUMMARY

Many of the UK's biggest organisations with an interest in mental health have come together to develop and promote this plan to address worsening mental health. Ahead of the UK general election, we will campaign for these policies to be adopted as part of a 10-year, cross-government mental health strategy, ideally to begin in the first year of the next parliament. Given this focus on UK general election policies, there is a concentration on England's health and other systems because the Westminster parliament has much more influence on them than in the devolved nations. Our broader recommendations, on welfare reform for example, would benefit the whole UK and all three devolved nations have long-term mental health strategies which we have drawn inspiration from.

Signatories of this document believe that a long-term, cross-UK government plan is essential to protect and promote the whole nation's mental health. It is necessary because mental health problems affect millions of people in every aspect of their lives. It is necessary because action across government could help to turn the tide of rising levels of mental ill health in our society today. And it is necessary because we cannot become a healthier, more equitable and productive nation without better mental health for us all.
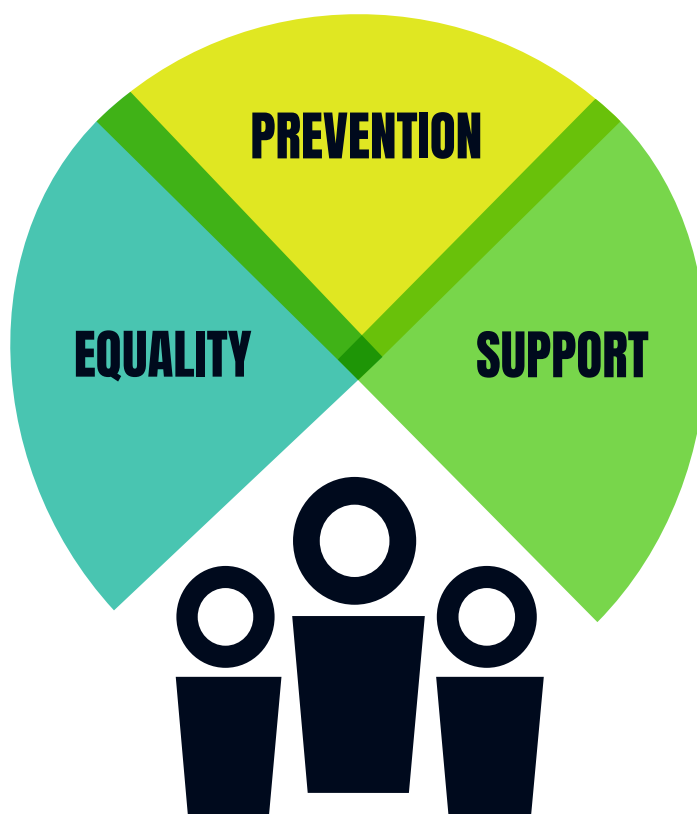
PREVENTION

MORE PEOPLE WILL ENJOY GOOD MENTAL HEALTH, FEWER WILL EXPERIENCE ILL HEALTH

By effectively addressing social determinants, like poverty and discrimination, and environmental factors, including housing and pollution, more of us can have better mental health. Investing in more powerful public health infrastructure is also key to preventing illness and promoting better health.

◎ **Give children the best start** by delivering on the Association of Directors of Public Health's call for a new Child Poverty Act to eradicate child poverty by 2030. In addition, every parent and carer needs access to effective support including evidence-based parenting programmes, and every school and college should be a mentally healthier place for children and young people.

◎ **Improve people's security** by ensuring everyone can afford a healthy life with enough money and a decent home. This should include instituting a Minimum Income Guarantee, reforming sick pay legislation and providing more social rent homes.

◎ **Create healthier physical environments** by accelerating the switch to cleaner energy and transport; better incentivising insulation, active travel and public transport; ensuring everyone can access green space; and improving protection from junk food, smoking, alcohol, gambling and pollution.

◎ **Boost public mental health infrastructure**, putting in place a 'Mental Health Test' of government policies and restoring the public health grant to its 2015 level with an annual £1 billion boost for local councils.

EQUALITY

THE HEALTH GAPS BETWEEN DIFFERENT GROUPS WILL BE CLOSED

Discrimination and disadvantage mean that risks to mental health are much higher in some groups, such as racialised communities. People with mental health difficulties are often treated less well in society, including in the social security and justice systems. And people with a severe mental illness have a life expectancy up to 20 years shorter than the general population. Addressing these injustices must be at the heart of creating a mentally healthier nation.

◎ **Tackle racism in all its forms**. This must include ending 'hostile environment' policies, preventing school exclusions that disproportionately affect racialised children, and taking sustained action to boost race equality throughout mental health services.

◎ **Set a target to close the health gap within a decade.** People with a severe mental illness shouldn't be dying up to 20 years too soon. They need fair access to health checks, stop smoking services, vaccinations and cancer screening.

◎ **Reform our social security system** to ensure it treats people with mental health difficulties fairly. The Work Capability Assessment and its equivalent for Personal Independence Payment should be replaced with a fairer system of assessment for disability benefits.

◎ **Reform the justice system.** This should include reducing reliance on prisons, boosting rehabilitative community sentences, and improving access to justice for people with a mental illness.

SUPPORT

EVERYONE WILL HAVE TIMELY, LOCAL ACCESS TO THE SERVICES THEY NEED

With the right support from properly resourced services, people are more likely to enjoy better mental health outcomes. Investing in mental health and social care works. No one should struggle to get help for their mental health, or be sent to hospital far from home.

Services should meet everyone's needs with a minimum use of coercion, backed up by a modernised Mental Health Act.

- **Fund mental health services fairly.** The government must make a long-term commitment to funding NHS mental health services and local authority social care at levels that enable them to expand the workforce sufficiently to meet rising levels of need.

- **Tackle long waits for mental health support** by implementing new access and waiting time standards for child and adult mental health services, with sufficient resources to achieve them.

- **Give children and young people easy access to mental health support.** Expand Mental Health Support Teams to all schools and colleges in England and fund a nationwide network of early support hubs for young people in every local authority area.

- **Modernise the Mental Health Act** to reduce the use of coercion and tackle racial disparities in the mental health system. This must be backed up by investment in the mental health estate and action to address safety concerns in mental health hospitals.

INTRODUCTION

Mental, and indeed physical, health results from an interaction between social determinants (such as poverty and discrimination), environmental factors (like housing and air pollution), personal attributes (including genes and behaviours), and the health care and other support available to people (Davie, 2021). The World Health Organisation, among other experts, say that social determinants account for up to 55% of health outcomes (WHO, 2017). Given that, from the 2007 banking crisis onwards, many social determinants have worsened for a lot of people, it is sadly not surprising that mental health is getting worse in the UK. Most recently, the Covid-19 pandemic, cost of living crisis and accelerating climate change – combined with a complex political environment and cuts to public services – have further reduced the resilience of people and the services that support them, stalling and even reversing healthy life expectancy (Marmot *et al*., 2020).

MENTAL HEALTH IN THE UK IS GETTING WORSE

Even before Covid and the cost of living crisis

MENTAL ILL HEALTH

was the most common cause of sickness absence (Statista, 2021) and demand on NHS services (BMA, 2023).

Sickness absence from work is at a 13-year high

Mental ill health

- Accounts for around **half** of the 1.8 million people a year absent from work due to illness and injury
- Leads to an estimated **17 million working days lost per year** (HSE, 2022).

Between 2017 and 2022, **rates of probable mental disorder among 17 to 19 year olds more than doubled** from **10%** to **26%** and increased in other age groups (NHS Digital, 2022a).

During **2021/2022** secondary mental health services in England received a record

4.6 million referrals

up 26% from **2018/19**

There were also an estimated

4.8 million referrals

in **2022/23**

(Royal College of Psychiatrists, 2023)

DEPRESSION AND ANXIETY PREVALENCE IS PROJECTED TO RISE BY 16%

adding to a shift in the share of the adult population living with major illness, from almost **1 in 6 in 2019** (6.7 million) to almost **1 in 5 in 2040** (9.1 million) (Watt *et al*., 2023).

Our worsening mental health is leading to higher levels of distress across the population, unsustainable demand on expensive and over-stretched treatment services, and economic inactivity that together costs approximately £119 billion a year in England alone (O'Shea, 2020).

These risks to mental health and the poor outcomes that follow do not fall evenly across the population: people living in poverty; those with physical disabilities and illnesses; people with neurodevelopmental conditions; children in care; people from racialised communities; and LGBTQ+ people all experience much poorer mental health outcomes because of intersecting disadvantage and discrimination. In addition, the life expectancy of a person with a severe mental illness is about 20 years shorter than someone without a diagnosis, and the gap is getting bigger (Centre for Mental Health, 2021).

The situation is difficult, but there is hope for positive change if the right actions are taken to address the factors that affect mental health. We know from programmes that have been properly funded, supported and measured, like the mental health elements of NHS England's Long Term Plan, Improving Access to Psychological Therapies, the Time to Change stigma-busting campaign, Sure Start centres for families, Individual Placement and Support, and the Better Mental Health Fund, that proper investment in evidence-based and informed interventions can support significant improvements, reducing distress and cutting costs. These innovations have taken place under Labour, Coalition Conservative/Liberal Democrat and Conservative-led governments, and we want to engage all political parties to make further positive changes.

To support this, many of the UK's largest organisations with an interest in mental health have come together to produce *A Mentally Healthier Nation*. Our aim is to share information and policy ideas in a bid to improve the nation's mental health by doing more to prevent illness, promote fairer outcomes, and build earlier and better support services including in public health, health, and social care services over the coming decade.

We call on the government to adopt these ideas and, with a UK general election having to be held by the end of January 2025 at the latest, we will be urging all political parties to consider our suggestions for their manifestos. We also encourage other bodies, such as devolved, regional and local governments, integrated care boards, and NHS trusts and boards, to consider how these policies (or adapted versions of them) could be adopted in their areas.

We know that mental health is made in communities: in the places we live and work, our schools, our families, our neighbourhoods and our social networks. The role of government is to create the right conditions for people and communities to thrive on their own terms. The ideas in this report are for policies that give society the best possible chance of a mentally healthier future. Our ideas are far from being an exhaustive list of the policies that will create a mentally healthier nation, and inevitably others will have further ideas about what needs to change. But they provide a starting point for debate, drawing on the contributions of many thousands of people to recent consultations as well as the best available evidence.

As we write, the government's Major Conditions Strategy case for change and strategic framework has set out important new pledges relating to mental health and mental health services. Many are included as recommendations in this report, and we welcome their inclusion in the emerging strategy. Our recommendations, however, go much further. We believe that a longer time horizon is necessary to make a sustained and significant impact on the nation's mental health. We believe that a specific focus on mental health is vital to bring about the concerted action that is needed. And we believe that commitment from the whole of government is essential to close the gaps.

We recognise that our recommendations amount to a very significant financial investment. But the evidence demonstrates that without it, the financial and human costs will be even greater as more people become more unwell. Indeed, the 2022 census carried out by the Office of National Statistics shows that half a million more people are out of the labour force due to long-term sickness (Office of National Statistics, 2022a). Children with poor mental health struggle in school and have far poorer long-term outcomes. And poor mental health often generates poor physical health, too. *A Mentally Healthier Nation*'s recommendations mean putting the public's wellbeing first, governing and leading the nation to a healthier and more equitable future.

PREVENTION
MORE PEOPLE WILL HAVE GOOD MENTAL HEALTH, FEWER WILL EXPERIENCE ILL HEALTH

The English language is full of the wisdom that 'prevention is better than cure' and 'a stitch in time saves nine.' In areas like tobacco control, road traffic safety and vaccinations, significant advances have been made to prevent illness, injury, early deaths, and the costs to society associated with them. Despite this common sense, a huge body of scientific evidence, and practical examples, it has been challenging to make the case for investment in prevention of mental ill health. Seemingly, more urgent priorities have demanded the attention of politicians, media, and services who, understandably, tend to think in short time scales and about the demand in front of them.

For example, the public health grant in England has been cut by 26% since 2015, with the most deprived areas subjected to even bigger cuts (Health Foundation, 2021). The King's Fund called these cuts 'the falsest of false economies' (Buck, 2015) and, unfortunately, predictions that such cuts would lead to more disease, earlier deaths and greater demand on expensive treatment services have come to pass.

Beyond formal preventative services overseen by national and local authority public health agencies, many of the wider determinants of health, such as child poverty (House of Commons Library, 2023), access to secure housing and public services that keep people well (like youth, library and leisure services) has also worsened. The deterioration of these protective factors due to austerity is likely to have contributed to poorer mental health outcomes. We recommend taking a public mental health approach, recognising the importance of wider improvements to equity, diversity and social determinants of health on population wellbeing (FPH and Mental Health Foundation, 2016). The evidence suggests that, by addressing the factors described below with evidence-based and informed interventions, we will both improve the general wellbeing of the population and prevent mental illness in many cases.

MENTAL HEALTH PROTECTIVE AND RISK FACTORS AMENABLE TO ACTION

PROTECTIVE FACTORS

- Secure and sufficient income
- Fair treatment
- Positive parenting
- Positive school experience
- Secure, decent housing
- Access to healthy, natural environments
- Exercise, healthy diet, abstinence from smoking and substances
- Community connectivity and relationships

RISK FACTORS

- Poverty
- Discrimination including racism*
- Child neglect, abuse, insecure attachment
- Bullying, excessive exam and social media pressure
- Homelessness, poor quality, insecure housing
- Polluted (air, water, noise), high-traffic places
- Inactivity, poor diet, smoking, alcohol, and drug use
- Unsafe and disconnected communities

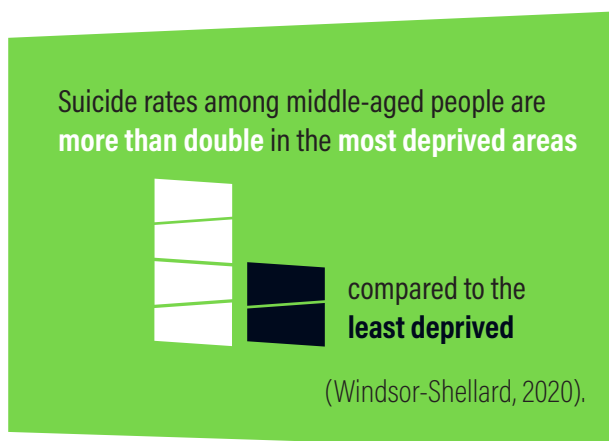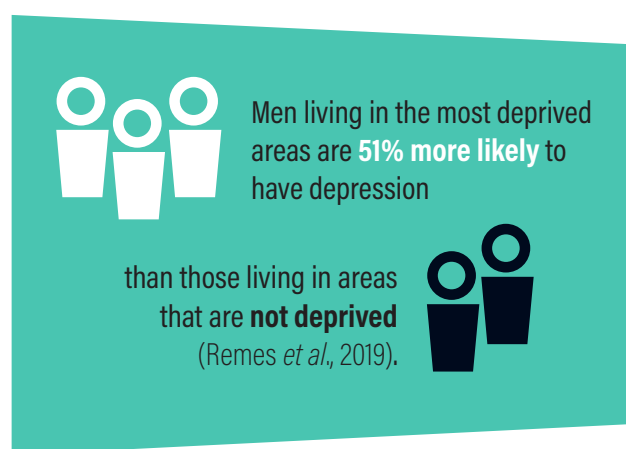# EVIDENCE AND SUGGESTED ACTIONS TO ADDRESS THESE RISK FACTORS

INCREASING INCOMES AND REDUCING POVERTY TO IMPROVE MENTAL HEALTH

The evidence is clear that poverty (income below 60% of average after housing costs) and economic inequality are extremely damaging to mental and physical health, and policy makers should therefore prioritise reducing them as an urgent public health necessity. Rates of depression, severe mental illness and suicide (not to mention nearly every physical illness and injury) worsen with poverty in a clear relationship – the greater the depth and duration of the poverty, the worse the outcomes. Additionally, being out of work due to prolonged mental illness can also lead to worsening financial circumstances without the right support. This shows a bi-directional relationship between poverty and mental illness, and the importance of alleviating poverty as a governmental priority.

Although mental and physical harm increases with poverty, economic inequality is bad for everyone: rich, poor and those in between. The work of world-leading British epidemiologists such as Professor Sir Michael Marmot and Professor Kate Pickett show that the most unequal developed economies (including the UK and the US) experience disproportionately higher levels of mental illness, stress, social problems and instability than more equal ones, such as those in Scandinavia, New Zealand and Japan (Wilkinson and Pickett, 2018). The studies reveal greater risk of depression in populations with higher income inequality relative to populations with lower inequality, while also showing subgroup effects, including greater impacts of income inequality among women and low-income populations (Patel *et al*., 2018).

Economic inequality intersects with other disadvantages, such as those caused by structural racism. Many racialised communities in the UK experience higher rates of poverty and worse mental health, creating multiple disadvantages which have been further exacerbated as a result of the Covid-19 pandemic (NHS Confederation, 2023). In the UK, poverty and inequality are getting worse, with high inflation overlapping with the impact of the pandemic. The Office for Budget Responsibility (2022) describes this as the compounding effects on the economy after Brexit and the austerity which followed the global financial crash of 2007. If the current trajectory of deepening poverty, widening economic inequality and worsening health continues, millions of people will suffer preventable harm, and health and social care services will be overwhelmed by demand. This is a public health emergency that requires urgent and concerted action.

THE ASSOCIATION BETWEEN DEPRIVATION AND POOR MENTAL HEALTH OUTCOMES

Children from the **poorest 20% of households** are **four times** as likely to have serious mental health difficulties by the age of 11 as those from the **wealthiest 20%** (Morrison Gutman *et al*, 2015).

Men living in the most deprived areas are **51% more likely** to have depression than those living in areas that are **not deprived** (Remes *et al*, 2019).

Suicide rates among middle-aged people are **more than double** in the **most deprived areas** compared to the **least deprived** (Windsor-Shellard, 2020).

HOW POVERTY HARMS MENTAL HEALTH

SOCIAL DETERMINANTS

◎ People with the lowest incomes are harmed the most by economic inequality, as it increases risk factors and reduces protective ones while damaging self-esteem and control

◎ Increases the risk of adverse childhood experiences

◎ Intersects with discrimination including structural racism leading to worse outcomes for racialised communities.

ENVIRONMENTAL FACTORS

◎ Reduces access to healthy food

◎ Makes living in overcrowded, insecure housing more likely

◎ Lessens access to green space & exercise

◎ Increases exposure to air pollution

◎ Deprived areas more likely to be saturated by unhealthy products like fast food, betting shops, cheap illicit tobacco.

INDIVIDUAL FACTORS

◎ Makes genetic risk more likely to convert to illness

◎ Increases stress

◎ Reduces sense of control, self-esteem & confidence

◎ Cuts 'mental bandwidth' for 'good' health choices (Mullainathan & Shafir, 2013)

◎ Creates vulnerabilities to unhealthy consumption such as smoking, substance misuse, unhealthy foods & alcohol.

ACCESS TO HEALTH CARE AND OTHER SUPPORT

◎ Deprived communities have less access to quality health care and other support services, as these areas are often underserved and under-resourced compared to more wealthy areas.

◎ This phenomenon is described by Tudor Hart as the 'inverse care law'.

ACTIONS TO REDUCE POVERTY, DEPRIVATION AND ECONOMIC INEQUALITY

Mental and physical health can be improved by increasing incomes and reducing the costs of the most deprived, as well as ensuring mitigations such as excellent local advice and other support.

The first step is committing to make ending poverty a national, regional and local imperative. Between 2010 and 2016, it was a statutory duty for central and local government to measure and have strategies in place to reduce child poverty – this and previous policies helped to halve child poverty from 4.4 million to 2.2 million. It would be sensible to restore a form of this duty and involve the whole community in eradicating child poverty.

Therefore, we ask the government to create a Minimum Income Guarantee so that everyone has enough money to afford to live a healthy life, alongside seeking to increase overall incomes, particularly for the most deprived. The Joseph Rowntree Foundation's call on the UK Government to deploy an Essentials Guarantee is one promising means of achieving this end.

INCREASE INCOMES OF THE MOST DEPRIVED BY:

◎ Encouraging community wealth-building schemes where anchor institutions (like local authorities, NHS trusts and universities) hire and buy more goods and services locally. An evaluation of such a scheme in Preston, Lancashire is associated with reduced anti-depressant prescriptions and a 9% increase in self-reported life satisfaction scores (Rose *et al.*, 2023)

◎ Increasing the minimum wage and social security payments, with other reforms (including to policies that place arbitrary limits on people's and families' benefit entitlements) which should both then rise with inflation, known as indexation

◎ Invest in education for both children and adults, so that people of any age can benefit from learning opportunities and boost their future incomes.

LOWER COSTS FOR THE MOST DEPRIVED BY:

◎ Building many more energy efficient social rent homes

◎ Insulating homes

◎ Supporting household and community renewable energy production

◎ Extending free child care, early years education, school meals and period products, as well as council tax exemption

◎ Providing better access to free or cheap bikes, bike storage, and cheaper public transport.

PROVIDING BETTER FINANCIAL ADVICE

The impacts of financial insecurity on mental health have been exacerbated by the current cost of living crisis that has created money and mental health problems for more people.

The Money and Mental Health Policy Institute (Bond, 2021) says that providing high-quality money advice would reduce risks associated with poor mental health among people experiencing financial difficulty. Currently, too few people can access this advice before their financial problems have become established and harder to recover from. Money and debt advice services should be free to access, face-to-face, and available to anyone experiencing anxiety and mental ill health associated with their finances. Mental health appointments and reviews should include the opportunity for people to express financial concern as a contributing factor to their mental health in order to link them up with appropriate services. To achieve this, there must be a commitment to funding integrated money advice services in all mental health and other health care services nationwide.

Financial difficulty drastically reduces recovery rates for common mental health conditions. People with depression and problem debt are 4.2 times more likely to still have depression 18 months later, compared to people without financial difficulty. Conversely, supporting people with money advice through NHS Talking Therapies could double recovery rates for people suffering with anxiety and depression related to problem debt.

People with mental health problems are three times more likely to be behind on at least one key payment – like energy bills, rent or credit cards – compared to people without mental health problems (19% compared to 6%). And nearly half (48%) of those who are behind on one or more bills have experienced mental health problems. Research also finds that people with mental health problems are nearly three times as likely to have felt anxious, unable to cope, or filled with dread about receiving communications from their creditors due to rising costs in the past three months (78% compared to 28%) (Bond, 2023).

GIVING EVERY CHILD A MENTALLY HEALTHY START IN LIFE

National and local government should work alongside communities, parents and schools, as well as voluntary, community and social enterprises, to build the most nurturing environments for children to flourish.

Most (75%) of lifetime mental health difficulties first occur before the age of 24, and 50% first occurs before the age of 14 (McManus *et al*., 2014). What happens to us as children profoundly affects our lifetime mental health and other outcomes. It is imperative, therefore, to give children the best start in life, where they are well attached to at least one well-resourced and supported caregiver, in a stable, decent environment with good services, and protected from abuse, neglect and other harms.

The prevalence of mental health problems among children and young people in the UK has been increasing. The most recent survey of the mental health of children and young people in England indicates that, between 2017 and 2022, prevalence of probable mental health disorders in children aged 7-16 years old has increased from 12% to 18%, and from 10% to 26% in 17-19 year olds (NHS Digital, 2021). The previous wave of the survey series also showed that more children and young people (39% for 6-16 year olds, 53% for 17-23 year olds) reported that their mental health had deteriorated between 2017 and 2021 than improved (22% for 6-16 year olds, 15% for 17-23 year olds) (NHS Digital, 2021). Further, there is evidence that children and young people's mental health needs are becoming more severe: the number of under-18s attending hospital emergency departments with recorded diagnoses of a psychiatric condition tripled between 2010 and 2019; 53% of young women aged 17-19 who had a diagnosable mental health disorder had self-harmed or attempted suicide (YoungMinds, no date).

Despite the well-documented deterioration of children and young people's mental health over the past 10 years, overall budget funding to local authorities has been halved, with the poorest councils being the worst hit. Many of the services councils have had to cut, like Sure Start centres, libraries, leisure centres, advice services and parks, are protective of mental health. As a result of eroded protective services and worsening mental health, spending on crisis services and late intervention has correspondingly increased by 37%, now making up 80% of local authority spending on children's services - likely reflecting the lack of early intervention service availability (Children's Society, 2022). This reliance on crisis services is unsustainable and requires a radical restructuring of existing services, alongside increased funding to prevent a failure of support services for children and young people.

Poverty is associated with an increased risk of experiencing multiple adverse childhood experiences (including neglect, abuse, bereavement, and having a parent/carer with a substance misuse issue or severe mental illness) leading to increased risk of mental ill health. Rates of child abuse and neglect are five times higher for children in families with low socioeconomic status compared to those with higher socioeconomic status (Centers for Disease Control and Prevention, 2022). Children's exposure to poverty creates and compounds adversity, driving poor health and social outcomes in later life.

The relationship between poverty and experiencing adverse childhood experiences such as exposure to violence may be causal, as suggested by research that shows that cash transfers to households reduce intimate partner violence (Haushofer and Fehr, 2014). There is a great deal of high-quality scientific evidence demonstrating that adverse childhood experiences lead to a substantially higher risk of poor wellbeing, mental ill health, and other negative outcomes during the whole lifetime of the person affected (Lippard and Nemeroff, 2020). For example, analysis shows that 46% of individuals with depression (Nelson *et al*., 2017) and 57% of people diagnosed with bipolar disorder (Post *et al*., 2013) report high levels of childhood maltreatment.

Where there is heightened risk of abuse, neglect and bullying, and therefore higher risk of poor mental health, public services need the resources to intervene early and effectively.

This means that national government should invest in:

◎ **Free, universal, high-quality child care** for every child from age two

◎ **Children's social care**

◎ **Well-resourced maternity services** (including perinatal mental health support, midwifery and health visiting), primary care and integrated early years support (including through Family Hubs, nursery care and after-school and holiday clubs), especially in areas of deprivation

◎ **Evidence based parenting programmes**, such as the Triple P-Positive Parenting Programme (Sanders *et al*., 2014). Parents should also be supported by a variety of services, including input from well-resourced health visitors and voluntary and community sector organisations in their community. More intensive specialist interventions should be made available for parents when they or their children have more intense needs.

EDUCATION AND CHILDREN'S MENTAL HEALTH

Schools, early years child care, youth clubs, colleges and other services that work with children and young people have a vital role in promoting their mental wellbeing and improving mental health literacy. There is growing evidence that children's mental health literacy can be boosted in their day-to-day relationships with trusted adults, including parents and teachers (Snell, 2022). Schools also have an essential part to play in picking up issues early so that young people experiencing mental health problems can get the support they need as quickly as possible.

Every school should be encouraged and supported to take a 'whole school approach' to mental health. This means that the entire school (or college or other setting) seeks to support the mental wellbeing of the whole population – including staff members. This should include:

◎ **Having a designated senior lead for mental health**, with proper training, skill and interest in mental health, who can signpost students and parents to appropriate services and support colleagues to become more mental health-literate

◎ **Taking action to prevent bullying**

◎ **Using evidence-informed classroom-based programmes as a core part of the relationships, sex and health education curriculum** (Mental Health Foundation, 2018)

◎ **Routinely measuring the wellbeing** of the school population

◎ **Adopting policies and practices that support improvements in children's behaviour and prevent exclusions**, which are known to cause long-term harm to young people's outcomes (Rainer, 2023)

◎ **Inclusive schools have also been found to reduce the incidence of bullying of LGBTQ+ students**, with consequent benefits to their mental health and wellbeing.

The UK government has endorsed the 'whole school approach' to mental health and introduced mental health education as part of the relationships, sex and health education curriculum. These are important steps forward for children's mental health. We call on the government to go further over the next decade, using the whole school approach as a framework for wider education policies, investing in teacher training in mental health and child development, expanding the best anti-bullying programmes nationwide, and enabling schools to create inclusive cultures that nurture every child's wellbeing and mental health literacy.

The education system should maximise wellbeing and resilience and minimise risks. This will benefit young people's educational attainment as well as their health and their long-term outcomes in life. The government should therefore review how the current system supports or undermines wellbeing (for example through the curriculum, testing and how behaviour is managed), and make changes to help protect the mental health of future generations. Proper consideration of children with neurodevelopmental conditions needs to be made in this regard. Children with special educational needs and disabilities are more likely to need mental health support which is often inadequately resourced, and they are more likely to receive restrictive interventions for behavioural problems that can exacerbate those difficulties (Centre for Mental Health, 2020). Further specialised support for children who have both special educational needs and mental health difficulties should be provided.

Schools can be a protective factor for children and young people's mental health by providing them with structure and routine, contact with trusted adults and peers, and support and guidance on both academic and wellbeing matters. Schools are integral to a good prevention strategy. An inclusive school culture supports young people's wellbeing and can also provide a space for early intervention – where young people can get support before their needs escalate, reducing pressure on NHS services.

- Given the disproportionate negative impacts of zero-tolerance behaviour policies and exclusion on racialised children and young people, those on free school meals, and those with special educational needs and disabilities, use of exclusions and suspensions should be subject to an impact assessment to ensure that they are not entrenching inequalities

- Training on mental health should be part of initial teacher training and continuing professional development

- Families should receive support and be treated with understanding if their child is struggling to attend school because of their mental health. Engaging parents, carers and young people should be the first step, rather than sanctions.

The quality of alternative education should also be improved so that young people have educational routes tailored to their strengths. Many pupil referral units are not currently providing high-quality support for vulnerable children, and more needs to be done to keep children at risk of exclusion in school. These children need a community psychology approach that can help them create change in their social environments, rather than one that focuses on individual behaviours.

Coproduction approaches are needed to work with vulnerable young people at risk of exclusion, and those who have entered the criminal justice system, to create services that adequately fit their needs and help them thrive. Community mentoring programmes, provided through local government or the voluntary sector, should be attached to youth services and build on existing relationships between young people and youth workers. These relationships can be particularly important for vulnerable young people and those who are more at risk, including LGBTQ+ and racialised young people.

Education also has an important role to play in supporting mental health during adult life. Adult education often provides invaluable opportunities for learning and promoting mental health among people who missed out during their earlier years. Government support for adult education is therefore essential for the nation's mental health.

HOUSING

Having a decent, affordable, secure home is fundamental to mental health, with insecure and overcrowded housing associated with stress and anxiety. Noisy, crowded or uncomfortable housing (and feeling stressed or anxious about housing) can also affect sleep quality, and poor sleep can lead to mental health problems or make existing problems harder to cope with (Walker, 2017).

In 2020, housing costs in the UK made up an average of 20% of disposable income, rising to 24% for renters and 34% for renters whose income is in the lowest quintile (OECD, no date). 22% of children in the UK live in damp housing, and 6% of houses were classed as overcrowded (UNICEF, 2022). Further, generational divides in home ownership significantly contribute to inequity in the population (Arundel, 2017).

On a given night in 2022, over 271,000 people were recorded as homeless in England, which is a rate of 1 in 208 people.

◎ This population is mainly made up of people who are homeless and living in temporary accommodation (almost 250,000)

◎ There are an estimated 123,000 homeless children, comprising almost half (45%) of all people recorded as homeless in England (Shelter, 2022).

The housing emergency has been driven by a decades-long failure to build enough homes that are genuinely affordable for households on low incomes: homes with social rents linked to local incomes. There has been such a chronic lack of social housing built that, with sales and demolitions, 2022 saw a net loss of 14,100 social homes. It brings the total number of social homes lost over the past decade to 165,000, while 1.2 million households are stuck on waiting lists for a social home in England – a rise of 5% in the past two years.

This lack of social housing has pushed more and more people into the private rented sector, where support for rising rents has not kept pace. The last uplift to Local Housing Allowance was made in 2020 and based on rents in 2019. Listed rents in the UK have risen at record rates over the last year: 20.5% in Manchester and 17.6% in Birmingham. This has led to an average shortfall of £151 per month. Any cost of living support that the government has given to households in recent months has been swallowed by this shortfall and not met the original aim of supporting people with increased energy or food bills. Recent research found that 1 in 12 private renters, or 941,000 households, are currently under threat of eviction (Shelter, 2022).

To tackle the housing emergency and lift millions out of bad housing and homelessness, *A Mentally Healthier Nation* backs Shelter and other housing charities in calling for:

◎ **Investment in a 10-year Affordable Homes Programme of £12 billion per year to deliver at least 90,000 social homes a year**. A minimum of 80% of grant funding in the programme should go to homes for social rent, to focus government grant money on the most affordable tenure

◎ **Overhauling 'cost minimisation' so that building good quality, genuinely affordable social rent homes is viable everywhere**

◎ **Reinvesting savings from the 7% social rent cap** back into the social housing sector.

The Government's current bill to reform the private rented sector, including greater protections from eviction and poor quality housing, is a welcome measure that will bolster mental health among tenants. We hope that this legislation is enacted and implemented in full.

THE WORKPLACE

Workplace conditions have also long been identified as significant risk and protective factors for mental health (Bonde, 2008; Wilhelm *et al*., 2004; Vinnikova, 2020), and evidence suggests that a mentally healthy workforce tends to be more productive (Allin, 2007). Workplaces are among the most important settings for promoting good mental health. And their responses to people experiencing periods of mental ill health play a vital part in facilitating recovery. Guidance from the World Health Organisation (2022a) sets out the actions that all employers can take to support the mental health and wellbeing of their workers, from organisation-wide policies and training programmes to individual interventions that enable people to return to work after a period of absence. Further information about how every workplace can support better mental health for its workers is available in the Greater Manchester Employment Charter guide (GMCA, 2020).

The role of government in supporting better mental health at work comes under three key areas:

First, the Government can encourage all employers to adopt high standards of mental health support at work. The *Thriving at Work* report (Stevenson and Farmer, 2017) set out a framework for mental health in all workplaces that has yet to be implemented in full. The Government should adopt the report's recommendations, including requiring all businesses with 250 or more staff to implement the standards it set, and encourage or incentivise smaller organisations to do likewise.

Second, the Government can lead by example, by ensuring that public services actively promote and support mental health at work, adopting policies and practices that improve wellbeing for all staff and contractors. Public sector organisations can go further by using social value procurement and other policies to encourage higher standards of mental health support in their supply chains. This must include taking active steps to prevent and tackle workplace bullying, racial discrimination, gender inequality and other forms of discrimination in public services. And it requires regular and transparent reporting about workplace mental health, for example to NHS trusts, boards and local councils.

Third, there is strong evidence that government policies to boost workplace rights and job security bring about benefits to people's mental health. Protecting people's working conditions is likely to improve mental health at the population level. One area where reform is needed urgently is the current sick pay system.

Flexible sick pay is key to keeping people in work through periods of mental ill health, and reducing the knock-on effects (such as financial strain) caused by being out of work. We suggest, in line with the *Thriving at Work* review, that the Government sets clear legislative expectations of employers to make Statutory Sick Pay more flexible for people with mental health problems, and to support phased returns to work where appropriate. Current Statutory Sick Pay policies are not working for people with mental health difficulties, and in some cases have caused employees to go into debt, increasing the strain on their mental health (Mind, 2022). Financial strain and stress have a causal relationship with mental health problems and recovery rates, potentially keeping people out of work for longer.

Many mental health conditions and symptoms fluctuate, underlining a need for enhanced protections for employees through legislation and clarification on the role of the employer in providing reasonable adjustments, including phased returns to work.

IMPROVING PHYSICAL ENVIRONMENTS FOR MENTAL HEALTH

There is increasingly strong evidence that features of the physical environment, like air pollution, affect mental health outcomes including depression (Roberts *et al.*, 2019), psychosis (Newbury *et al.*, 2019) and suicide (Heo *et al.*, 2021).

Imperial College London recently published an air pollution evidence review (Fuller *et al.*, 2023) suggesting that the establishment of links between air pollution and brain health, including mental health and dementia, are among the most significant new findings over the last decade of research. The review includes the following studies:

◎ After adjusting for external factors such as smoking and socioeconomic status, people exposed at age 10 to higher levels of Nitrogen Oxides (NOx) and Particulate Matter 2.5 (PM2.5) air pollutants were at higher risk for a mental health diagnosis, including conduct disorders and depression (Latham *et al.*, 2021)

◎ Another 2021 study found that increased NOx exposure was linked to increased rates of mental illness among participants (Reuban *et al.*, 2021), and a 2017 review indicated that airborne pollutants were associated with higher risks of psychotic disorders (Attademo *et al.*, 2017)

◎ Airborne pollutants also cause and worsen physical ailments including cardiovascular, respiratory and neurological diseases, which in turn increase risks of mental ill health (Dominici *et al.*, 2006).

In addition to the direct effects of air pollution on mental and physical health, the most significant sources of air pollution are also associated with other mental health risks:

◎ Urban road traffic reduces social contact, increasing mentally unhealthy isolation (Hart and Parkhurst, 2011). Conversely, urban environments with better walking, cycling and public transport connectivity support social contact and reduce loneliness (Williams *et al.*, 2021)

◎ Dependency on fossil fuels, subject to international inflationary pressure, increases poverty (Daley and Lawrie, 2022) which, in turn, worsens mental health

◎ The worsening effects of climate change increase the risks of anxiety and other mental health difficulties. Climate anxiety (or eco anxiety) is particularly present amongst young people (Palinkas and Wong, 2020; Hickman *et al.*, 2021).

Furthermore, poorly insulated homes without affordable heating can damage mental health (Clair and Baker, 2022), and so measures taken to switch to lower-cost renewable forms of energy and better insulation would both reduce pollution and make homes more affordably warm in the winter and cooler in the summer.

Finally, there is compelling evidence that physical inactivity is associated with poorer mental health, and that exercise is associated with better mental health (Heissel *et al.*, 2023). But there are significant barriers for many people, including poor access to safe green spaces or affordable leisure facilities. It is therefore vital for national and local government to make structural changes to encourage more physical movement in everyday life. Walking, wheeling and cycling to get about is a great source of exercise and can be encouraged by investing in pedestrianisation, high quality walking routes, protected cycle lanes and public transport.

It is therefore vital that central and local government does everything in its power to reduce air pollution, tackle the climate crisis and improve the environments we all live in.

A Mentally Healthier Nation suggests the following policy changes:

- ◎ Consultation on a ban of domestic solid fuel burning in towns and cities
- ◎ Accelerate the switch to renewable energy
- ◎ Improve support for electric public transport and active travel
- ◎ Disincentivise fossil-fuelled travel, especially by air
- ◎ Ensure everyone has access to green spaces
- ◎ Encourage town centre revival, densification and pedestrianisation
- ◎ Encourage low traffic neighbourhoods, congestion and pollution charges.

ALCOHOL

Alcohol use increases the risk of mental health problems, both through biological effects and negative social effects (Goodwin, 2022). At the same time, worsening mental health can result in an increase in alcohol use and risk of disorder through using alcohol to cope (Goodwin, 2022).

There are common risk factors for alcohol use disorders and mental health problems, including exposure to traumatic events (including in childhood) or genetic and environmental risks (Goodwin, 2022).

Reducing alcohol consumption overall would have a large benefit on physical and mental health. There is a wealth of evidence on the most effective policies for reducing population-level alcohol consumption, including restrictions on marketing, pricing measures such as minimum unit pricing and alcohol duty reform, increased treatment funding and training for professionals, and restrictions on availability through stronger licensing powers. Public Health England published a thorough analysis of alcohol policies' effectiveness and cost-effectiveness (Public Health England, 2016).

TACKLING AFFORDABILITY

The affordability of alcohol is directly linked to alcohol harm, with heavier drinkers tending to consume products that are both cheaper and stronger on average (Griffith *et al*., 2017). Alcohol taxation and pricing policies are some of the most effective and cost-effective alcohol control measures (World Health Organisation, 2018).

An increase in excise taxes on alcoholic beverages both reduces harmful use of alcohol while raising revenue for vital public services (World Health Organisation, 2018). Thousands of additional deaths have occurred due to cuts and freezes in alcohol duty in both England and Scotland between 2012 and 2019 (Angus and Henney, 2019). Duty rates must keep rate with inflation so that alcohol does not become more affordable over time, eroding the impacts of any duty hikes.

England should follow Scotland and Wales in introducing a minimum unit price of at least 50p, along with a mechanism to regularly review and revise this in line with inflation (Alcohol Health Alliance, 2022). In Scotland, minimum unit pricing has been effective in reducing overall alcohol consumption by 3-3.5% (Giles *et al*., 2022). In the first year of implementation, Scotland saw a 10% reduction in alcohol-specific deaths within the first year, rising to 13.4% by the end of 2020. The largest reductions were found for those living in the 40% most deprived areas. In June 2023, Public Health Scotland published a comprehensive review of the benefits of minimum unit pricing which are considerable and greater amongst the most deprived, thereby addressing health inequalities.

RESTRICTING ALCOHOL MARKETING

Alcohol marketing normalises alcohol consumption and exposes children and vulnerable people to alcohol products, leading people to drink more and at an earlier age (Jernigan *et al*., 2016).

The World Health Organisation recommends comprehensive marketing restrictions as a most effective 'best buy' to reduce alcohol harm and protect children and vulnerable people (World Health Organisation, 2022). Until a full comprehensive ban is introduced, the following policies can help reduce children's exposure to alcohol marketing:

◎ Ending alcohol sports sponsorship

◎ TV watersheds

◎ Online bans

◎ Restricting advertising in public spaces

◎ Restricting the visibility of alcohol in the retail environment

◎ Providing relevant information on labelling.

LIMITING AVAILABILITY

Local authorities need to be able to better control the availability of alcohol in their areas. Making public health a licensing objective can support public health bodies' position as a responsible authority in reducing health harms (Public Health England, 2017).

SMOKING

Smoking is undermining government goals to improve the physical health of people with mental health difficulties:

◎ High smoking rates among people with mental health difficulties are a leading cause of premature death and disease. Smoking accounts for two-thirds of the reduced life expectancy of people with a severe mental illness

◎ Smoking rates are high in most groups with poor mental health. The highest rates of smoking are among people with substance use issues (70% of those receiving treatment for opiates smoke)

◎ People with severe mental illness have just less than three times the smoking rate of the general population (41% versus 14%). The rate among people with depression and anxiety is just under twice that of the general population (26% versus 14%) but they account for around 1.6 million smokers (PHE, 2020).

Higher levels of poor mental health in the population (Jackson *et al*., 2023), particularly among young people, may increase the risk of smoking uptake and reduce the likelihood that smoking rates will continue to fall.

Increasing the rates of people quitting can improve population level mental health, reduce the burden on the NHS and improve the wealth and employment prospects of people with mental health conditions:

◎ **Stopping smoking improves mental health**: There is now good evidence that stopping smoking improves mental health (Taylor *et al*., 2014)

◎ **Smoking exacerbates levels of poor mental health**: There is growing evidence that smoking contributes to development of some mental health conditions including schizophrenia and depression (Firth *et al*., 2020)

Without targeted action, people with mental health difficulties will be left behind. People with a mental health condition are similarly motivated to quit compared to people without a mental health condition, and with the right support can be equally successful – but higher levels of addiction and multiple other barriers undermine quit success (Centre for Mental Health, 2020).

RECOMMENDATIONS TO REDUCE SMOKING

◎ A comprehensive set of measures to reduce smoking for the whole population in line with recommendations made by the All Party Parliamentary Group on Smoking and Health, including a levy on tobacco companies and a consultation to raise the age of sale for tobacco from 18 to 21

◎ A new Tobacco Control Plan for England with a commitment to secure faster progress for people with a mental health difficulty, including:

  ◇ A target for reducing rates in this population

  ◇ Scaled up support for people using all mental health services including NHS Talking Therapies

◎ Commitments made through the NHS Long Term Plan to provide smoking cessation support to everyone with long-term mental health conditions must be fully implemented and sustained.

NHS England is investing in new support through the NHS Long Term Plan to help smokers in secondary mental health services to quit. Implementation has been slowed by the pandemic, and mental health services are lagging behind implementation of similar support in maternity and acute settings. Commitment must be maintained, and the NHS needs to ensure that new services are sustained for the long term.

VAPING, E-CIGARETTES AND MENTAL HEALTH

Over the last decade, vaping has become the most popular route for quitting smoking and is used by a growing proportion of people who have quit smoking to prevent them from returning to smoking. Estimates from University College London suggest that vaping has contributed to thousands of additional quits each year in addition to the number who would have quit anyway (Patten, 2021).

The growing evidence that vaping is more effective than many stop-smoking medications (and that it is much less harmful than smoking) has led National Institute for Clinical Excellence to advise that vaping is a valuable aid to quitting smoking.

Vaping may have particular importance for people who smoke and have mental health problems (who tend to be more addicted to smoking), and has been shown to work for this population. They have proven an effective aid for supporting the implementation of smokefree policies in mental health hospitals.

ASH estimates that 9% of adults are currently vaping, the vast majority current or ex-smokers. Among people aged 11-17, it is estimated that 20.5% have tried vaping and 7.6% are currently vaping. The proportion of young people vaping has increased over the last two years and is a source of concern, particularly in terms of young people who have not smoked. ASH and other health charities have called for further regulations to reduce the appeal and availability of vaping products to young people.

It is important that the mental health effects of nicotine and vaping are further researched, and that future studies of the risks and benefits of vaping include populations with poor mental health.

◇ DIET

Food and diet are intrinsically linked to mental health and should be considered in any broad public mental health approach to prevention. The links include:

◎ Eating disorders and the normalisation of disordered eating

◎ Food insecurity as a significant contributor to poor mental wellbeing and a risk factor for several common mental health problems (especially within the context of a less equal society). Low incomes are associated with poorer quality diets including high proportions of ultra-processed foods high in salt, sugar and trans-fats and low in fibre, vitamins and other nutrients

◎ Emerging evidence that low-quality diets may alter stress responses and could be associated with stress-related mental health problems (Bremner *et al*., 2020). There is increasing evidence on the relationship between gut health and mental health, which supports the need for more education on what factors impact gut health and could be contributing to poor mental health.

Due to the high rate of mortality and disability caused by eating disorders (Van Hoeken and Hoek, 2020), and the fact that demand for eating disorder services is growing in the UK (Iacobucci, 2021), future and current public health interventions should always consider their impact on people with disordered eating. We recommend that people, specifically young people, with lived experience of concerns related to body image and their mental health should be consulted in the design and implementation of public health campaigns and strategies, to promote positive messages about body image, avoid potentially harmful depictions and prevent exacerbation of disordered eating.

Further, we suggest that public health teams consider weight-neutral approaches to health promotion in all areas where appropriate: emergent evidence suggests that this approach may be as or more effective than weight loss focused interventions for improving physical health (Dugmore *et al*., 2020). For example, people with eating disorders have criticised the requirements for calorie labels on menus; this intervention has limited evidence of efficacy (Crockett *et al*., 2018) and should be monitored for impact across mental health issues related to diet.

In cases where weight loss would be beneficial to a person's health, such as in the case of type two diabetes, there should be a focus on de-stigmatising available support. While we acknowledge that this may be contentious, we feel that the evidence supports a less weight-centred approach to health promotion, given the potential harms related to disordered eating.

Access to affordable, minimally-processed foods with a wide variety of fruits and vegetables should be promoted at all levels, in line with the National Food Strategy (2021). Schools should ensure children are provided with nutritious and accessible school meals, and food in government-funded institutions (including hospitals and prisons) should be held to a high nutritional standard. Policies to regulate the promotion of ultra-processed foods should be explored alongside methods to improve access to fresh fruits and vegetables and affordable alternatives. Finally, social security levels should allow people on benefits to access healthy food.

We also call for a national initiative to end food insecurity and reduce the reliance on food banks and similar community interventions. 14.3% of adults in the UK experienced food insecurity in 2022, and the Trussell Trust reported that the use of their food bank services increased by 120% between 2017-2023 (Bull *et al*., 2023). The overall impact of this on wellbeing is difficult to calculate but will undeniably affect the mental health of a significant proportion of the UK population.

ACCESSIBLE PHYSICAL ACTIVITY

There is a wealth of evidence showing the association between mental wellbeing and physical activity, alongside other physical health benefits of moving more (Smith and Merwin, 2021). However, there are many barriers to accessing sport and physical activity. For example, 47% of adults (Sport England, 2023) reported that a reduction in disposable income due to the ongoing cost of living crisis would have a negative effect on their ability to be physically active. Similarly, there are significant differences in participation in physical activity by gender and ethnicity, and 33% of people in lower socioeconomic groups report being inactive (Sport England, 2023). Therefore, we recommend promoting low-cost activities, or ways that exercise could be used to save money in people's day to day life.

Further, working to remove structural barriers to exercise for people will be essential – these include changing planning and transport laws and guidelines to reduce car-dependency, encourage walking and cycling, and support everyday physical movement while ensuring access for disabled people.

Therefore, we recommend that the Government should support (through legislation where necessary) and adequately fund local councils to boost physical activity in all areas, including through infrastructure such as cycle paths, pedestrianisation and accessible leisure facilities.

GAMBLING

Gambling is an under-recognised cause and exacerbator of mental health difficulties. Further, the UK gambling landscape has significantly changed over the last 10 years, in the context of smart phones and the developing digital media landscape.

Evidence suggests that gambling-related mental health problems are also significantly under-treated, with a recent *Lancet* article (Bowden-Jones *et al.*, 2022) suggesting that only 5% of problem gamblers seek treatment. The NHS has taken steps to improve access to specialised treatment for people with the most severe gambling addictions as part of the NHS Long Term Plan's implementation.

Steps have also been taken to address gambling-related harms, including a white paper (Department for Culture, Media and Sport, 2023) introduced to discuss necessary changes to the 2005 Gambling Act and supported by the UK Gambling Commission (2023).

We recommend that this work be carried forward to update the existing legislation and provide further protection for people who may be at risk of gambling-related harms, to prevent problems wherever possible, and to intervene earlier to reduce risk of escalation.

SUICIDE PREVENTION

In 2021, there were 5,583 suicides registered in England and Wales, equivalent to a rate of 10.7 deaths per 100,000 people. While this was statistically significantly higher than the 2020 rate of 10 deaths per 100,000 people, it was consistent with the pre-coronavirus (Covid-19) pandemic rates in 2019 and 2018 (Office of National Statistics, 2022b). Men remain the highest risk group, and the North East region has the highest rate of suicide in England, with middle-aged men being the most at risk. Suicide rates are also frequently elevated amongst minoritised populations, including autistic people and some racialised and LGBTQ+ communities. For example, the rate of suicide among Gypsy, Roma and Traveller men in Scotland is close to seven times higher than that of the general population (Public Health Scotland, 2022). Working to prevent suicide is an essential part of promoting a mentally healthier nation.

A national suicide prevention strategy has just been launched by the UK government. It is vital that this is adequately funded, sustained and updated throughout the next decade. To supplement this strategy we recommend full adoption and resourcing of the Samaritans' guidance for suicide prevention at the national level (Samaritans, 2023):

◎ **Refresh the target from the NHS Five Year Forward View for Mental Health to reduce suicide rates in England to the lowest on record**. This target should be met by 2028 (Garratt, 2023)

◎ **Strong accountability and high ambition for the new plan**: with an ambitious new national target to reduce suicide rates; a cabinet committee, cross-government ministerial working group or similarly senior body to oversee progress; rigorous evaluation to build understanding of 'what works' for suicide prevention; and an independent advisory group to scrutinise plans and delivery

◎ **Strong links between local and national progress on suicide prevention**: with co-ownership of the refreshed plan by the Department for Levelling Up, Housing and Communities and Department for Health and Social Care; renewal of dedicated funding and dedicated staffing for local suicide prevention work; and updated guidance on local suicide prevention planning to support integrated care systems

◎ **Suicide prevention approached as a socioeconomic inequality policy issue**: by ensuring that financial and employment support is available to everyone with a mental health care plan that needs it, and conducting an impact assessment for every new piece of legislation in terms of suicide risk

◎ **Radically improved data collection**: with an annual audit of the forthcoming National Real Time Suspected Suicide Surveillance system, and recording of ethnicity on death certificates as soon as possible

◎ **People living with suicidality always taken seriously**: with 'no wrong door' for anyone experiencing suicidal thoughts or self-harm wherever they come to the attention of public services, including health, social care and emergency services, and with no barriers or exclusions from support

◎ **Substantial investment in early intervention**: with funding for open access mental health support for people in groups that are more likely to die by suicide, such as autistic people, and in geographical areas with higher suicide rates; maximising the 'touchpoints of the state' in people's lives to intervene and support those at risk; investment in suicide awareness training for all public sector workers; and public-facing campaigns to break down stigma

◎ **A step change in support for people who self-harm**: with introduction of specialists in NHS Talking Therapies services for anyone who has been referred for support with self-harm; open-access community support in every locality; and audits for compliance with NICE guidelines

◎ **Increased and integrated support for people in crisis**: with a consistent offer in every part of England for people who are in suicidal crisis that includes non-clinical and non-statutory provision, and a range of ways to access de-escalation and safety planning support. This should build on NHS England's efforts thus far to broaden the range of complementary and alternative crisis services to maximise the coverage of these services across the country

◎ **Further action on access to means of suicide**: with new legislation for online retailers, timely data collection on methods and 'designing out' suicide risk at high frequency locations

◎ **Further investment in bereavement support**: with personalised support that recognises the diversity of families, signposting support across a range of relevant public services, and a new employment right to statutory bereavement leave and pay

◎ **A broader focus on responsible communications**: with a strong new online safety system; consistent protection across mainstream media, online content and streaming services; and investment in media and online advisory services.

CREATING SAFER, MORE INCLUSIVE ONLINE AND PHYSICAL ENVIRONMENTS

SOCIAL MEDIA AND ONLINE HARMS

Social media use and mental health are frequently discussed and remain a concern, especially when discussing the mental health of children and young people. 10% of 12-15 year olds have seen something of a sexual nature online that made them feel uncomfortable (Royal College of Psychiatrists, 2020), and 13% of 11-16 year olds report being bullied online (NHS Digital, 2022). Further, evidence from whistleblowers suggests that social media companies are aware of the negative mental health effects of their products and choose not to act to prevent harm (Gayle, 2021).

However, the evidence suggests that the full picture is complex. The overall mental health effect of screen time (Tang *et al*., 2021) and social media use (Meier and Reinecke, 2021) is small, and highly dependent on the way that users interact with digital media – 'active' participation in online communities may be protective of mental health, while 'passive' viewing of posts or exposure to cyberbullying and trolling can have a profound adverse effect. Further, 'internet addiction' is associated with suicidal ideation, especially among children (Cheng *et al*., 2018). While the evolving landscape of social media may seem overwhelming to policy makers, it is important to respond to these social changes in a way that doesn't create unnecessary moral panic.

In response to this issue, we call for:

◎ **Ongoing support for the Online Safety Bill to protect children and young people**, with adequate funding provided to support regulation by OFCOM and to enable regulators to adapt to new algorithms and social media platforms as they evolve

◎ **Schools and other agencies to receive support to tackle cyberbullying** and delivering evidence-based curricula to students about responsible social media use

◎ **The regulator to establish a levy on tech companies proportionate to their worldwide turnover.** This would be used to fund independent research and training packages for clinicians, teachers and others working with children and young people (Royal College of Psychiatrists, 2020)

◎ **More investment into independent research on online safety**, and social media companies to be compelled to share information about their algorithms for this purpose.

LONELINESS AND COMMUNITY CONNECTIVITY

The experience of the lockdown measures during the Covid-19 pandemic revealed to many how loneliness and lack of social connection can be harmful to mental health. It can cause or exacerbate mental health problems, as well as potentially being associated with higher rates of physical illnesses in people with pre-existing mental health problems (Erzen and Çikrikci, 2018; Clarke and Currie, 2009). Loneliness can affect everyone, but some groups, such as older people (Lee *et al*., 2021), are more at risk of both being isolated and developing adverse outcomes due to their loneliness.

Local authorities should be empowered to resource interventions through social prescribing (The King's Fund, 2020; McNally, 2017), with the voluntary and community sector alongside the grassroots community building activities that strengthen connectedness. Social prescribing is increasingly being delivered in primary care settings to good effect (NHS Digital, 2022), but there needs to be further research into its effectiveness, so that it can be commissioned at a larger scale.

Support for community hubs, as described in other sections of this document, should contribute to generating more social connections. Spatial planning can also support connectivity in communities by minimising traffic, which is shown to disrupt social connections, and by creating public spaces where people can come together. Green space, pedestrianisation, walking and cycling infrastructure, public benches and pro-social spaces (such as libraries, community centres and parks) can aid this.

STRUCTURAL REFORM

To create the best possible framework for action to prevent mental ill health, *A Mentally Healthier Nation* calls for:

◎ **A cross-governmental 10-year mental health strategy**, ideally to begin in the first year of the next Parliament, that incorporates the suggestions in this document, with statutory requirements associated with key outcomes and funding commitments as appropriate

◎ **A 'mental health test' to be applied to all government policies**, with a broader public policy framework in place that reduces risk and protects mental health

◎ **Creation of a statutory Mental Health Commissioner for England** with the necessary powers, resources and independence from government, similar to that of the Children's Commissioner

◎ **A better resourced Office for Health Improvement and Disparities** (OHID) established as an arm's length body

◎ **Proper resourcing of local authority public health services**, with at least £1 billion additional annual funding to replace cuts (Health Foundation, 2021), with a strong remit to improve mental health and a greater focus on and investment in the wider determinants of mental health. Currently, little of the money that is spent on public health is spent on public mental health; specific funding should be earmarked for this purpose. The one-year Better Mental Health Fund that distributed £15 million to 40 of the most deprived local authorities in England gives a glimpse into what a properly resourced public mental health system could look like (Woodhead *et al.*, 2023)

◎ **A new financial settlement for local government**, recognising the role it plays in providing wider services that contribute to health, including social care, housing, education, leisure and transport

◎ **The adoption of trauma-informed practices across all public services** (Wilton and Williams, 2019). There is compelling evidence that trauma-informed approaches significantly benefit people who have had traumatic experiences, but do no harm to those who have not (Wilton and Williams, 2019)

◎ **The Government, in line with the Hewitt Review, to increase the share of total NHS budgets at integrated care system level going towards prevention**, including mental health prevention, and help develop a shared definition of preventative spending so this can be measured

◎ **A long-term commitment to fully fund both adult and children and young people's Every Mind Matters platforms**, including an element designed for and with adults in later life.

EQUALITY
THE HEALTH GAPS BETWEEN DIFFERENT GROUPS WILL BE CLOSED

Even before the Covid-19 pandemic, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and £20-32 billion a year in lost tax revenue and benefit payments (Public Health England, 2021). This amounts to £68 billion a year, or the equivalent of 43% of the current NHS budget (Public Health England, 2022). A combined, well-funded response from government, public services, and the voluntary and community sector will be required to address these situations, both in terms of service provision and in identifying community needs through embedded community participation.

Mental health inequalities mean that while it is true that anyone can experience mental ill health, the risks are much higher for certain groups who experience structural discrimination and disadvantage, with significant intersections of disadvantage compounding mental health risks. Outreach to all poorly served groups should be immediately prioritised, with focused support in areas of deprivation.

People in the 10% most deprived communities

are nearly **four times as likely** to be detained under the Mental Health Act (NHS Digital, 2022b)

and **twice as likely** to die by suicide (Windsor-Shellard, 2020)

as the least deprived 10%

4 TIMES as many Black people

and **TWICE** as many Asian people

are sectioned under the Mental Health Act as white people (NHS Digital, 2022c)

Black people are **11 TIMES MORE LIKELY** to be subject to a Community Treatment Order than white people (NHS Digital, 2022d).

RACIALISED COMMUNITIES AND MENTAL HEALTH DISPARITIES

Racism and discrimination can have a profound and lasting impact on mental health. The cumulative effect of daily experiences of racism have been linked to a range of poor mental health outcomes, including anxiety and depression (Bignall *et al*., 2019). Racial discrimination and violence are also traumatic – which can be the result of direct or indirect, single, or cumulative and intergenerational experiences of racism. The impact of this has been likened to post-traumatic stress disorder (PTSD) where an individual continues to relive their ordeal and have ongoing negative thoughts associated with it (Synergi Collaborative, 2018).

The effects of racism are felt not just by individuals subjected to acts of aggression. For a community, exposure to others' experiences and the fear of abuse can have a collective impact on mental health. Seeing people who are Black or Muslim, for example, repeatedly being treated unjustly, either in person or on television or social media, can have a profound cumulative impact (Commission for Equality in Mental Health, 2020). Irish, Eastern European, Jewish, and Gypsy, Roma and Traveller communities can also face significant discrimination and adverse mental health outcomes as minoritised groups.

Racism is suffused within our society: it is systemic and wide-reaching. Young people from racialised communities describe how everyday experiences of racism in school, in their neighbourhoods, from the police (including recently in the policing of lockdown laws – Abdinasir and Carty, 2021), in traditional media and on social media have a cumulative effect on their mental health (Khan *et al*., 2017).

To address racialised inequity in mental health, we support the Black Mental Health Manifesto's calls for:

◎ **The Government to support the Patient and Carer Race Equality Framework** (PCREF) for as long as it is needed, with the necessary resources to be a truly transformational process. This must be sustained until all mental health service providers in all sectors (statutory, voluntary and private) have adopted the PCREF in full and can demonstrate that their services work equitably with people from all racialised and minoritised communities

◎ **Complete Mental Health Act reform**, putting in place modernised legislation and providing sufficient resources for it to be implemented in full within the next Parliament

◎ **Data regarding ethnicity in mental health datasets to be both collected and included** in all evaluations in a meaningful way

◎ **The Government to develop and implement a comprehensive strategy to eradicate racism from society**

◎ **The Department of Health and Social Care to actively fund and co-design social prescribing approaches** to mental health in Black communities

◎ **Government should acknowledge that racial injustice at all levels and in all manifestations is a direct cause of harm to health**, and therefore take decisive action to prevent racism. This should include taking immediate steps to end all 'hostile environment' policies and practices, and to review policies and practices that apply disproportionately to people from racialised communities – for example, the use of school exclusion and imprisonment

◎ **Schools and other institutions should be supported to tackle racism**, including microaggressions (Centre for Mental Health and Not So Micro, 2023) and unconscious bias. Teachers and other people working with children and young people should receive anti-racism training (including on microaggressions) as part of their qualifications

◎ **Schools should be aware of the intersections between gender, sexuality, race, socioeconomic position, disability and neurodiversity**, and provide support for teachers in helping students who may experience difficulties related to these characteristics.

REFUGEES AND ASYLUM SEEKERS

Refugees and asylum seekers face unique challenges related to their mental health and are often at greater risk of developing mental health problems. We are calling for the Government to take a more trauma-informed approach by changing the way the asylum system works so that people are not retraumatised by their experiences of the system. Additionally, the Government should commit to rolling out trauma-informed training, specific to the experiences of asylum seekers and refugees, across staff in the public sector, to ensure that people are always treated with compassion, dignity and respect.

To better support the mental health of asylum seekers and refugees in the context of the cost of living crisis, we are calling for the Government to:

◎ **Include people with no recourse to public funds in its cost of living support measures**

◎ **Review the asylum-support allowance in line with the cost of living**

◎ **Ensure that, where people qualify for asylum financial and accommodation support, this is provided without delay**

◎ **Extend the current move on timeframe for withdrawal of Section 95 Support** (financial and accommodation support under the 1999 Immigration and Asylum Act) for new refugees

Finally, the UK Government should develop a clear strategy for refugee integration in the UK, working alongside the devolved governments, local authorities and the voluntary sector. This strategy should include plans for tailored English-language support, bespoke employment support, actions to facilitate peer support, improved support to assist refugees in engaging with mainstream services, and actions tailored to support positive mental health.

WOMEN AND GIRLS

Women and girls are at significantly higher risk for multiple mental health problems, notably anxiety, major depression, and eating disorders. This is due to both the physical and psychosocial experience of womanhood, with menarche, pregnancy and menopause being significantly associated with development of mental ill health (Hosang and Bhui, 2018). For example, adolescent girls are up to three times more likely to be diagnosed with depression globally (Salk *et al.*, 2017). Further, women were more likely to experience adverse mental health effects associated with the Covid-19 pandemic (Hossain *et al.*, 2020; Almeida *et al.*, 2020).

Experience of domestic abuse (including physical, sexual and emotional abuse and coercive control) is also gendered and is a significant risk factor for mental ill health in women and children (Khalifeh *et al.*, 2016; Oram *et al.*, 2013; Oram *et al.*, 2022). Between October 2021 and March 2022, 1.7 million women and 699,000 men reportedly experienced domestic violence in England and Wales (Office for National Statistics, 2022c). Experiences of domestic violence among women in mental health services are even more common, with estimates of domestic violence experience being over six times more likely in this group. Likewise, women are at significantly higher risk of experiencing sexual assault (approximately 7.7% of women in England and Wales have experienced rape – Office for National Statistics, 2023), another significant risk factor for mental ill health.

Women who have experienced extensive physical and sexual violence are more than twice as likely to have a problem with alcohol than those who have little experience (Scott & McManus, 2016). Survivors can be turned away from refuges due to their alcohol needs. Research found only 26% of refuges reported they "always" or "often" accept women who use alcohol or other drugs (Against Violence and Abuse, 2014). Office for National Statistics figures show that around 10% of those accessing domestic violence support services had an alcohol use need and 40% had a mental health problem (Office of National Statistics, 2018).

It is also important to recognise the ways in which gendered racism affects women and girls from racialised groups. The Agenda Alliance reports that women from racialised communities "are also at particular risk: 29% Black and mixed race women, and 24% Asian women has a mental health problem, compared to 21% White British and 16% White other women" (Agenda, 2019).

As outlined in the previous section, racism has a profound effect on mental wellbeing and health, and this is experienced differently across genders. It is important to have a gendered approach to racism when considering the impacts on mental health and how women and girls from racialised communities receive care.

The Women's Mental Health Taskforce report, published in December 2018 by the Department of Health and Social Care, included thoroughly sourced recommendations centred around the voices of women. However, we do not see evidence that these recommendations were adequately implemented, despite showing a clear need for changes to services.

Therefore, we recommend:

◎ **Promotion of policies to address gendered disparities in society**, such as enforcing gender pay equity, promoting flexible working patterns and child care provision, and prosecuting perpetrators of domestic violence and sexual assault

◎ **Incorporation of gender specific, trauma-informed strategies in mental health services** (Hosang & Bhui, 2018)

◎ **Recognition of the specific needs of women and girls from racialised and migrant communities**, including providing culturally sensitive services

◎ **Provision of resources and training within mental health services designed to manage the intersection between mental health and domestic abuse**, both for perpetrators and victims, and the involvement of mental health professionals in any new multi-agency responses to domestic abuse (Hosang and Bhui, 2018)

◎ **Continued support and expansion of perinatal mental health services** developed as part of the NHS Five Year Forward View for Mental Health to support pregnant and postpartum women, alongside their families, and provide the best start in life for children (Public Health England, 2019; Howard and Khalifeh, 2020). This should include research funding to develop interventions and robust evaluations of the care provided within existing services.

MEN'S MENTAL HEALTH

Men have specific mental health needs and are vulnerable to adverse outcomes. While rates of suicide among men dropped between 2020-2021, males accounted for 75% (Office for National Statistics, 2022b) of suicide deaths in England and Wales during this period, and this trend extends globally. Men tend to under-utilise mental health services (Sagar-Ouriaghli *et al.*, 2019) and are not always served by current diagnostic criteria (Bilsker *et al.*, 2018).

When considering equality within public mental health, it is essential that the gaps in funding between services used generally and services specific to the needs of disadvantaged populations are closed. Funding services for disadvantaged populations should mean expanding overall funding for public mental health initiatives and mental health services, not taking away funding from services that are there to meet the needs of men within the population.

LGBTQ+ COMMUNITIES

People who identify as LGBTQ+ are twice as likely to report depression than heterosexuals (Bachmann and Gooch, 2018), and homophobia, biphobia and transphobia is a distinct risk factor for depression (Vargas *et al.*, 2020) and suicidality. The intersection of experiencing both racism and homophobia, biphobia and/or transphobia simultaneously compounds (and potentially worsens) the effects of these discriminatory behaviours on mental health.

Research (Just Like Us, 2021) has found that Black LGBTQ+ young people were more likely to be worried about their mental health on a daily basis during the pandemic than their white peers (61% versus 56%). Older people who identify as LGBTQ+ are often excluded from LGBTQ+ focused interventions, but carry the mental health risks associated with experiencing a lifetime of discrimination (McCann and Brown, 2019).

People who identify as transgender, nonbinary or prefer a different gender identity experience high rates of mental ill health (Rees *et al.*, 2021; Jones *et al.*, 2019). Research has shown that trans people's mental health and wellbeing is severely impacted by health care waiting lists and inaccessibility of specialist care. The TransActual Trans Lives survey (2021) found that "40% of respondents felt that lack of access to NHS transition-related healthcare has impacted them 'very much'" (Henderson *et al.*, 2022).

Further, while many members of the LGBTQ+ community report good experiences within mental health services now, this is not universal, and the intersectionality of multiple marginalisations is frequently not acknowledged (Rees *et al.*, 2021; White and Fontenot, 2019; Huang *et al.*, 2020; McDermott *et al.*, 2021). A national survey by Stonewall highlighted the types of discrimination LGBTQ+ people face across health care settings, such as being outed without their consent and experiencing discriminatory or negative remarks from staff. Staff in mental health services must have the skills and knowledge to appropriately support LGBTQ+ people.

NHS staff who identify as LGBTQ+ are also more likely to have a worse experience working in the NHS than those who are not. The last NHS staff survey found that one in five LGBTQ+ staff experienced violence from patients or relatives compared to one in seven of their colleagues, with bisexual and transgender staff experiencing particularly high rates of violence (McCay, 2003). LGBTQ+ staff also experienced higher rates of bullying and harassment both from patients and from colleagues and managers. The NHS Confederation has produced The Health and Care LGBTQ+ Inclusion Framework to help address this issue (Truscott, 2022).

There are some examples of good practice in the NHS, where services are striving to improve access to support for people who identify as LGBTQ+ (NHS Confederation 2021). The national research project, Queer Futures 2, sets out a model for how to improve early mental health support for young people who identify as LGBTQ+ and has developed commissioning guidance.

There is also a suggestion that the hegemonic view in UK policy space that LGBTQ+ equality has been "fixed" has actually hampered further research into health inequity within this community (McDermott, 2021; Woodhead, 2019).

While the UK Government has pledged to ban conversion practices for people with minority sexual identities, reports of loopholes in the proposed legislation have been widely criticised by LGBTQ+ advocates and mental health practitioners (BBC, 2021; BBC, 2022; Stonewall, 2023). Conversion practices are abusive and put people at risk of a range of mental health problems, including post-traumatic stress disorder, eating disorders and suicide (Alempijevic, 2020). A complete ban on all such practices is necessary to protect all LGBTQ+ people from this form of abuse.

PHYSICAL HEALTH EQUALITY

The lives of people diagnosed with a severe mental illness are, on average, 20 years shorter than those without a diagnosis (Public Health England, 2018). This is related to greater likelihood of experiencing physical health conditions such as obesity, asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease, stroke, and heart failure (Public Health England, 2018).

Globally, people with serious mental illness have also faced a three times greater risk of mortality from Covid-19 (Fond *et al*, 2021).

The relationship between physical health and mental health is complex. For example, there are several factors that contribute to people affected by severe mental illness being more likely to smoke, including use of smoking to alleviate boredom or distress, and greater likelihood of living in deprived areas or in proximity with others who smoke (Sinclair, 2020). People living with a mental illness can experience weight gain as a side-effect of some medication, and other lifestyle factors including using food to manage mental illness.

The Government and the NHS must make a commitment to support people with a mental health diagnosis to enjoy better physical health and close the life expectancy gap. There must be a commitment to measure the gap annually and set a 10-year target to reduce the number of people living with a mental illness who die prematurely. This will require system-wide action to close the gap, including:

- **Supporting primary care services to improve access to the full annual six-point health check for everyone on their GP's Severe Mental Illness register**, in line with the NHS England Core20PLUS5 plan for targeting health inequality (NHS England, 2023), including improved data to track access to follow-up interventions

- **Providing access to mental health-aware opportunities for weight management and physical activity**

- **Improving time series data regarding the prevalence of physical health conditions among those living with a mental health difficulty**, to measure the success of support to improve physical health

- **Prioritising people with severe mental illness for vaccinations** (including flu)

- **Providing smoking cessation support**

- **Providing access to mainstream prevention and screening programmes**, including for cancer, oral health, and sexual health, offering adaptations to make these services accessible where necessary

- **Offering diet and exercise support.**

WORK, HOUSING AND MONEY

Too many people living with mental health difficulties face disadvantage and discrimination in the labour market, with housing and with personal finances. All mental health services should offer easy access to high-quality welfare advice.

Rates of employment for people living with a mental illness are significantly lower than the general population, even though many people with mental illness and other disabilities say that they want to work or to take other steps that would allow them to live more independently. Those who rely on the social security system are required to make ends meet on a modest income, and we know that financial difficulties can play a role more broadly in the development of poor mental health. Other aspects of the social security system can pose serious risk to people's mental health, including in extreme cases to the point of crisis and suicide (NAO, 2020).

It has been estimated that more than 70% of the general population has been exposed, either directly or indirectly, to a traumatic event, where a traumatic event is defined as witnessing a death, experiencing a near-death experience, a death threat, serious injury or sexual violence (Benjet *et al*., 2015). Trauma can impact people's ability to work, and social security staff and systems should be equipped to work well with people who have experienced trauma in their lives.

We call on the Government to:

- **Ensure a well-funded social security system that is designed to meet the needs of everyone**, including people who live with mental health difficulties

- **Reform disability benefits to replace the current assessments for Universal Credit and Personal Independence Payment with a fairer system** that must be coproduced with people who have lived experience of mental health difficulties

- **Establish that the Department for Work and Pensions (and its agencies) have a statutory duty of care** to safeguard the wellbeing of people claiming, or making enquiries about claiming, social security benefits

- **Establish a new, independent body to investigate any future cases of serious harm** that arise because of the social security system

- **End the use of benefit conditions and sanctions** for people who are on out-of-work benefits and for anyone waiting to go through an assessment. There is no evidence that conditionality helps people with mental health difficulties to seek or get work, but there is compelling evidence of the harms these measures can cause

- **Extend access to Individual Placement and Support employment services** for anyone with a mental health problem who wants help to secure paid work

- **Create a simple process where disabled people who stop claiming ESA or Universal Credit due to trying paid work can return to their previous benefit entitlement** and conditionality group, within a year, without a Work Capability Assessment

- **Make employment support voluntary and available to anyone who wants to access it**, without affecting the outcomes of their Work Capability Assessment

- **Reform Department for Work and Pensions practice to become trauma-informed**; ensuring that services are equipped to listen to and value people's stories, show an understanding of the traumas they have experienced, and respond to their needs without creating new traumas.

We also support the Money and Mental Health Policy Institute's (2023) recommendations, including:

◎ **The Department of Health and Social Care should automatically offer Mental Health Breathing Space** to people detained in hospital due to their mental health, to ensure that more people experiencing a mental health crisis can benefit from this vital support (Bond *et al.*, 2018)

◎ **The Department of Health and Social Care and NHS England should ensure that money worries are embedded in Care and Treatment Plans, physical health checks, and other support plans**. This would see health care professionals routinely ask people about their financial position, and to signpost and refer people to support services (Bond & Preece, 2022)

◎ **Essential services firms should review and develop their suite of third-party access mechanisms** to ensure they offer people more granular levels of flexibility when their mental capacity fluctuates. This enables people with mental health problems to retain control of their accounts when unwell and simultaneously balances their need for support (Bond *et al.*, 2019).

CRIMINAL JUSTICE AND MENTAL HEALTH

The Government should seek to reduce incarceration, with better community sentences that aim to rehabilitate people who might otherwise receive a short prison sentence for non-violent offences. This will require investment in community-based support, including for people whose sentences include mental health, drug or alcohol treatment requirements. Approximately 10% of prisoners in the UK miss out on support because they are sentenced to custodial sentences rather than using community orders with mental health treatment requirements (Royal College of Psychiatrists, 2021). Most children and young people in the criminal justice system have complex and unmet needs, and have frequently experienced multiple adverse childhood experiences, even before entering the youth justice system. Entry into prison is a clear period of risk for mental distress and self-harm, including for young offenders (Pope, 2018). However, the knowledge about prevalence and character of mental health needs in UK prisons is hampered by the lack of a robust survey of the prison population's needs since 1997 (House of Commons Justice Committee, 2021; Durcan, 2021).

Evidence also suggests that there is a high level of significant unmet need within prison services. The House of Commons Justice Committee stated that:

> *"Around 10% of prisoners were recorded as receiving treatment for mental illness with one suggestion that as many as 70% may have some form of mental health need at any one time. NHS work is long overdue to quantify the gap between mental health treatment needs and the services provided."*
> (House of Commons Justice Committee, 2021)

Furthermore, the annual prison performance ratings for 2022/23 highlighted self-harm as an area of poor performance (MoJ, 2023).

A large proportion of people in prison are remanded or on short sentences and are frequently subject to multiple unpredictable short prison stays. These people are reported to have the most complex mental health needs but are subject to the most disruption. Often, little provision is made for this need after they leave prison, arguably leading to repeat offending and worsening of the cycle (House of Commons Justice Committee, 2021; Durcan, 2021).

As well as modernising the Mental Health Act, Parliament should legislate to repeal provisions in the 1976 Bail Act that allow the courts to imprison a person for their own health or safety.

The Ministry of Justice should end the remaining Imprisonment for Public Protection sentences that have yet to be completed, over a decade since these provisions were removed from the statute book (Ministry of Justice, 2023b).

Further, we recommend that:

◎ **All prisons and young offenders' institutions work to become trauma-informed environments**; mandatory training for all prison staff should be provided which covers understanding and managing trauma, and the common vulnerabilities within the prison population

◎ **Steps are taken to minimise use of short prison sentences and remands**

◎ **The Government commits to implementing recommendation 131 of the independent review of the Mental Health Act** to create a new statutory independent role to manage transfers from prisons and immigration removal centres

◎ **The NHS and local social services are resourced sufficiently to provide continuity of care** to people leaving custody with mental health difficulties

◎ **The NHS initiates a review of care access for people from racialised communities** within the prison service.

REGIONAL INEQUALITY

Mental ill health is common within the UK, but the spread and burden of mental health problems are not evenly distributed within or between the nations. The 2022 GP patient survey found that recorded prevalence of mental health problems varied between integrated care systems from 9.1% to 15.6%, with the highest rates in the North of England and the lowest in the South East (Baker and Kirk-Wade 2023). Suicide rates also vary widely across England. The North East had the highest rate, with 14.1 deaths per 100,000 people (Office for National Statistics, 2022d), well over double the rate in London, which is 6.6 deaths per 100,000 people.

Regional inequality has long characterised the UK landscape, with pockets of extreme wealth and deprivation clustering in specific areas of the UK. This includes very significant levels of deprivation and poor mental health in some rural and coastal areas, which are often hidden by measures of deprivation at local authority area levels. This has been the subject of many headline policy initiatives, most recently the 'Levelling Up' agenda (Department for Levelling Up, Housing and Communities, 2022). However, the promises of these recommendations have been widely critiqued for not going far enough (The Economist, 2022; Pope, 2023). Further, there is barely any discussion of mental health despite clear regional mental health inequality. There is strong evidence that improving economic equity in regions experiencing deprivation would also be associated with improved mental health outcomes (Rose *et al.*, 2023).

We call for future regional equality frameworks to put health outcomes, and specifically mental health outcomes, at the centre of the discussion.

SUPPORT
EVERYONE WILL HAVE TIMELY, LOCAL ACCESS TO THE SERVICES THEY NEED

People who can benefit from mental health, social care and other support should get high-quality services when and where needed.

The NHS Long Term Plan and the Five Year Forward View for Mental Health have supported the much-needed expansion of mental health services and begun to make up for decades of underinvestment. The National Audit Office (2023) suggests that NHS mental health services have expanded for both children and adults since 2017, with significant growth in certain parts of the mental health care workforce. We recognise and welcome this growth.

However, the pandemic has significantly increased demand for mental health support, the cost of living crisis is likely to exacerbate it further, and there is still much to do to address the high level of unmet need. NHS England has estimated that at least 1.2 million people are on mental health waiting lists. In 2023, we remain a long way from the ambition of achieving 'parity of esteem' for mental health services compared with physical health care. Partnership between voluntary and community sector, local authorities and NHS funded services will be essential, and sustainable funding for all three sectors is needed to expand support services to meet the growing national mental health need.

A STRATEGIC APPROACH TO MENTAL HEALTH SUPPORT

The Government and NHS England have the opportunity now, as the end of the current Mental Health Implementation Plan nears, to set a clear direction of travel and make the vital improvements and investments that are necessary to build on what has already been achieved. There is a long way to go before we get close to 'parity' for mental health services. We urge the following actions from the Government and NHS England:

◎ **Publish a comprehensive update to the Mental Health Implementation Plan to cover the years 2024-2029**, building on the expansion that has been achieved so far with further resources and workforce development

◎ **Introduce the new mental health services access and waiting time targets** proposed in the clinically-led Review of Standards, which will need to be supported with additional resources and workforce expansion (Garratt, 2023; Baker and Kirk-Wade, 2023)

◎ **Improve the urgent and emergency care pathway** and expand help for people in a mental health crisis. This should build on NHS England's efforts thus far to broaden the range of complementary and alternative crisis services, including those provided by voluntary and community sector organisations, to maximise the coverage of these services across the country.

◎ **Continue to fund and roll out the mental health response vehicles**, and those conveying people with mental health difficulties, and the interface between ambulance services, NHS 111 services and mental health providers. These and other measures are needed to provide safe, appropriate, alternative responses to police and emergency department interventions

- **Continue the improvement and expansion of primary and community care**, which is vital to ensure people have the best possible care and treatment close to home. Where minimal inpatient stays remain necessary, these should be local to the person needing care and the NHS should eliminate inappropriate out-of-area placements. The transformation of community mental health services has made good progress in many areas, but it is by no means complete

- **Provide adequate funding and staffing to support the expansion and improvement of primary care led mental health services**, including locating mental health practitioners within primary care networks (PCNs) to support GP surgeries and social prescribing initiatives to provide a wider range of options for people with mental health difficulties

- **Ensure adequate care is provided for people whose mental health needs are frequently deemed too severe for primary care level interventions in GP practices and schools**, for example, but do not meet the threshold for secondary mental health care. This includes people with complex traumas and those with co-occurring substance use or physical health conditions. This major gap in service provision should be closed either through the funding and commissioning of new services or the expansion of existing services

- **Expand NHS-funded talking therapy training** across the full range of evidence-based modalities, covering both children and young people's and adult services, to address the gap in provision between services for common mental health problems and high threshold specialist provision

- **Commit to the public tracking of progress against the commitments in the Long Term Plan** and future policy initiatives and strategies, including funding, so that there is greater understanding about how improvements are being made to mental health services

- **Make an ongoing commitment to implement the Advancing Mental Health Equalities strategy and the Patient and Carer Race Equality Framework**, with sufficient resources for as long as it takes to address inequities in access, experience, and outcomes from services

- **Improve provision for transient communities**, specifically students or Gypsy, Roma and Traveller communities (Office for National Statistics, 2022e), who frequently struggle to access support, in part due to poor communication between local mental health services

- **Take steps to improve mental health support for older people**, including equitable access to NHS Talking Therapies services, and tailored support for older citizens from racialised and marginalised communities

- **Continue the Mental Health Investment Standard** (MHIS) to ensure that every integrated care board invests an increasing proportion of its spending on mental health services, and a greater proportion still on support for children and young people.

NO WRONG DOOR: MENTAL HEALTH SERVICES IN 2032

In 2022 the NHS Confederation and Centre for Mental Health produced the *No Wrong Door* report setting out a 10-year vision for better mental health, autism and learning disability services (Pollard and Bell, 2022) which forms the basis of our recommendations here.

These services need to be transformed to improve the quality and safety of services, and reduce health inequalities and inequities, especially racial inequalities. In a decade's time, our vision is that these services will look very different in the following ways:

- **Early intervention**: Over the next 10 years, services will not wait until someone is in crisis to offer help. Instead, early intervention will be the norm, with support front-loaded at an early stage to prevent more serious difficulties developing later. Services will meet people where they are at, including online, at school, and in community spaces where they feel comfortable.

- **Access to quality, compassionate care:** There will be no wrong door for anyone seeking support for mental health, autism and learning disability needs. 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 get the right support.

- **Seeing the bigger picture:** Mental health, autism and learning disability services will see the big picture as they support people to live their lives. People will get support with what matters most to them and services will help people with money, work and housing – with a package of support that is not limited to 'health care' per se.

- **Whole-person care:** Over the next decade, services will support people with their physical and mental health and social needs together. Services will treat people as a whole person, being mindful and respectful of their needs, assets, wishes and goals.

- **Equality focus:** Mental health, autism and learning disability services will be proactive in addressing structural inequalities and injustices. They will understand and challenge the intersecting inequalities that underpin the unequal risks of poor wellbeing and the subsequent inequities in access to support, experiences of services and outcomes achieved.

- **Coproduction:** There will have been a shift in the power imbalance between people who use mental health, autism and learning disability services and the organisations that provide them. Coproduction as an equal partnership will be the norm in the design, development and delivery of services.

- **Autonomy, human rights and community support:** By the end of the coming decade, people who access services and support should be reaping the benefits of a major investment in community support. As changes to the Mental Health Act will have channelled investment away from institutional and inpatient services, comprehensive support in the community will have risen to meet people's needs.

- **Workforce:** Not only must mental health workforce numbers and disciplines be commensurate with the need, but workers must be representative of the communities they serve, paid fairly, well supported and managed with proper regard to their wellbeing

- **Outcomes that matter:** By the end of the next decade, services at all levels should be holding the outcomes that matter to service users as their lodestar. They will be able to measure these outcomes and be held to account for them. The system will no longer be driven by the outputs that matter to institutions, but by the outcomes that matter to people.

To achieve this, the following three key requirements need to be in place:

1. Sustained and sufficient investment to expand services and meet increased needs, but also to have the stability to innovate and transform what they offer, rather than having to respond to crisis levels of demand and acuity, and to replace outdated facilities.

2. Effective long-term workforce development and planning, both to ensure that enough people are working in mental health, autism and learning disability services, and to diversify the workforce and locate support where it is most needed.

3. A deep commitment to large-scale reform, innovation and change, starting with reform of the Mental Health Act and transforming the nature of what is offered so that people get access to services they trust, that meet their needs and that treat them equitably.

MENTAL HEALTH ACT REFORM

There is a broad consensus for reforming the Mental Health Act, which has its mandate from the Independent Review of the Mental Health Act (Wessely, 2018). The current Act is largely 40 years old, and the reforms are essential to reduce the number of people being detained under the Act, especially people from racialised communities, and improve patient choice and safeguards. Modernising the Act is a foundation stone for a mentally healthier nation.

At the time of writing, a draft mental health bill goes some way to modernising the Act (Department for Health and Social Care & Ministry of Justice, 2022). Should this bill not be passed before the end of the current Parliament, we call for the next Government to act and pass these reforms as a top priority.

Reforming the Mental Health Act must come with action to modernise the mental health estate, tackle racism within mental health services, and develop the workforce to implement the proposed new or expanded safeguards.

LIBERTY PROTECTION SAFEGUARDS

It is crucial that proper safeguards are in place to protect vulnerable individuals who are subject to the Mental Capacity Act. Liberty Protection Safeguards were introduced through the Mental Capacity (Amendment) Act 2019, and are designed to replace the Deprivation of Liberty Safeguards system. This change is designed to offer a simplified system, reducing bureaucracy, and improving care, outcomes and compliance with the law. The implementation of Liberty Protection Safeguards has been delayed – and the significant backlog of Deprivation of Liberty Safeguards applications means that many people are currently being deprived of their liberty without the proper safeguards, and not receiving vital care. The government needs to complete the introduction of Liberty Protection Safeguards in a timely way, ensuring a smooth transition from Deprivation of Liberty Safeguards including taking steps to address issues generated by this delay.

The legislation will only take us so far, so this needs to be linked to wider transformation of mental health services. This includes improving the quality and safety of services; reducing health inequalities and inequities; transforming community-based provision; and bringing care closer to home, with less reliance on inpatient services. We will need the workforce and capital funding to bring about these changes.

Some of this transformation is already under way. The Long Term Plan for the NHS has committed to transforming community mental health provision and integrating it with primary care and other community services, including voluntary sector services. The Patient and Carer Race Equality Framework (PCREF) has been piloted and is now being rolled out nationally. Mental Health Support Teams in schools are providing additional capacity to support children and young people with some mental health needs. It is essential that this work continues to be funded, developed, and rolled out nationally so everyone can access them.

MENTAL HEALTH SOCIAL CARE

Mental health social care is essential for the nation's mental health. It is of equal importance to NHS mental health services. This is not well understood or recognised, even though:

◎ The Association of Directors of Adult Social Services reported in 2022 that more people are seeking support for a mental health need from their local authority (ADASS, 2022)

◎ Local authorities have statutory responsibilities for mental health, including the provision of Approved Mental Health Professionals (AHMP), Section 117 aftercare and other legal duties, including under the Mental Health Act, the Mental Capacity Act, the Care Act and the Carers' Act

◎ Local authorities are major commissioners of voluntary and community sector mental health support, offering a diverse range of services to people with mental health difficulties and carers.

Mental health social care supports people of all ages who live with a severe mental illness. It does this through:

◎ Advice, community support and social care crisis services

◎ Personalised support, including through direct payments

◎ Specific support for carers of people with a mental illness

◎ Working with partners in the NHS to prevent unnecessary admissions and reduce both length of hospital stays and inappropriate out-of-area placements.

Failing to invest in social services is a false economy. For example, according to NHS England data from July 2022, 57% of instances of delayed discharges in mental health hospitals were due to a lack of available social care provision (NHS England, 2022).

We are pleased that the Better Care Fund Policy Framework 2023-25 highlights that mental health is an integral area of the fund and should be considered on an equal footing to physical health when decisions are made on the use of the funding.

We would now like government to set out reforms that address the broader challenges facing social care, such as: improving awareness of mental health social care support; improving awareness of rights to care and support under the Care Act and Mental Health Act; ensuring local authorities have the capacity to assess all individuals with a mental health need who would benefit from support; and ensuring individuals do not have to choose between meeting their living costs and receiving care. In addition, government should provide a sufficient, sustainable and long-term funding settlement for adult social care that works for people of all ages, and develop a workforce plan for the social care sector, which includes voluntary and community organisations and complements the NHS Long Term Workforce Plan.

SUPPORTED HOUSING

It is difficult to imagine anyone maintaining good mental health without first having a safe, stable, affordable and high-quality place in their community that they can call home. It is this home that acts as a stepping stone to the other factors we know are central to maintaining good mental health – such as securing and maintaining the right job or getting involved in one's community. In mental health, the lack of supported housing options is a major factor in delayed discharge – meaning patients are in hospital much longer than they need to be. This impacts available beds for other people who need them, sometimes leading to people being sent far from the familiarity of their local community, friends, family and professionals usually involved in their care for treatment. This not only undermines quality and effectiveness of care but comes at great expense to the NHS.

The passing of the Supported Housing (Regulatory Oversight) Act has shone a light on the current oversupply of extremely poor quality provision offered by those wishing to profiteer from the special status of supported accommodation under the benefits system, and has introduced valuable laws to root out rogue providers. However, there remains a dearth of good quality supported housing for those who need it. The sector has faced a turbulent funding and commissioning environment for some time, making it difficult for those with an interest in providing quality supported housing to have the confidence to invest.

IMPROVING THE QUALITY OF INPATIENT CARE AND SAFETY

When someone requires inpatient mental health services, they should expect high-quality, person-centred care in the least restrictive environment, delivered in line with the principles of the reformed Mental Health Act. This means:

- **Care delivered by enough highly trained, compassionate staff**, with minimal reliance on temporary staff and regular reviews of their use. Emphasis should be placed on developing and maintaining emotional and psychological safety in addition to physical and procedural safety

- **All treatment should be in line with NICE guidance** and care planning should always be coproduced using a collaborative approach

- **The use of restrictive interventions such as restraint and seclusion should be an absolute last resort**, with their use continually reviewed in collaboration with people using the service

- **The quality of care and people's experience of receiving care should be regularly reviewed by services using appropriate outcome measures**, with steps taken to address concerns at the earliest opportunity, in collaboration with the person

- **Where issues of safety arise, investigations should be immediate and transparent**, involving all those concerned, including families and carers where appropriate.

Whilst the majority of mental health services (both NHS and independent sector) are rated good or outstanding by the Care Quality Commission, there remain too many inpatient services rated as requiring improvement or inadequate; this amounts to around 20% of inpatient services (Care Quality Commission, 2022). Regulatory authorities such as the CQC have a key role to play in identifying issues of safety using the CQC Single Assessment Framework, which crucially gathers an increased amount of feedback from people using services and their families and carers.

We are calling on the Government to implement the recommendations of the Rapid Review to ensure that data is used to best effect and always measures what matters most to people. As highlighted in the Rapid Review report, involving people with lived experience (together with families and carers) is of paramount importance in maintaining patient safety, and there need to be coproduced solutions to the challenges faced by mental health services where there are concerns about safety. Government should also follow through and share recommendations from inquiries into patient safety across systems to ensure learning is implemented throughout. We support Inquest's No More Deaths campaign to ensure lessons are learned from deaths in public sector settings, including those concerned with mental health.

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

All the recommendations in this section are relevant to mental health services for people of all ages. However, specific actions are also necessary to provide improved mental health support for children and young people. To achieve this, we are calling for:

◎ **A continued increase in the number of children and young people aged 0-25 accessing NHS-funded mental health services** to reduce the treatment gap and address the transition between children's and adult mental health services

◎ **Additional funding to improve children and young people's eating disorder services** so existing targets can be met in the wake of a rise in referrals since 2020

◎ **All pupils in England to have access to a Mental Health Support Team** (MHST). The ongoing national rollout needs to adopt the recommendations from the evaluation, including a clear referral pathway to higher-intensity funded counselling interventions.

◎ **The establishment of a nationwide network of community-based early support hubs for young people**, based on the Youth Information, Advice and Counselling Services (YIACS) model. The expansion of open access hubs presents a cost-effective solution for providing young people with timely and early help with their mental health; an estimated 500,000 young people would be reached annually at a cost of approximately £825,000-£1,350,000 per hub. The range for operating costs is £750k-£885k per hub.

◎ **The Government to provide funding for local authorities, police and crime commissioners and integrated care boards to commission community-based recovery services for child abuse victims**, including therapeutic and pre-trial support

◎ **Government, Ofsted and council children's services should adopt the recommendations from the May 2022 review of childrens' social care**, especially in terms of responding to mental health issues in a timely manner and integrating mental health support into Regional Care Cooperatives (NSPCC, 2022)

◎ **Meaningful implementation of a whole-school approach to behaviour and mental health** across all statutory and non-statutory guidance. This includes banning isolation rooms and providing post-pandemic support for children who were disproportionately affected

◎ **Young people to be involved, where possible, in the coproduction of behaviour policies** within the school environment

◎ **The use of permanent exclusion to only be considered as a last resort**, and for the Department of Education to publish statutory guidance to ensure it is only used as such.

School and college counselling services can also provide an important opportunity for children and young people to access specialist therapeutic provision, thus helping to alleviate psychological distress (Cooper *et al*., 2021). It should be noted that not all schools and colleges have access to a trained professional counsellor, with many schools cutting in-house provision due to financial pressures. Availability of school counselling services goes some way to fill the gap, or the 'missing middle' between lower-level psychological interventions offered by Mental Health Support Teams (where these have been rolled out so far) to working with children and young people who don't meet the threshold for higher tiered children and young people's mental health services.

LONG-TERM HEALTH CONDITIONS

People living with a long-term physical illness face twice the average risk of having a mental health problem. Untreated mental health needs among people with long-term physical conditions are distressing for individuals and families, and carry a heavy cost to the NHS: representing about £1 in every £10 of NHS spending (Naylor *et al*., 2012). Yet few receive support for their emotional or psychological health, and many people find that the help available is not adequate to meet their needs. This leads to poorer outcomes for people's physical health condition as well as avoidable distress for them and their families and carers. While the NHS Talking Therapies programme has a specific service for people with long-term conditions, this has yet to reach full coverage, and it does not provide the full range of interventions that people need.

The Government and the NHS must prioritise mental health support for people with long-term conditions, introducing a 'stepped care' approach including wellbeing support to prevent mental health difficulties, training health care staff in psychologically informed practices, offering evidence-based interventions when they are required as part of the person's treatment for their physical illness, and boosting practical and peer support (National Voices and Centre for Mental Health, 2021). Kidney Research UK and Centre for Mental Health recently published a report on supporting people with physical illnesses with their mental health which included a set of recommendations for improving emotional and psychological support.

TREATMENT FOR ALCOHOL AND DRUG PROBLEMS

Alcohol dependence can either exacerbate existing conditions or cause new issues to occur, with 44% of people in Community Mental Health Treatment and 85% of people in alcohol treatment having a dual diagnosis of a mental health difficulty along with a substance use problem (Weaver *et al*., 2003). In 2020/21, English hospitals had over 227,000 admissions for 'mental and behavioural disorders' due to alcohol use – this accounted for 25% of all alcohol-related hospital admissions (NHS Digital 2022e). Research has also found a close relationship between alcohol, suicide and self-harm: those who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population (Samaritans, 2022), and over half of hospital presentations for self-harm involve alcohol use (Ness *et al*., 2015).

Despite this known relationship, and the prominence of dual diagnosis, treatment for each condition is often dependent on a patient recovering from one condition first (Care Quality Commission, 2015). In a survey of alcohol and mental health practitioners carried out by the Institute of Alcohol Studies and Centre for Mental Health (2018), 84% of respondents believed that having an alcohol use disorder was a barrier to getting any kind of mental health support. A rapid evidence review also found that the lack of uniformity in service delivery for people with dual diagnosis, and inconsistencies in regional and UK policy and guidance, mean there is still a long way to go to address this issue (ACUK, 2019).

Research has shown that treatment for alcohol problems and mental health problems must happen in parallel to improve outcomes (Foulds *et al*., 2015).

We need commissioners and providers to ensure quality services for people with co-occurring mental health and substance use disorders, as well as concrete national and local actions to address dual diagnosis, including:

- **Better training for health care professionals on the relationship between alcohol and poor mental health**, including for GPs, who frequently see patients with mental health and alcohol problems
- **Compulsory placements for all trainee psychiatrists in addiction services** (Institute for Alcohol Studies and Centre for Mental Health, 2018)
- **The inclusion of actions to address the link between alcohol use and deliberate self-harm** within local suicide prevention plans (Institute for Alcohol Studies and Centre for Mental Health, 2018)
- **Screening for alcohol use when patients present with common mental health problems**, considering a typical under-reporting of alcohol consumption by 40-45% (Public Health England, 2018b)
- **A greater focus on needs-based treatment** rather than diagnosis-led services. This has been proven to be more successful for those experiencing both self-harming behaviours and alcohol use (ACUK, 2021)
- **Incorporate support for parents, partners and children of people who are managing substance misuse disorders** through statutory and voluntary and community sector services.

The Government should continue to deliver its committed investment (as advocated by Dame Carol Black in her independent report on drugs) to restore funding for substance use disorders to a comparable share of public health spending to that of 2013/14. Our analysis of the latest net current spending data from the Department for Levelling Up, Housing and Communities has shown that, in real terms, local authorities are spending £260 million or 26% less in their planned figures for 2023/24 than in 2013/14 (across adult and youth services, treatment, prevention and harm reduction combined).

The Government should also make an allocation of £90 million of capital funding for drug and alcohol services in its next Spending Review to support implementation of the Dame Carol Black review with new facilities and estate.

CAPITAL FUNDING FOR MENTAL HEALTH SERVICES

Mental health services need to be allocated sufficient capital funding to modernise the estate, invest in digital services, and ensure no one is treated in a hospital or other building that is not fit for purpose. The mental health estate has experienced years of underinvestment and is home to some of the oldest estates in the NHS. Data for 2021/22 has shown that 15.5% of mental health and learning disability sites in England were built before the NHS was established, compared to 9.2% of general acute sites. Eight NHS trusts were found to have more than a quarter of their mental health and learning disability estate erected prior to 1948 (NHS Digital, 2022f).

The Care Quality Commission (CQC) has repeatedly raised concerns about the physical environment and condition of mental health buildings and the impact this has on both patients' wellbeing and staff morale (for example, see CQC, 2015). There is evidence that better physical spaces for people treated in mental health services may be associated with better outcomes (Daykin *et al*., 2008). However, the maintenance backlog of high risk across mental health and learning disability sites has almost trebled from £16.2 million in 2019/20 to £48.3 million in 2021/22. High risk maintenance is defined as "repairs/replacements (that) must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution." Furthermore, inadequate local provision of mental health beds causes harm and frequently leads to inappropriate out of area placements, especially for children and young people.

Only two of the 40 schemes originally announced by the Government to be part of its New Hospitals Programme were for mental health facilities. We understand that around 50 bids were submitted for support as part of a planned competition for funding a further eight projects, which was abandoned because of urgent repairs within the acute sector. The reaffirmed commitment to eradicate dormitories across England and the £150 million for urgent and emergency mental health services before April 2025 is very much welcome, but must be seen merely as a small step on the road to sustained investment in mental health estates.

A mental health specific infrastructure plan would help drive improvements in outcomes and could also focus on eliminating mixed-sex accommodation, ensuring all single rooms have ensuite facilities - almost 6,500 (more than a third) lacked these in mental health and learning disability services in 2021/22 (RCPsych, 2021) - improvements to IT infrastructure, and essential safety improvement projects.

The Government should also set a mental health investment standard specifically for capital allocations to ensure funding is fairly apportioned to mental health redevelopment and improvement schemes - both within integrated care systems and nationally. The recent commitment from the Government to review capital allocations in its response to the Hewitt Review is a welcome step, but not enough without a firm commitment to parity.

DIGITAL MENTAL HEALTH SUPPORT

While seeking to address digital exclusion (by supporting people to use digital platforms and ensuring other means of accessing services for those who cannot), digital technologies, platforms and applications are a reality within the delivery of mental health care pathways in England. The Covid-19 pandemic saw an explosion in the use of, and interest in, digital innovations and how they can meet population needs either caused or exacerbated by lockdowns and social distancing.

Many of these solutions are now a part of the wider health care landscape focused on improving the mental health of the population and the delivery of health services. Yet challenges remain in how digital is described, what the key purpose of digital solutions are, and how clarity is given to the system on the role and place of digital mental health. There is a place to utilise digital further to improve population mental health and the delivery of services as part of a local and national ecosystem, but more clarity, coordination and collaboration is needed.

Digital has the potential to play a much more significant role in meeting additional unmet needs in a way that traditional service models cannot. It can make operations and services more efficient, for example through electronic patient records; it can deliver services in ways that widen access and enable earlier interventions; and it can support people while they are on a waiting list for care or treatment. To realise this potential, collaboration and partnerships between the statutory, voluntary and independent sector are critical to success. Success will also rely on engagement and coproduction with people who use mental health services, and members of the public more broadly. It is essential to address digital exclusion as part of plans to improve digital mental health support, to avoid exacerbating inequalities (Centre for Mental Health, 2022).

MENTAL HEALTH SERVICE WORKFORCE

In the mental health sector, recruiting enough skilled staff to meet the needs of patients was already an urgent and substantial challenge before the pandemic. The recruitment and retention of staff has been widely recognised as the most significant risk to the delivery of mental health commitments in the NHS Long Term Plan and achieving parity of esteem. While we welcome the recent announcement of a Long Term Workforce Plan, the Government must continue to take the lead on building a sustainable mental health workforce, across the mental health and social care sectors, which can deliver the services we deserve. This requires commensurate additional funding and not just reallocations from existing stretched budgets.

We are calling for the Government to expand the NHS mental health workforce, at least in line with the Long Term Workforce Plan, and take essential steps including:

◎ **Funding pay rises for mental health services staff** over the next Parliament to ensure that the NHS, local councils and voluntary and community sector organisations are able to fund pay settlements that enable them to recruit and retain staff members while also expanding provision to meet rising levels of need

◎ **Increasing the number of medical school places to 15,000 by 2031** to help facilitate an initially sustained and then growing number of psychiatrists. The Royal College of Psychiatrists estimates that doubling places could increase the numbers becoming consultants by between 450 and 675 posts a year

◎ **Expanding the mental health nursing workforce**. We welcome the Workforce Plan envisaging a 93% increase in nursing school places. To ensure this translates into an expansion of the mental health workforce, the Government should review the impact of tuition fees on mental health nursing and explore whether a bursary scheme should be reinstated

◎ **Funding apprenticeship routes for mental health practitioner roles** to expand and diversify the mental health workforce

◎ **Developing the workforce across a range of roles and professions,** creating a wider range of career pathways within the range of allied health professionals and in peer support

◎ **Developing a robust and fully-costed workforce plan for the social care sector**, which includes voluntary and community sector organisations and complements the NHS Long Term Workforce Plan. Analysis by the Association of Mental Health Providers has found that one in eight people receiving support for their mental health are receiving support from this sector (AMHP, 2023)

◎ **Creating a wider range of placement opportunities for trainee mental health professionals**, including in voluntary sector organisations and a wider range of community settings

◎ **Investing in retention and in mental health support for health and care staff**, recognising the impacts of the pandemic on the mental health of the entire workforce

◎ **Ensuring resources are made available to recruit the additional workforce deemed necessary** to deliver the clinically led Review of Standards and the Mental Health Act reforms

◎ **Creating a more diverse and representative workforce that reflects the populations it serves,** and ensuring that data on the diversity of the workforce is shared routinely and publicly, as part of accountability for improvement. This is especially important in this area given the well-evidenced discrepancies in experiences of people from racialised communities, and it is a core element of the PCREF.

RESEARCH

Research funding is a key input to the mental health ecosystem. By setting funding levels and designing funding programmes, policy makers and statutory, charitable and commercial research funders directly influence what kind of research is being done, where, by whom, and at what scale and pace. Existing analyses have generally concluded that mental health research is underfunded relative to the burden of disease and have found that considerable gaps exist in the funding landscape.

Mental health has had a decade of sub-par funding compared to its physical health counterparts, resulting in drag and lag in the development of new drugs, digital therapeutics and clinical treatments for mental health difficulties, as well as a paucity of high-quality research into social interventions.

The Covid-19 pandemic has highlighted the long-term value of research investment. Building on the Government's Life Sciences Vision, we believe there should be prioritisation of research and innovation to drive advancements in public mental health and care. Allocating funding for research studies, clinical trials and technology-driven solutions can facilitate the development of evidence-based practices, improved treatment modalities and innovative interventions. Collaboration between academia, health care providers and industry can accelerate progress in understanding mental health conditions and developing more effective interventions.

CONCLUSION

The nation's mental health is a precious resource. Securing better mental health for more people will create a happier, healthier and more prosperous future for us all.

Sustained and concerted action and leadership from government is at the heart of making that possible. While our mental health is made in the communities we live and work in, government policies and decisions have big impacts on our chances of having good or poor mental health. And for people living with mental health difficulties, decisions made in government can have profound consequences.

England needs a comprehensive long-term plan for mental health and wellbeing. With a strategic approach to the nation's mental health, the Government can craft a coordinated plan that will give more people a better chance of a mentally healthy life. By instituting a 'mental health in all policies' approach, the Government can embed a new way of making decisions that will benefit all of us. And by committing to the long-term improvement of mental health services, we can make 'parity' a reality, not a false promise.

The recommendations we have made in this document are drawn from many years of research and from the knowledge and experience of many thousands of people who live with mental health difficulties and work in mental health services. Their voices deserve to be heard.

Our recommendations are not an exhaustive list of all the contents of a government mental health strategy. But we believe they are the essential elements that are necessary to turn the tide on rising levels of mental ill health and growing demand for mental health support. We cannot continue as we are. Too many people's lives are being affected by mental illness, without the right support being there when they need it. People are dying too soon.

We know that this can change. Since 2019, in the most challenging of times, the NHS in England has expanded mental health services and grown the workforce. New mental health teams are being set up in schools, primary care and maternity services, and more people are getting physical health checks. So this must be sustained, and accompanied by investment in social care and public health.

But we need to have as much focus on what creates good mental health as we do on treating mental ill health. Both are of equal importance, and both require long-term planning and commitment from national government as well as the NHS, local councils, business and civil society. A comprehensive national plan will help to create the conditions for the nation's mental health to thrive. It's time to start work and build a mentally healthier nation.

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