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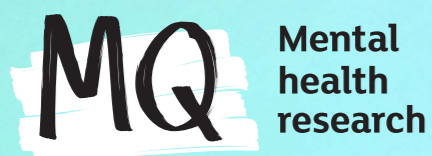


THE MAJOR CONDITIONS STRATEGY – A 10 YEAR FAILURE FOR MENTAL HEALTH

A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP ON A FIT AND HEALTHY CHILDHOOD

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A LETTER FROM LEA MILLIGAN

CEO, MQ MENTAL HEALTH RESEARCH

The scale of the impact that scrapping the 10-year mental health plan will have can only be seen as equal to the very scale of the problem it was meant to tackle! Today I along with colleagues from across politics, research, frontline services, lived experience and the NHS call for a response to the state of mental health and the urgent need for a comprehensive and effective 10-year Mental Health Plan in the UK.

Our nation is facing a crisis, with a significant decline in mental well-being over the past decade. The prevalence of mental health disorders in both children and adults has reached alarming levels, and the impact of the COVID-19 pandemic and the cost-of-living crisis has further exacerbated the situation.

The blow that the scrapping of the long-anticipated 10-year mental health plan has landed, leaves us without a concrete roadmap for addressing the pressing mental health challenges we face. However, this void must be filled, and it is our responsibility to advocate for a robust and forward-thinking strategy.

To this end, we have set out to comprehensively present the key recommendations for a 10-year Mental Health Plan that can serve as a blueprint for transformative change. These recommendations include prioritising prevention and increasing public awareness, facilitating early intervention and timely access to services, promoting integrated and holistic care, guaranteeing sustainable funding for research and services, growing the mental health workforce, and fostering dynamic collaboration among stakeholders.

It is imperative that we address the inequalities and disparities that exist in mental health services across the devolved nations of the UK. Inadequate funding, variations in service provision, lack of integration, and limited access to culturally sensitive care have contributed to the existing inequities. These disparities have had a disproportionate impact on marginalised communities, exacerbating the mental health crisis further.

While the Government brings the task of planning all over again, folding mental health into its new Long Term Conditions Plan, the Opposition have elevated mental health to become a core pillar of its 'Health Mission'. This Opposition Health Mission rightly considers the need for workforce growth, investment in life sciences and digital solutions and yet it rings oddly familiar to the Government's Mental Health Missionⁱⁱ that pre-dates it and equally the Governments latest NHS Long

Term Workforce Planⁱⁱⁱ seems to repeat the Oppositions boast of "investment" and "reform".

With a General Election looming we are in real danger of mental health becoming a political point scoring exercise instead of the cross-party strategy that we truly require! We must ensure that initiatives put forth by our leaders effectively address the root causes of the mental health crisis and provide comprehensive support to individuals in need, regardless of the changing winds of Government and Opposition.

This report produced by experts across the field and with direct experience of mental ill health will outline the current state of mental health in the UK, the impact of austerity measures and lack of investment, and the urgent need for long-term planning and sustainable solutions. We will explore the recommendations put forward by experts and stakeholders, emphasising the importance of early intervention, equitable access, integrated care, and a whole-society approach.

Recommendations for a 10-year Mental Health Plan

- Prioritising prevention and increasing public awareness
- Facilitating early intervention and timely access to services
- Promoting integrated, holistic services and addressing health inequalities
- Guaranteeing sustainable funding for research, mental health services and workforce development
- Growing the workforce and capacity building
- Partnership working and dynamic collaboration.

Together, we can strive for a mental health system that supports every individual, eliminates stigma, and fosters resilience and well-being. I urge all parties across the United Kingdom to deliver a joint 10-year plan for mental health – move the issues out of the shadows of stigma, away from the pitfalls of politics and into its rightful place; at the heart of our nation's needs.

Lea Milligan
CEO, MQ Mental Health Research



CHAPTER 1: MENTAL HEALTH SERVICES AND PROVISION: A HISTORICAL PERSPECTIVE

Perceptions of mental ill health have changed a great deal in the last 150 years.

Historically, people with mental illness were widely considered to be ‘abnormal’ and detained as ‘inmates’ of asylums where they were restrained and often physically abused.^{iv}

Prior to 1948, the vast number of public institutions charged with responsibility for mental health care constituted a virtual ‘national asylum service’ legitimised by the 1913 Mental Deficiency Act.

Those confined within asylums were termed ‘mentally-defective’ and the legislation reflected the steely attitudes of the time and the stigma associated with mental illness. Radical improvements in physical health and quality of life ensuing from the formation of the NHS in 1948 were not matched by comparable advances in the field of mental health. The newly formed NHS inherited a mental health system but it was not integrated with wider NHS services. However, milder treatments and attitudes had started to become more prevalent from the 1920s^v with some movement towards supervision in the community and general hospital out-patient care, yet the Victorian asylum situation proved tenacious. Numbers of people in confinement continued to rise and scaled a peak of over 150,000 by the 1950s; amounting to 40% of all NHS beds^{vi}.

In post-war Britain, despite tentative advances in therapeutic practice, the ‘breakthrough’ was considered to be the development of anti-psychotic and anti-depressant drugs; enabling many people to be treated outside institutions and within the community^{vii}.

However, little attention had been paid to the amount and nature of support that would be needed for those leaving asylums (including the economic and social consequences of long-term dependency on medication).

The 1961 ‘Water Tower’ speech of Health Minister, Enoch

Powell marked a shift towards what became known as care in the community:

‘In fifteen years’ time there may well be needed not more than half as many places in hospitals for mental illness as there are today.’^{viii}

This was a new focus on relocating the treatment of mental illness from asylums to general hospitals and developing new services in the community complemented by an expanding social work profession.

However, rather than ensuring that mental illness now became a fully fledged NHS responsibility, the emphasis on community care in effect shunted the emphasis towards ‘social care,’^{ix}

Following the Conservative Government’s 1984 reorganisation of NHS administration, general management was introduced via a new structure of health authorities.^x

At this time, dissatisfaction began to emerge about the deficiencies in relying on medical modes of intervention; also the inadequacies in support available for those whose behaviour posed a risk to others, combined with widespread criticism about the lack of availability of psychological help for those people with mental illness. These concerns are no less relevant today. The Griffith report commissioned by the Government^{xi} also proposed that services should be put out to tender to maximise the involvement of profit-making firms and that access to these services should be means tested.

To date, policymakers have failed to keep pace with the urgent need to address matters of prevention, intervention and the maintenance of wellbeing, but unless they do so with immediate effect, children will not develop the resilience that is the hallmark of good mental health.

Unfortunately, but as predicted^{xii} the reforms served to increase the burden of unpaid care on women, de-professionalised the social care workforce and decreased the

level of support available to elderly people, adolescents and children. In 1990, the National Health and Community Care Act placed the lead responsibility for community-based care firmly upon local authorities^{xiii}.

Until 1997, public spending on mental health was low compared to physical health; particularly with regard to services for elderly people, children and adolescents.

The history of child and adolescent services is marked by legislative action to remove children from workhouses and gradually recognise their needs for education and support outside institutions whilst at the same time accepting a need for inpatient care. Unified Child and Adolescent Mental Health Services (CAMHS) were created in 1986 and by 1998 had become firmly established; superseding the earlier multi-disciplinary child guidance approach. CAMHS services largely support children until school leaving age and are organised locally, operated by the NHS but jointly financed by the NHS and local government. This system is still in place; virtually unchanged.

The 1997 Labour Government began what would become common practice for successive administrations; releasing and re-releasing innovative strategies and explicit guidance for improved mental health provision; whilst supplying insufficient resources to effect the recommended changes or manage day-to-day issues. Financial outlay on mental health did rise although not in line with the general increase in NHS expenditure.

The 1999 National Service Framework for Mental Health outlining specific objectives for adults of working age was followed by an NHS Plan in 2000 citing mental health as one of three clinical priorities alongside heart disease and cancer. This move towards parity for mental health was accompanied by targets, promises of future funding and an unprecedented amount of detailed guidance from the Department of Health.

The 2004 National Service Framework combined with the ‘Every Child Matters’ strategy set out a 10 year plan leading to more high quality research and an emphasis on early intervention prompting some positive changes in service care. The Global Financial Crisis of 2008 heralded the dawn of the austerity era but research findings at the time started to build an economic case for improved mental health instead of incurring the cost of neglect; lost productivity and increased financial burden on public sector services.^{xiv}

In 2006, the ‘Improving Access to Psychological Therapies’ (IAPT) programme introduced with a clear aim of reducing the economic burden to the country of mild/moderate mental illness, raised hopes for a more secure funding framework.

As a consequence of the Coalition Government’s Health and Social Care Act (2012) for the first time, the NHS was required

18% of children aged 7-16 and 22% of young people aged 17-24 have a probable mental health disorder



to place mental health on a par with physical health and this 'parity of esteem' applied also to the mental health of children and young people. The 2011 'No Health Without Mental Health' strategy promised early support for mental health problems and in 2014, 'Closing the Gap' set out priorities for essential change in mental health provision including ambitions to improve access to psychological therapies for children and young people.

The 2015 – 2017 Conservative Government despite a background of austerity introduced a number of progressive measures:

- Specific objectives to improve treatments for children and young people by 2020/1 (The Five Year Forward View for Mental Health, Feb 2016)
- Ending the practice of children and young people being detained in police cells as a place of safety or whilst awaiting MH assessment
- New funding for mental health including specific investment in eating disorders for teenagers

- A Green Paper: 'Transforming Children and Young People's Mental Health' setting out proposals to motivate and support all schools/colleges to identify and train a Designated Senior Lead for mental health; to fund new Mental Health Support Teams supervised by Children and Young People (CYP) Services staff and to pilot a four-week waiting time for access to specialist NHS CYP services.

The direction of policy since 1997 has (to a far greater extent than formerly) seen successive UK administrations coming to realise that tackling mental health is as much part of government responsibility as physical health. Yet a pace of change of perspective best be described as gradual, has been undermined by the fact that the devolution of care away from the NHS as a result of care in the community was used to justify budget cuts. In addition, the healthcare system's ability to adapt to change was severely circumscribed by the fact that parity of care was only formalised in legislation during the predominance of austerity policy.

In January 2019, the NHS Long Term Plan reaffirmed the direction of the Five Year Forward View for Mental Health;

setting out further measures to improve the provision of, and access to, mental health services for children and young people. In September 2020, the Relationships and Sex Education guidance came into force and included mental health and wellbeing as well as physical health in its statutory requirements for health education. The Covid-19 Mental Health and Wellbeing Recovery Plan was published in 2021 and over £17 million was announced by the Government to improve mental health and wellbeing support in schools and colleges in order to assist their recovery from the challenges and changes of the pandemic. This was followed in May 2022 by an additional £7 million for schools and colleges for the purpose of training a Senior Mental Health Lead and up to 8,000 more schools and colleges received a guarantee of grant support.

In 2022, the Government launched a discussion paper and call for evidence to inform a new cross-government ten-year plan for mental health and wellbeing in England. The urgent mental health needs of children and young people are reflected by findings that 18% of children aged 7-16 and 22% of young people aged 17-24 have a probable mental health disorder (Newlove-Delgado, T. et al 2022 Mental Health of Children and Young People in England, 2022. NHS Digital, Leeds). Suicide is the leading cause of death for children and young people^{xv}.

However, in January 2023, the ten-year plan was replaced by the Major Conditions Strategy in which mental health was listed as one of the 6 major groups of health condition that most affect the population in England:

- Cancers
- Cardiovascular disease, including stroke and diabetes
- Chronic respiratory diseases
- Dementia
- Mental ill health
- Musculoskeletal disorders.

A public consultation on the strategy opened on 31 May 2023. However, 19 leading mental health charities and social enterprises have already:

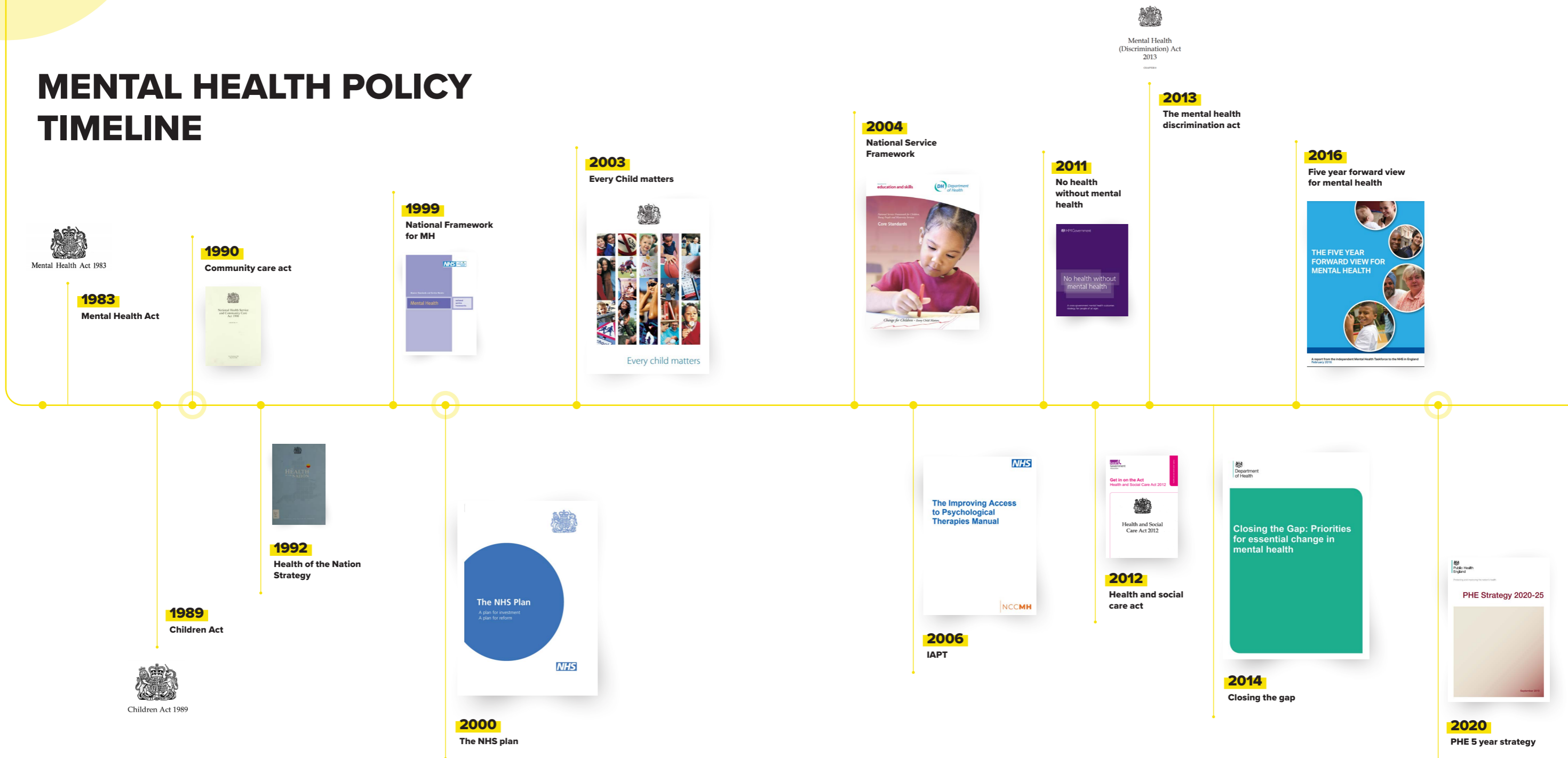
'.....branded the newly announced Major Conditions Strategy a betrayal of the Government's promise to develop a visionary new plan for mental health, from cradle to grave, from prevention to treatment.'^{xvi}

Historically, mental health services for children and young people have left much to be desired with the inglorious errors of the past at risk of determining the future.

'What we need is a concentrated strategy for the Government that focuses on levelling up mental health services, provides access to early intervention for all children and an investment in mental health research. Without this focus, we run the risk of letting down the one in four people in the UK impacted by mental illness.'

Lea Milligan, Chief Executive, MQ Mental Health Research

MENTAL HEALTH POLICY TIMELINE



CHAPTER 2: POST-PANDEMIC MENTAL HEALTH OF THE UK

The UK mental health service provision is familiarly termed a ‘Cinderella service’ and widespread criticism of its nature and quality preceded the Covid-19 pandemic.

Carers, family and friends are a key disaffected group; frustrated by the historically rigid and inflexible barriers inhibiting information sharing, combined with concerns about the quality of care provided. Too often, treatment has been characterised by ‘containment’ of a supposedly ‘stable’ status quo and an acceptance of mental health stigma rather than access to the latest treatment options and recovery-focused compassionate care. Parents in particular have found the transition of their child from CAMHS to adult services nothing less than a culture shock.

For service users, ‘all of the above’ has been the hallmark of what they have become resigned to expect with the addition of potential harm from the psychiatric system, lack of choice in care both with regard to inpatient and community services, potential coercion via the use of Mental Health Assessments (MHA) and incorrect diagnosis. Added to the litany has been an ever-pervasive and squalid atmosphere of stigma and discrimination combined with practical inadequacies (involving PIP and benefits) limited options with regard to person-centred support including user-led care and inadequate trauma-informed provision.

When a person of whatever age becomes mentally ill, the route to support and recovery is invariably tortuous with a built-in disconnect between mental and physical health services and a substantial and seemingly tacit acceptance of inequality in physical illness mortality from people with serious mental illness^{xvii}.

The mental health services; in addition to their traditional relegation as ‘secondary’ in quality, delivery and outcome to their physical counterpart have served to entrench pre-existing inequalities experienced by marginalised groups in the course of their daily lives and this is the subject of a PhotoVoice study carried out by the McPin Foundation in Harrow and Lambeth:

‘We encouraged people to reflect on their experiences of social and structural inequality in relation to mental health

– largely by taking photos, but also by making videos to voice their opinions, convey their feelings and share their understandings.’^{xviii}

In respect of legislation, progress on the reform of the 1983 Mental Health Act, as announced by the then Prime Minister, Boris Johnson in the 2019 Queen’s Speech continues to be slow. Serious reservations about a failure to address both rising detention rates and racial inequalities have been expressed by the Joint Committee assigned to review the Draft Bill^{xix} as well as dismay from many organisations working in the field of children and young people at the absence of statutory provision for preventative/early intervention measures in school and community settings.

Given the above scenario, drawing precipitate conclusions about the pandemic’s impact on mental health would be unsafe, but added to inherent difficulties much of the large quantity of published research is considered to be deficient in methodological accuracy and ways of measuring and assessing data.

For example, a living systematic review (concluded in May 2022) screened 141,168 titles and abstracts seeking studies of a defined population that used valid, reliable measures with at least two data points, but just 275 were found to be sufficiently rigorous and only 35 focused on those under 18 years of age.^{xx}

Flawed research on children’s mental health pre-dates Covid-19; illustrated by findings from a meta-analysis of 41 population-based mental health surveys of school age children (n=87,742). The wide variation in reported prevalence of mental health conditions was caused by methodological differences rather than year (1985-2012) or location (27 countries)^{xxi}

Pre-Covid-19, comparative data on the same individuals has proved to be the most reliable source of the pandemic’s impact on mental health.

A systematic search of four databases (March 2020 – December 2021) reported on 51 methodologically reliable studies of children and young people. However, little information was available for the under 10s and variation



abounded on the identification criteria for children and young people including how representative they were of their communities; time and method of data collection; content of the questionnaires and whether these were completed by child or parent. Only four out of a predominantly poor-quality set of studies achieved high systematic assessment ratings.

In 2017, The English National Survey Series (generator of Government Official Statistics) collected data from children and young people aged 2-19 years. Those agreeing to re-contact were invited to follow up in July/August 2020, February/March 2021, April/May, 2022 and March/April 2023. Findings included:

- An increase in proportion of those studied with probable mental health disorders throughout the age range
- This encompassed both genders and all ethnic groups; rising from 11% in 2017 to 16% among 5-6-year-olds in 2020
- Waves 2 and 3 reported that the deterioration had been maintained (Wave 4 repeats in autumn 2023)

- In 2022, 18% of 7-16-year-olds had a probable mental health disorder
- The mental health of emerging adults deteriorated suddenly in 2022; 22% of whom had a probable mental health disorder.

Children and young people living with a parent affected by poor mental health or in financial or food insecure families were likelier to have a probable mental health disorder. Other aggravating features were social isolation, sleep disturbance, on-line gambling and substance misuse. However, as yet, none of the Covid-19 follow up data (including comparative work on eating disorder prevalence) has been archived for assessment by approved researchers. This has had an adverse effect on the design of future policy and practice.

Current evidence is emerging of increased prevalence of mental health problems in children and young people from marginalised communities and those experiencing significant inequalities.

The REACH study (Risk, Resilience, Ethnicity and Adolescent Mental Health) based at King's College London and funded by the European Union was established in 2016 and is currently taking place in 12 south London secondary schools.

To date, 4,000 young people (Years 7-9) have been invited to take part^{xxii} and activity includes an online survey designed to ascertain the impact of school closures and social distancing measures on young people's mental health and wellbeing. A diary project dated September 2020 - February 2021 aimed to gain understanding of the daily experiences of young people during the pandemic; their coping strategies and what aspects they found most difficult to deal with.

Published papers have stressed the complexity of the emerging mental health problems between different groups with some young people recording a clear deterioration in their mental health.^{xxiii}

Evidence from the McPin Foundation^{xxiv} suggests that during the pandemic there were greater levels of reported mental health problems for disabled young people, those not in education, employment or training, care experienced young people, those from low-income households and from ethnic minority communities. McPin have collaborated with The Social Innovation Project (TSIP) and The Black Thrive partnership to report on the need to work with local communities so that the recovery from Covid-19 will be fair to all; in particular with regard to basic needs such as food, health support and technology alongside work and education free from toxic environments^{xxv}.

Black Thrive in written evidence to Parliament said:

'In Lambeth, 26% of the population identify as Black African or Caribbean. However, 50% of patients in high secure and 67% of the patient population in low and medium secure psychiatric wards are from Black backgrounds. This is not solely a Lambeth phenomenon and high detention rates are observed nationally. Additionally, mental health services do not deliver the same positive outcomes for Black people compared with their White counterparts. For example, data held by Black Thrive shows that in Lambeth, Black people accessing Talking Therapy were 1.4times less likely to meet

national recovery thresholds. Our concern is that the lack of access to culturally appropriate therapy and Covid-19 will exacerbate these inequalities.'^{xxvi}

The Activity Alliance's Annual Disability and Activity Survey (2022) revealed that many disabled people still feel forgotten as recovery from the pandemic is underway; in particular, children with intellectual disabilities.^{xxvii} The Activity Alliance has recommended an inclusive action plan to encourage all people to resume (or to start) physical activity post pandemic and the positive associations between physical activity and mental wellbeing are already established. If physical activity levels are increased, evidence from the World Health Organisation (WHO) suggests that it is possible to reduce 'disease burden and overall mortality, as well as promoting wellbeing and mental health for all.'^{xxviii}

In their 2022 Children and Young People's Active Lives survey^{xxix} Sport England consider mental health from a perspective of happiness levels; concluding that children and young people who are more physically active are happier than those who are not. The Good Childhood Report^{xxx} asserts that children's wellbeing has declined and is significantly lower than a decade ago, with 30% of children still feeling that the pandemic has had a negative effect on their levels of happiness.

The Department for Education also made the link between physical activity and mental wellbeing within the introduction of the new curriculum from 2020 of Relationships Education, Relationships and Sex Education (RSE) and Health Education.^{xxxi}

30% of children still feeling that the pandemic has had a negative effect on their levels of happiness



However, publishing the new content during the pandemic has had the unfortunate outcome that it has not as yet had any clearly defined effect.^{xxxii}

Educating children and young people about the importance of healthy lifestyles will require more time; also ensuring that the approach includes older adolescents (at a vital stage in terms of their mental and physical health prior to adulthood). In the post-pandemic phase, tailored public health messaging is needed in order to connect with a group that is difficult to reach and too often at risk of being by-passed by health messaging.

During the pandemic, a massive increase in referrals to services for 'eating disorders' occurred but this is not yet capable of accurate assessment. However, a significant rise in the prevalence of sub-clinical eating difficulties (which may progress to more severe mental health problems or add to their severity) during the pandemic has been reported; particularly in the case of children aged 11-16; girls and older teenagers.^{xxxiii}

Despite a body of available research impaired both by methodological weaknesses and the need for greater harmony in approach, sufficient evidence exists to state that the mental health of children, young people and emerging adults deteriorated during the Covid-19 pandemic and that this has been sustained. Anxiety, depression eating difficulty and disorder and self harm are preponderant and even small increases at population levels can instigate large surges in demand that can swamp services.

Sufficient data on younger children is, as yet, unavailable, but 'lockdown babies' (or those born just beforehand) are now starting early years education and primary school having had much less social contact; in particular, with other children. According to anecdote, they are exhibiting increased levels of language delay and poor social skills which could jeopardise future academic progress, mental health and wellbeing. Reliable research is needed on the increasing number of children who are persistently absent from school or not attending at all.

Poor mental health in childhood is not time-limited and findings from British Child and Adolescent Mental Health surveys prior to the pandemic (1999 and 2004) show that half of the 10% of school-aged children with clinically impairing mental health disorders met diagnostic criteria when reassessed three years later.^{xxxiv} This suggests that the mental health impacts of the pandemic will not be temporary for a significant number of children and young people and in the absence of a statutory national early intervention strategy, conditions may persist and deteriorate.

Many adults living with mental health illnesses report that their first episode occurred during childhood; 50% by age 15, 75% by 18 and even more among those needing help from mental health services. It is probable that high and increased pressure of demand on the already seriously burdened adult mental health services will continue for the foreseeable future.^{xxxv}

Today's children and young people with poor mental health are likely to pay a heavier developmental price than their predecessors because the adverse impact on education, social and mental health outcomes would seem to be greater.^{xxxvi}

The pandemic changed the outward face of healthcare and the introduction of remote digital mental health provision drew a mixed response from service users, staff and carers according to one study:

'Some service users valued the convenience of remote methods in the context of maintaining contact with familiar clinicians. Most participants commented that a lack of non-verbal cues and the loss of a therapeutic 'safe space' challenged therapeutic relationship building, assessments and identification of deteriorating mental wellbeing. Some carers felt excluded from remote meetings and concerned that assessments were incomplete without their input. Like service users, remote methods posed challenges for clinicians who reported uncertainty about technical options and a lack of training. All groups expressed concerns about intersectionality exacerbating inequalities and the exclusion of some service user groups if alternatives to remote care are lost.'^{xxxvii}

The study also recorded the negative impact of the pandemic upon the mental health of the workforce and the authors have subsequently observed that workforce burnout and difficulty in new staff recruitment are increasing the pressure on all mental health service providers.

Innovative schemes such as a London pilot of maternal mental health services can inject new thinking and fresh approaches into tired systems, but when the pilot is completed and the overseeing team has been dispersed, it is difficult to see how, in the absence of secure funding, the momentum can be maintained or replicated elsewhere.^{xxxviii}

There are also initiatives occurring elsewhere such as the Release, Recover, Discover Programme with TRE UK, set up as an initiative to support schools and with outcome data validated by Canterbury Christchurch University:

'We can be 99% confident that the results on the physical, mental and emotional improvements are not due to chance but a genuine statistical effect...high-level anxiety and depression was down over 60%.'

The post-pandemic mental health landscape of the UK is still unfolding; current research is not yet fit for the purpose of making definitive judgement and this will remain the case for some time. However, it is clear that the service as a whole has buckled under the strain of Covid-19 to the detriment of users above all (and in particular, children, young people and vulnerable groups as described) but also staff, carers and the workforce.

Covid-19 has left current mental health service provision stretched further than ever before by increased demand. Unless timely and effective interventions can be accessed by all children and young people as a Government priority, the health, education and future contributions to society of the next adult generation will be massively reduced at financial cost to us all.

75%
of mental illnesses
develop before
adulthood

CHAPTER 3: PREVENTATIVE, COMMUNITY AND EARLY INTERVENTION STRATEGY

In the absence of a single agreed definition of mental health, the World Health Organisation (WHO) has described it as:

‘A state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively, and fruitfully, and is able to make a contribution to his or her community.’^{xviii}

True lifetime prevalence rates of mental illness are much higher than generally assumed and more than half the population will experience a period with high levels of psychological distress that meets the diagnostic criteria for mental illness at some stage in their lives.^{xix}

A substantial proportion of mental illness gains a grip during childhood development^{xx} and at least 50% of all adult mental ill health is manifest by age 14.^{xxi}

Prevention early in development is therefore not only desirable; it is essential and the wide-scale consensus among professionals is that provision of appropriate care for mental ill health must be delivered in tandem with a robust population-focused approach to community-based initiatives for the primary and secondary prevention of mental illness.

To date, policymakers have failed to keep pace with the urgent need to address matters of prevention, intervention and the maintenance of wellbeing, but unless they do so with immediate effect, children will not develop the resilience that is the hallmark of good mental health.

Early intervention identifies and supports children and young people at risk of poor outcomes^{xxii} and it is never too soon to take action. Recent attention for example, has focused on the preconception period as a unique opportunity to improve the mental health of the next generation.^{xxiii}

Poor maternal and paternal health however, is linked with disadvantageous outcomes in children, and policymakers (and therefore the public) must be enabled to appreciate the extent to which foetal, infant and adolescent brains can be impacted by beneficial (loving parenting, appropriate direction and good nutrition) and adverse (alcohol, smoking, abuse, neglect) influences during the first two decades of life.^{xxiv}

A number of biological dispositions, socio-cultural contexts and psychological processes are likely to interact serving either as protective or risk factors. The cost to society of perinatal mental health problems is about £8.1 billion for each one-year cohort of UK births.^{xxv}

Cumulative childhood adversity is closely aligned to increased risks of adult mental illnesses, substance and alcohol misuse, suicide, self harm and shortened life expectancy.^{xxvi}

Adult mental ill health is now widely understood to be the product of progressive life course trauma rooted in early childhood and encompassing contemporary disadvantages such as poor housing, social and economic precarity, unemployment, discrimination, violence, and fear of crime. Some of the adversities experienced are known to be sexual, physical or emotional abuse, neglect, racism, multiple loss events, periods of institutionalised care or incarceration, living with parents who use substances and/or with parents who are mentally ill themselves. There are many others. People who are neuro-diverse are also at enhanced risk as are children of parents with psychosis who may experience neglect or fear when their parent is unwell or detained and could benefit

from targeted preventative help.

Children and young people whose early signs of mental illness are allowed to ‘slip through the net’ are also at risk of radicalisation by extremist, paramilitary and terrorist groups. In the statistics for the operation of police powers under the Terrorism Act 2000 and subsequent legislation up until December 2022; of the 166 arrests, the largest increase was the ‘17 years and under’ category accounting for 19% of arrests; an increase on the previous year.^{xxviii}

The Senior National Co-coordinator for Counter-Terrorism Policy, Tim Jacques cited the influence of powerful online extremist content shared and distributed, saying:

‘This risk is increasingly manifesting itself in the younger age groups, where it can take potentially deeper hold.’^{xxix}

Some examples highlight this:

- May 2022: a 13-year-old boy was arrested for dissemination of terrorist material under section 2 Terrorism Act 2006, where he shared extreme Islamist material online^l
- March 2023: two teenage boys (16 and 17) were arrested in north London as part of an ongoing investigation for the dissemination of terrorist materials under section 2 Terrorism Act 2006^l
- March 2023: at Central Criminal Court, Oliver Riley admitted to a series of terrorism offences including dissemination of terrorist material linked to the neo-Nazi ideology when he was 16 and 17 years of age. In his mitigation, it was submitted that Riley had traits of autism spectrum disorder and suffered from a chronic sense of under-achievement.^{lii}

In summary, effective policies to prevent mental illness should be predicated on the assumption that the many and varied aspects of a child’s history, experiences, cultural background and wider environment can conjoin to impair mental health and provide risk to them and also to the communities in which they live. There is a need to consider multiple aspects of environment (family, community workplace, living space) together with individual coping schemes and resilience when formulating a coherent strategy and partnership between tiers of government and the communities it represents is therefore essential.

The Covid pandemic and resulting lockdowns led to a deterioration in children and young people’s mental health^{liii} and it has been argued that preventative approaches to mental health are likelier to succeed if the lessons of Covid-19 on the value of partnership between governments and communities are learned.

A pathway to partnership working had seemed to unfold with the institution of the first National Service Framework (NSF) in 1999 for quality mental health services. NSFs were 10-year service programmes designed to improve specific areas of health and social care with a remit to:

- Set national standards and identify key interventions for a defined service or care group
- Put in place strategies to support implementation
- Establish ways in which to ensure progress within an agreed timescale
- Form one of a range of measures to raise quality and decrease variations in service.

For mental health, this involved determining the role of community teams and protective functions such as assertive outreach, early intervention, home treatment and crisis intervention as well as psychological therapies. However, NSFs were swept away in the 2010 reorganisation of the NHS to be replaced by NHS England.

Community-based provision has continued to be bedevilled by insufficient and inconsistent levels of funding with a knock-on effect on workforce quality and numbers.

Many specialist teams have been merged or located within other community teams and despite some aspects of home treatment, crisis teams and early intervention being relatively well protected, other aspects of community service have been poorly resourced; in particular the treatment of non-psychotic or serious mental illness. Unless people are found to be sufficiently unwell and there is no emergency, they are not guaranteed to receive the help that they need when they need it; to include those with disabling anxiety and depression, self-harm and personality difficulties.

Overall, services are preponderantly inflexible; reliant upon rigid pathways and teams rather than signalling adaptability (even in clinician decision-making) because what is not commissioned invariably cannot be delivered.

For children, making the transition into adult services is often traumatic and lacking in wrap around and tailored care. There is a clear shortfall in provision for adolescents and young adults and a major omission in all service plans is to ensure that they are culturally competent and that all policies and appropriate interventions are designed in full cognisance of the corrosive, destructive and pervasive influence of structural racism in society and in the lives of individuals.^{liv}

It is crucial that children and young people can access mental health support within community settings such as mental health hubs, primary care settings and schools.

Schools can play a vital role in identifying mental health issues amongst their pupils but should not be the only source of community setting support because some children may not wish to engage with mental health support services in their school environment; or may not be able to attend school due to mental health difficulties. Mental health hubs, primary care or other community settings could be more appropriate for them.

Many issues affecting children and young people including anxiety, depression, self-harm, eating disorders and trauma remain unaddressed due to limited access to the correct level of support; too severe for low-level intervention but insufficiently severe (yet) for CAMHS. This can lead to the escalation of mental and physical health problems, poor academic performance, substance abuse and increased suicide risk.

The ETHOS Trial study^{lv} demonstrated the value of counselling in improving young people's confidence and self-esteem, relationships with parents/carers and ability to manage anger. The research showed that counselling had affected medium/large improvements in the attainment of individual goals. Parents and carers agreed with the findings and around 70% of the young people who had received counselling expressed positive feelings about it.

Younger children for whom counselling and talk therapies may not be appropriate, derive great benefit from play and creative arts therapies^{lvii} validated by an estimable history of service provision and much practice-based evidenced data testifying to their effectiveness. Both counselling and play and creative arts therapy services employ highly qualified and professionally accredited workforces but there is no statutory provision for their national roll-out by the Government; rather a decision to rely on partial or targeted options of their own.

Mental Health Support Teams were announced by the Government in 2018 as an early intervention measure in school-based settings for children and young people aged 5-18 with mild to moderate mental health illness.

However, the roll-out has been too slow; by the end of 2024, children in 73.5% of primary schools and 53.5% of secondary schools will have had no access to a Mental Health Support Team and responses received from NHS Integrated Care

Boards (ICBs) who responded to a Freedom of Information Request from Munira Wilson MP indicated wide spending disparity per pupil on Mental Health Support Teams in different parts of the country.^{lviii}

Local government has strong potential for partnership strategy in preventive and early intervention mental health strategies and in 2022, its key role as a leader in health promotion was again recognised in the Levelling Up White Paper.^{lviii} A diverse range of 'wider' determinants of mental health include social, economic and environment as described above and the 2010 Marmot review emphasises the strong and persistent link between social inequalities and health outcomes^{lix}.

Local government's unique role in an area can contribute to improved mental health and wellbeing through:

- Local leadership: offering connections with other stakeholders such as employers and business groups
- Relationship development: engaging with voluntary and community groups who have previously had more direct commissioner-provider arrangements
- Holistic support: early signposting; support offers; expanding access to activities and the outdoors and creative/artistic expression; advocacy and advice around benefits, finances and housing
- Place-based: recognising the range of settings that can influence wellbeing such as parks, playgrounds, leisure facilities
- Use of evidence and resources; using local evidence to make local approaches bespoke and effective.

Health and Wellbeing Boards, first established in 2013 are invaluable tools in the prevention, community, and early intervention agenda. As statutory bodies, capable of bringing together a wide range of partners from within and without the local health system, HWBs are uniquely placed to address the wider causes of health issues such as employment, transport and housing.^{lx}

While Integrated Care Systems (ICs) offer the potential to deliver mental health services through system-wide collaboration, local authorities are already long-established as collaborative bodies and have been doing much already in the prevention and early intervention arena. Some examples are below:

- The City of London's Bridge Pilot is a suicide prevention plan developed as a joint initiative between the City of London Corporation, City of London Police, the Samaritans and the Royal National Lifeboat Institution (RNLI)



- Free-to-access public playgrounds are the most common places for children to play according to a national study from the University of Reading^{lxi}. With budgets from central government cut, planning authorities in local government have been unable to promote and extend the number of these spaces which enable children's good mental health and wellbeing. Many have closed and their many advocates favour properly co-ordinated national roll-out
- LifeLink was a social prescribing project piloted in 2018 in Haverhill and subsequently (thanks to funding from GP practices) covering West Suffolk^{lxii} Local authorities have used social prescribing for decades to improve mental health and wellbeing via coaching support, involving people in community groups and providing support available on the doorstep.

Local government has continued to innovate in the field of prevention and early intervention for mental health and wellbeing despite having its budgets tightened progressively over the past 13 years.

It should be integral to a national mental health strategy for early intervention and prevention that is wholeheartedly prosecuted by the Government with financial resources that are both sufficient and guaranteed.

CHAPTER 4: THE COMPOSITION, NEEDS AND TRAINING OF THE MENTAL HEALTH WORKFORCE

Supporting the mental health of the community is a multidisciplinary enterprise involving people who work in various capacities and in different settings. Unless there is sufficient funding to guarantee that staffing matches need and that the professionals employed are well-educated, well-supported and well-rested, the workforce as an entity will be neither robust nor resilient.

Safeguarding the mental health of prospective parents should be an integral training requirement for the professionals involved. To identify and understand the mental and emotional needs of expectant parents, health visitors, midwives and GPs should be educated in perinatal mental health so that they are better equipped to help new families with initial problems. As part of the routine post-natal experience, programmes such as baby bonding and attachment should be delivered at health centres and doctors' surgeries.

Throughout the pre-school years, the professional team supporting new families should be enabled to have confidence in guiding them towards appropriate early help and advice. This will often take the form of local community groups and charities; themselves in need of a secure funding future. Increasing the access of these grassroots local organisations to Government grants is cost-effective and will offset the burgeoning remedial costs of interventions at a later stage.

Mental health awareness should be included in all Initial Teacher Training (ITT) and Continuous Professional Development (CPD) to enable teachers to pick up early warning signals about their pupils' emotional or mental health and feel confident in signposting. However, teachers must not be expected to provide support in matters beyond their scope or to be solely or even primarily responsible for them. The Health and Safety Executive (HSE) should require all employers to advertise staff access to a qualified therapist or psychologist and in order to avoid professional and caregiver burnout, this should be a recognised funding priority for the Government.

The largely community-based mental health services for children and young people can be free at the point of use like CAMHS (usually mental health specialists and counsellors working in community and primary care settings including clinics, schools and youth services), Mental Health Support Teams, school and youth counsellors - or privately funded such as counsellors, psychotherapists and play and creative arts therapists.

Only privately-funded children and young people can exercise the potentially empowering experience of choosing their own therapist; enabling those who may have trauma or trust issues to have some control over their individual treatment plan.

However, a significant inequality exists within mental health service provision whereby only those who can afford to pay can access the type of care that they need in a way that works for them.

Suitably qualified counsellors, psychotherapists and play and creative arts therapists in the UK can register with Professional Standards Authority Accredited Register holders in order to demonstrate the quality of their training, commitment to ethical working and accountability. Their training will have been self-funded and the Accredited Register holders are reviewed and re-assessed regularly to ensure that the registering body's high standards are maintained. Failure to meet the minimum standards required will lead to removal from the Register.

In the public sector there is currently no nationally enforced policy in the provision of counselling, play /creative arts therapy or psychotherapy services for children and young people. Much guidance is supplied in the 2016 document *Counselling in schools: a blueprint for the future*^{lxviii} but it is seldom followed



and a large amount of former counselling support has been, or is being, replaced by non-counselling-related mental health provision in a short-term cost-cutting exercise.

This is to the detriment of pupils, teaching and non-teaching staff and support providers such as Children's Wellbeing Practitioners or Educational Mental Health Practitioners; many of whom experience exhaustive burnout mental health conditions and work-related stress because they lack the skills, training or experience necessary to fulfil the functions needed by schools.

Some individual schools or multi-academy trusts use their own budgets to provide counselling/creative arts and play therapy services but only when the Senior Leadership Teams are sufficiently confident to source these themselves; there is no official guidance to assist them.

In some instances, Mental Health Support Teams or Children's Wellbeing Practitioners work with cases outside the scope of their training and make referrals to local counsellors, play and creative arts therapists or psychotherapists. However, because this is neither integrated nor managed through national policy,

there are often significant gaps in a multi-agency approach. A national strategy would reduce reliance on crisis services, avoid further workforce disillusion and make better economic sense. Children and young people would be likelier to receive the right help when needed and avoid their condition escalating.

The Royal College of Psychiatrists was one of 100 organisations calling for the Government to publish a comprehensive NHS workforce plan with independently

26 verified forecasts for the numbers of doctors, nurses and other professionals that will be needed in five, ten-and-fifteen years' time.^{lxiv}

Prior to its publication in late June 2023, the consensus in the health sector was that it should include a commitment to provide adequate financial investment and address the critical areas of retention and recruitment. It was also argued that the plan should ensure parity of esteem between mental and physical health and a needs-based allocation of time, effort and resources for the workforce.



Improved mental health services and increased access to them necessitates a robust workforce but the current number of psychiatrists is unequal to demand.

The 2012 Royal College of Psychiatrists Workforce Census^{lxv} showed a 30% increase in the number of vacant or unfilled consultant posts since 2017 in England with children and adolescent psychiatry, eating disorders psychiatry and addictions psychiatry recording the highest number of specialist vacancies.

Other findings included:

- Between January 2013 - January 2022, the number of Full Time Equivalent (FTE) psychiatrists at all grades working for the NHS increased by 16.4% compared to 35.1% for all other specialities
- A decrease of 10.8% FTE consultant psychiatrists in post across the NHS workforce; equivalent to a reduction of 0.2%
- Only 215.3 FTE consultants have been added to the workforce since March 2016 as against the Health Education England (HSE) National Health Service England

(NHSE) target of an additional 750 in post by March 2022 or 910 by March 2023.^{lxvi}

- Only 4,000 more Mental Health Nurses are expected to be in post by March 2024 compared to March 2016 as against the 12,320 required according to Stepping Forward and the Long-Term Plan.^{lxvii}

The continued depletion of the workforce amid ever-increasing services demand will pile further pressure on existing staff to the detriment of their morale and the patient experience.

Workforce constraints have a huge impact on staff wellbeing with constant reports of excessive workloads, poor work-life balance, and pressures on access to appropriate Continuous Professional Development (CPD). More consultants are likely to take early stress-related retirement which has been greatly exacerbated by the Covid-19 pandemic.

Throughout the sector, the number of doctors retiring early has increased and these have tripled across the decade according to NHS figures. The Royal College of Psychiatrists 2021 workforce census^{lxviii} shows that 193 consultants were reported to have retired in England in 2020/1; a 49.6% increase from 2016/17.

Psychiatry is currently a shortage speciality, and a clear plan is needed to encourage more students to choose it. It takes 13 years to train a consultant psychiatrist and a long-term planning strategy is essential, beginning by doubling medical school places to 15,000 by 2028-9. The estimated cumulative cost of this would be £802m by 2024/25 (should places reach 11,000 per annum by then).

Meanwhile, other components of the workforce are under strain, and it is crucial that all elements of the multidisciplinary team should feel that they are properly valued and supported.

Physician Associates (PAs) are healthcare professionals with a generalist medical education. Their vital role in mental health teams is to ensure that patients receive the highest standard of continuous and holistic care. Working with a dedicated medical supervisor, they manage a varied caseload using their generalist skills whilst receiving specialist training in mental health. From 2022/23 onwards, at least 10% of the 1,000 PAs who are trained each year work, in mental health (including liaison services and GP practices).

Particularly after the strain borne by these services during the pandemic, the Government should invest significantly in staff retention and mental health support for health worker staff because of the duty of care and also to mitigate the impact of mental health related absence; consistently the most reported reason for sickness absence. The Government should also support NHS Trusts to meet an annual 4% improvement target in retention of mental health staff by:

- Focusing on existing staff wellbeing; addressing matters of high workload, lack of CPD and unsatisfactory work-life balance
- Flexible working; possibly adapting current roles according to interest for older worker post holders and facilitating a return to services after retirement
- An improved revalidation process for retired psychiatrists wishing to return to work and making this less costly
- An increase in the number of trust-supported academic activities with academic sessions safeguard
- A graded scheme enabling senior MH professionals to take paid sabbatical leave based on length of service.

It takes 13 years to train a consultant psychiatrist and a long-term planning strategy is essential

CHAPTER 5: WHAT WOULD BE A LEVEL PLAYING FIELD FOR MENTAL AND PHYSICAL HEALTH?

There has been growing recognition of the importance of mental health and the need for equitable treatment alongside physical health. Increased media coverage during the pandemic (often focusing on children and young people) intensified awareness of the medical interdependency of physical and mental health.

'Doing sport releases endorphins, helping relieve stress and developing in children, a greater wellbeing which can in turn benefit their studies.'^{lxix}

The Children's Commissioner at the time, Ann Longfield said that the lack of physical activity as a consequence of lockdown saw children becoming:

'More withdrawn, they are really suffering in terms of isolation, their confidence levels are falling.'^{lxx}

and the Association of Physical Education (AFEP) emphasised the positive role that physical education and movement can play in helping children to recognise, respond to and regulate their feelings and emotions^{lxxi}.

KICK London^{lxxii} is a Christian value-driven charity, specialising in physical education, street dance, mentoring and school and community chaplaincy to work with children and young people. Adam Charlton, a KICK coach and mentor commented on the physically restrictive effect of Covid lockdown on primary school children who on returning to school:

'Struggled with social interactions amongst each other and low self-esteem...'

However, using the example of one pupil:

'After after implementing more soft skills and character development through mentoring and spending more time focusing on this.....there are still moments when he struggles with anxiety, but he has made great progress. It has been great to see children of all abilities and levels

engaged in PE lessons, both from a physical perspective and a mental benefit.'

Compared to the general population, people who are mentally ill have more health-related behaviours increasing their risk of mortality and a higher prevalence of multimorbidities. These include chronic conditions (cancers, hypertension, ischemic heart disease, respiratory health problems, cerebrovascular events and type two diabetes) and infectious diseases such as tuberculosis and HIV.

They are likelier than people who are not mentally unwell to have comorbidity with alcohol and substance use disorders and tobacco use; known to be contributory factors in the incidence of early mortality.^{lxxiii} Comorbidities and multi-morbidities are the primary source of premature mortality across the broad mental illness spectrum but their prevalence is higher among people with severe mental illness.

Statistics demonstrate a large variation in lifespan between people who have a mental illness and those who do not but the underlying biological and social reasons for the divergence are complex and multi-faceted^{lxxiv} and include income inequalities, financial insecurity and hardship; all of which have adverse effects on both mental and physical health.

In addition, people with mental illness are more likely to encounter systematic social exclusion due to homelessness which is also linked to premature mortality. Some minority ethnic groups face disparities in the incidence of severe mental illness and have worse outcomes.^{lxxv}

The Mental Health Foundation has found that:

- Black people are four times more likely to be detained under the Mental Health Act than White people
- Older South Asian women are an at-risk group for suicide
- Refugees and asylum seekers are more likely to experience



mental health problems than the general population including higher rates of depression, anxiety and Post Traumatic Stress Disorder (PTSD).^{lxxvi}

Mental ill health has long been associated with entrenched and pervasive stigma and discrimination; a situation that remains unchanged today, even though confinement asylums are largely consigned to history.

Physical ailments are regarded with all due gravity and concern by society as reflected in the media and absorb the lion's share of funding, resources and popular support. Milder, more common mental health conditions such as low mood, anxiety, stress and burnout have gained wider acceptance and understanding; especially, perhaps, when attached to the sympathetic 'relatable' experience of a 'celebrity', but more serious disorders such as schizophrenia and psychosis lag far behind. They are still seen as frightening and 'other' and in terms of schizophrenia, the existing negative perception is even deteriorating.

A study of 10,000 people over three decades to 2000 found that by nearly all measures, stigma towards the schizophrenia had worsened. Separate research projects show that:

- People are less likely to want someone with schizophrenia as a housemate or co-worker than in 1990

- Feelings towards a person with schizophrenia are more likely to be those of fear rather than a desire to help
- Few people would recommend a person with schizophrenia for a job
- Even mental health professionals hold negative attitudes towards people with schizophrenia.

Meanwhile, 15% of people still face losing their job or being demoted after disclosure of their mental health problem. Again, media presentation is influential; even definitive, especially in case of severe mental health conditions such as psychosis which is the perennial subject of horror films and real-life murder stories - attracting much wider audiences now than beforehand due to the ubiquity of the internet.^{lxxvii}

In comparison to physical health services, mental health services are routinely under-resourced and under-staffed which in practice means a poorer patient experience. Long waiting times, limited availability of mental health professionals and inadequate funding contribute to the inbuilt inequity between mental and physical health services and medical training for the workforce may also add to service disparities.

Physical illnesses are treated by doctors who work for medical services, but mental illnesses are treated by psychiatrists or

In comparison to physical health services, mental health services are routinely under-resourced and under-staffed which in practice means a poorer patient experience.

psychologists who are employed by separately organised mental health services. The divergent training and career paths of the professionals mean that whereas medical doctors will specialise in a body part such as 'Ear, Nose and Throat' (ENT) mental health physicians treat mental illness with less consideration by comparison of the embodied brain upon which the mind is dependent.

The division between mental and physical ill health is not now so rigid as in the days of 'lunatics' being exiled to remote asylums – but the deeply entrenched distinction remains; to the disadvantage of patients on each side of the divide and the many with 'feet in both camps'.

'A 55-year-old woman with arthritis, depression and fatigue, and a 25-year-old man with schizophrenia, obesity and diabetes, have at least this in common: they will probably both struggle to access joined-up healthcare for body and mind. Psychological symptoms in patients with physical disease are potentially disabling yet routinely under-treated. Physical health problems in patients with major psychiatric disorders contribute to their shockingly reduced life expectancy, about 15 years shorter than people without them.'^{lxviii}

Funding for research is of paramount importance to the entire mental health field.

By establishing and designing funding levels and programmes, policymakers and those who determine such financial resources have direct influence over the type of research conducted; where, by whom and at what scale and pace. Existing analyses have found that in general, mental health research is under funded relative to the burden of disease, exposing considerable gaps in the funding landscape. 74% of the UK's mental health funding comes from public sources.^{lxvix}

The last decade has seen a continuous pattern of sub-par funding for mental health compared to its physical health counterparts, resulting in delay, and stalling in the development of new drugs, digital therapeutics and treatment in its widest sense for mental health conditions. Achieving parity for mental and physical health cannot be instantaneous but it must be reliant on a coherent strategy; accepted, executed and communicated by all protagonists.

- Education and awareness are crucial in the eradication of stigma and discrimination and must be prioritised as of urgency. Challenging misconception and encouraging understanding and empathy can excise fear of the unknown, creating an environment in which mental and physical health conditions are held to be of equal importance to the benefit of the individual and society
- Integrating mental health services into primary care



settings is a logical way in which to bridge the gap; enabling collaboration between healthcare professionals, earlier identification and intervention for mental health issues and holistic care for patient

- Mental health services are inadequately funded and resourced, leading to a poorer patient experience. Fair and equitable funding by government and policymakers would encompass increasing mental health professional numbers, improving treatment option access and increasing investment in research and prevention programmes
- Achieving parity necessitates legislation and the Government should use statute to safeguard the rights of people with mental health conditions, outlaw discrimination and mandate the equitable provision of mental health services. Advocacy by mental health organisations and community support groups can drive change by using their collective voice to lobby the Government to enact laws that will drive change and advance parity.

'Parity of esteem' between mental and physical health is in the interests of both and must become a central pillar of the healthcare system. This requires an agreed definition of 'parity' so that regular and ongoing assessments of progress towards the goal can be made. Fully-integrated care would be people and community-centred necessitating improved data and data share; partnership working, cross-sector workforce planning

and increased involvement of the Voluntary, Community and Social Enterprise Sector (VCSE) to address long-term health inequalities and determinants of mental ill health.

The adoption of a 'whole-person' approach to mental health would facilitate the provision of holistic support for those with complex or multiple conditions. All health care services (including, but not confined, to those exclusively dealing with mental health) should be psychologically informed to ensure optimal treatment for those with severe mental illness. It is essential that an active anti-racist approach is adopted and monitored at all times; delivering culturally appropriate care and support to all people in need and outlawing practices that suppress and oppress minority communities.

By addressing parity barriers such as stigma, inadequate funding and resources and making a commitment to equality integral to the provision of services, society can make purposeful progress towards a healthcare system that treats mental health conditions with the same degree of urgency, seriousness, and importance as physical illness. A truly comprehensive and holistic approach will involve education, service integration, sufficient and equitable funding, policy reforms and effective and collective advocacy. **Only by striving for parity within our health services can we ensure that everyone has access to the care that they need to live their lives in a way that will be healthy and fulfilling for one and all.**

CHAPTER 6: A SECURE LONG TERM FUNDING STRATEGY

The spiralling mental health challenges facing society are in urgent need of a secure long-term funding strategy, encompassing research and service delivery.

In a post-pandemic world, the historic need to prioritise mental health research is greater than ever as argued in the paper 'Global priorities for mental health research in the COVID-19 pandemic'.^{lxxx}

A compelling case is made for further investigation into the long-term effects of Covid-19 as one of its devastating legacies has been a significant rise in mental health illness; specifically anxiety, depression and post-traumatic stress disorder (PTSD). Some priority research areas are identified, to include understanding Covid-19's impact on vulnerable populations such as frontline health workers and quantifying the effects of quarantine and social distancing. The authors advocate for increased mental health research funding and a coordinated global research effort to address the post pandemic mental health landscape.

Mental health is a crucial component of overall wellbeing, and a long-term and secure funding strategy must focus on the intertwined imperatives of research and service delivery. Investing in research broadens the knowledge base about mental health conditions, their origins and how best to treat them.

Research funding contributes to identifying risk factors, early warning signals and prevention strategies; also enabling the development of new medicines, therapeutic techniques and technology-driven solutions in the interests of better outcomes and an enhanced quality of care. It is also essential in promoting the type of early intervention that is specifically tailored to meet the needs of the individual and it is considered to be crucial in mitigating the impact of mental health issues, reducing the potential for long-term disability and improving overall wellbeing.

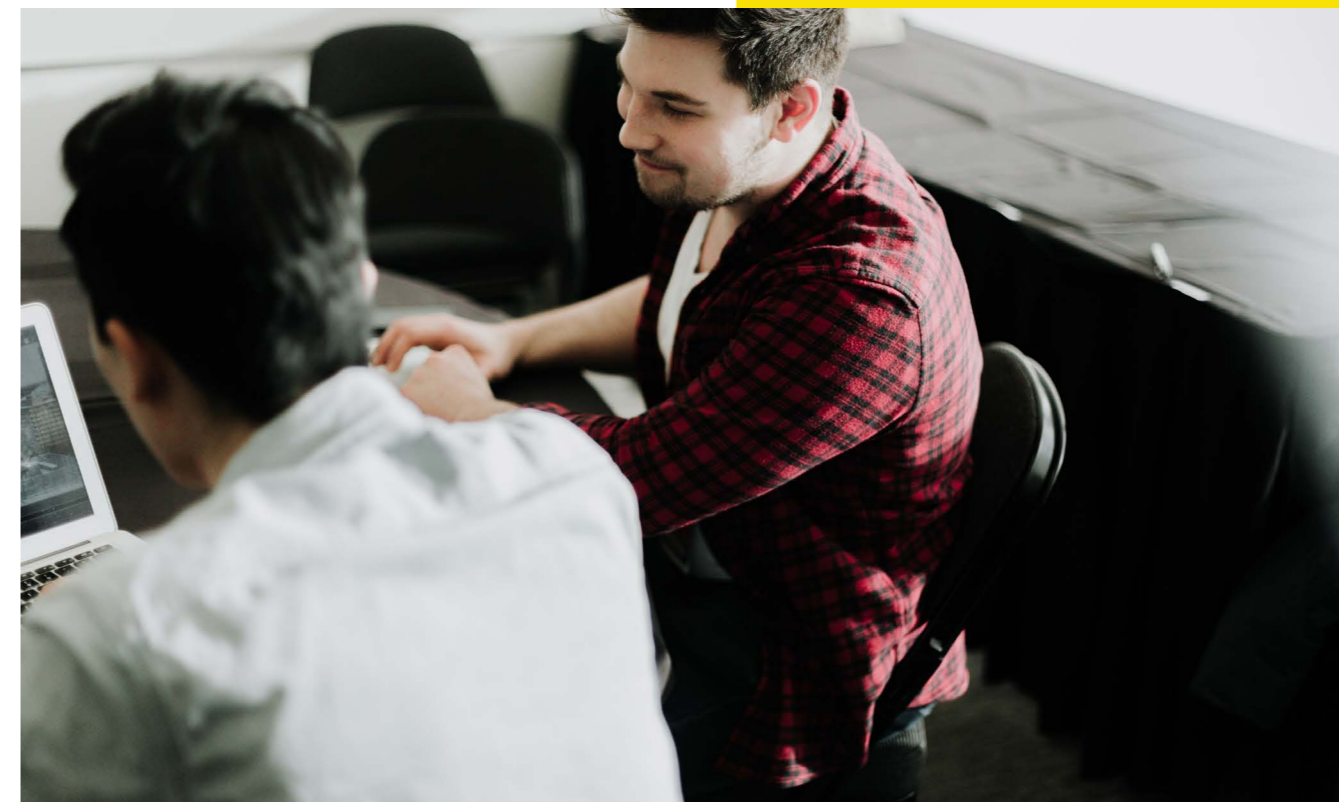
UK mental health research is severely under funded in comparison with research into physical health conditions - whether for example, cancer, cardiovascular or infectious diseases.^{lxxxi}

In 2011, the UK spent £521 million on cancer research amounting to roughly £1,571 per cancer patient as against an average spend on mental health of £115 million; equating to around £9.75 per adult with a mental health problem.

Some efforts are being made to increase funding:

- UK Research and Innovation (UKRI), has committed to an investment of £35 million in mental health research projects with a focus on improving prevention, diagnosis and treatment. This programme supports research into a range of mental health conditions including depression, anxiety, eating disorders and also the development of new treatments and interventions. UKRI prioritises funding research that has the potential for impact on policy and practice.^{lxxxii}
- Another major source of funding for mental health research is the Wellcome Trust; an independent charitable concern making provision for research into the causes, treatment and prevention of mental health disorders. The Trust's range of available opportunities includes giving grants to early-career researchers, and funding for collaborative research programmes and infrastructure.^{lxxxiii}

However, according to the International Alliance of Mental Health Research Funders (IAMHRF), the overall funding landscape for mental health research (although varied) remains inadequate.^{lxxxiv}



A growing awareness of mental health issues in recent years has been unmatched by commensurate funding and global investment in research remained static at around \$3.7 billion per year in real terms between 2017-2019; roughly 50 cents per person per year. Funded mental health research is largely 'basic' and not 'translational' meaning that despite uncovering new knowledge of underlying phenomena, it cannot be applied to devising treatments for conditions.

Investment in mental health research funding is primarily concentrated upon adults (62%) as opposed to young people (33%) and the elderly (5%) and the IAMHRF report underlines the fact that unless funding for mental health science is greatly accelerated across the board, progress towards making significant beneficial difference to as many people's lives as possible will be far slower than is desirable and necessary.

It is increasingly seen that mental ill health in the UK population is a considerable drag on productivity and overall growth strategy. A report by The Mental Health Foundation and the London School of Economics (LSE)^{lxxxv} estimated that the overall cost of mental health problems to the UK economy was at least £117.9 billion per annum; approximating to 5% of UK Gross Domestic Product (GDP). The report's authors advised that the £117.9 billion costs are likely to be an underestimate; based on a lack of available data in some key areas:

Investment in mental health research funding is primarily concentrated upon adults (62%) as opposed to young people (33%) and the elderly (5%)



'Health service costs are based on the number of people receiving treatment and do not consider the many people who would benefit from treatment but do not receive it because of pressure on services or do not seek help. Additionally, no costs are included for reduced performance at work due to mental health problems, costs to criminal justice and housing systems linked to poor mental health, costs associated with addiction issues, or the costs associated with self harm and suicide.'

Almost three quarters of the cost (72%) is due to the lost productivity of people living with mental health conditions and the costs incurred by unpaid informal carers. Across the UK there were 10.3 million recorded instances of mental ill health over a one-year time span and the third most common cause of disability was depression.

Research by Deloitte^{lxxxvi} has found that:

- The cost to employers of poor mental health increased to up to £56 billion in 2020-2021 compared to £45 billion in 2019

- The cost of poor mental health to employers has increased by 25% compared to 2019
- 28% of employees either left their jobs in 2021 or were planning to do so in 2022 with 66% citing poor mental health.^{lxxxvii}

In the US and Canada, employers bear significant healthcare costs and therefore have a direct financial interest in improving workforce health and promoting early intervention. International studies have found that for every one dollar invested in a set of interventions, 24 dollars in health and economic benefits are expected to be returned to the economy over the course of 80 years. The studies also demonstrate that interventions with the highest acknowledged return on investment (ROI) were treatment of mild depression and school-based prevention of anxiety and depression.^{lxxxviii}

The Covid-19 pandemic has highlighted the long-term value of research investment and the Government's Life Sciences Vision^{lxxxix} has set out ambitious goals to make the UK the world leader in trialling and testing products at scale,

underpinned by an ever-improving genomic and health data infrastructure. It aims to encourage Life Science companies to flourish and grow in a superlative business environment in which innovation and investment align with incentives and structures supported by the financial weight of the City of London and underpinned by a world-class regulatory system. As the lynch pin, the NHS is envisaged as the nation's prime deliverer of innovation via the development, testing and embracing new technologies at population scale for use in enabling rapid and accurate diagnosis and treatment and building trust and confidence in the fruits of collaborative working between the NHS and the sector.

A secure long-term funding strategy for mental health research would involve:

- Commitment from the Government to guaranteed long-term investment in research and service delivery to include allocating dedicated funding streams, establishing sustainable budgetary provision and prioritising mental health within healthcare systems
- Public-private sector collaboration; engaging private organisations, philanthropic foundations, and corporate entities can diversify funding sources, increase the opportunities for investment and foster innovation in mental healthcare
- A central and respected role for the advocacy and awareness raising ability of mental health organisations and individuals with lived experience in reducing stigma, engaging and mobilising public support and sharpening political will to achieve the goal of a secure, long-term mental health funding strategy
- Methods of evaluating and assessing the impact of investment and ensuring accountability aligned to a secure funding strategy for mental health. Regular assessments of funded programmes, research outcomes and service delivery metrics can inform and improve decision making, optimise resource allocation and drive a continuous improvement in mental health services.

Funding both research and service delivery appropriately, would enable the Government to advance knowledge, develop effective preventive and early intervention strategy whilst simultaneously ensuring the accessibility, affordability, and quality of care for people who need mental health support. Mental health services should be viewed not as a drain on the economy, rather in the light of vital infrastructure and a public good. In this way, a secure funding strategy guaranteed by the Government could boost the economic health of the nation as well as enable a brighter, happier, and more productive future for individuals living with mental health conditions.

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CHAPTER 7: MENTAL HEALTH SERVICES AND RESEARCH: THE DEVOLVED UK NATIONS AND THE WIDER WORLD

By studying best practice in other countries, the devolved UK nations can enhance their own mental health systems, confront common challenges and improve the effectiveness of existing practices and programmes. Addressing the manifold challenges associated with mental health requires collaboration both nationally and internationally and the UK should contribute to, and learn from, the rest of the world in at least equal measure.

A clear imperative is in the field of research where forging international partnerships has the potential to foster cross-cultural insights, the sharing of expertise and the adoption of best practice. Collaborative action between the devolved UK and the wider world can advance the knowledge and understanding of mental health to mutual benefit via initiatives which augment the development of evidence-based practice and promote innovative interventions and effective policy frameworks.

Cooperation and collaboration are therefore critical to ensuring that potential breakthroughs in the understanding and treatment of mental health will be to the benefit of all. Leveraging their experiences, expertise and resources, the UK nations can contribute to mental health initiatives with a global resonance; helping to ensure that good mental health is an international priority and driving the collective impetus for positive change on a worldwide scale.

Mental health issues were thrust into sharp relief because of the Covid-19 pandemic and remain a growing cause for concern across the devolved UK nations. According to the Office for National Statistics, almost 1 in 4 women and 1 in 3 men report high levels of anxiety.^{xc}

In 2020, 5224 people in England and Wales, 805 in Scotland and 219 in Northern Ireland took their own lives.^{xcii} There is considerable variance in population size across the devolved nations but clearly it is necessary to explore what can be seen to work in each part of the UK. Although significant progress has been made in improving mental health services and

facilitating research overall, significant variations persist across the devolved nations leading to unequal access, differing quality of care and disparate outcomes.

Funding discrepancies are intrinsic to an uneven landscape of care, fuelling poorer comparative patient experiences. The overarching budgets for mental health differ across the devolved nations and within each nation, under-funded regions will result in reduced availability and accessibility of mental health service provision and increased patient distress.

Mental health services differ in range, scope, and availability across the UK. Rural areas are home to specific geographic challenges and individuals in remote or under served locations may find that they face potential delays in diagnosis and treatment and less access to essential mental health support.

In addition, the level of integration between mental health services, primary care and social care can vary across the devolved nations. Insufficient integration will lead to fragmented care pathways and the likelihood of individuals with complex mental health problems missing out on timely support from multiple providers. Different populations may be unable to access mental health services that are culturally sensitive and intrinsically diverse, leading to further marginalisation for certain communities including ethnic minorities, people identifying as LGBTQ+ and those living in circumstances of socioeconomic difficulty.

📍 SCOTLAND

In 2017, the Scottish Government launched a ten-year strategy for mental health^{xcii} Four priorities were identified:

- Prevention and early intervention
- Accessibility of treatment
- The link between physical and mental wellbeing
- A human rights-based review of existing legislation.

The review occurred in 2022 and a cross-party parliamentary group acknowledged that progress had been made despite the intervening pandemic. Initiatives such as the Mental Health Access Improvement Support Team had been introduced for example, in order to enhance service delivery and afford timely access to care. However, there was a need to do more to reduce inequalities in mental health provision and service.^{xciii}

📍 NORTHERN IRELAND

Northern Ireland has the highest suicide rate in the UK and this prompted calls for a ten-year strategy with a focus on prevention and early intervention.^{xciv}

The Northern Ireland Commissioner for Children and Young People stated that although awareness of the need for early intervention was increasing, under funded services remained unable to meet demand.

In 2021, the Northern Ireland Department for Health launched a ten-year Mental Health Strategy.^{xcv} This was the consequence of a collaborative process; co-produced with stakeholders including healthcare professionals and those who lived with or cared for people with mental health issues.^{xcvi}

The strategy is organised into three themes:

- Promoting mental wellbeing, resilience and good mental health across society
- Providing the right support at the right time
- New ways of working.

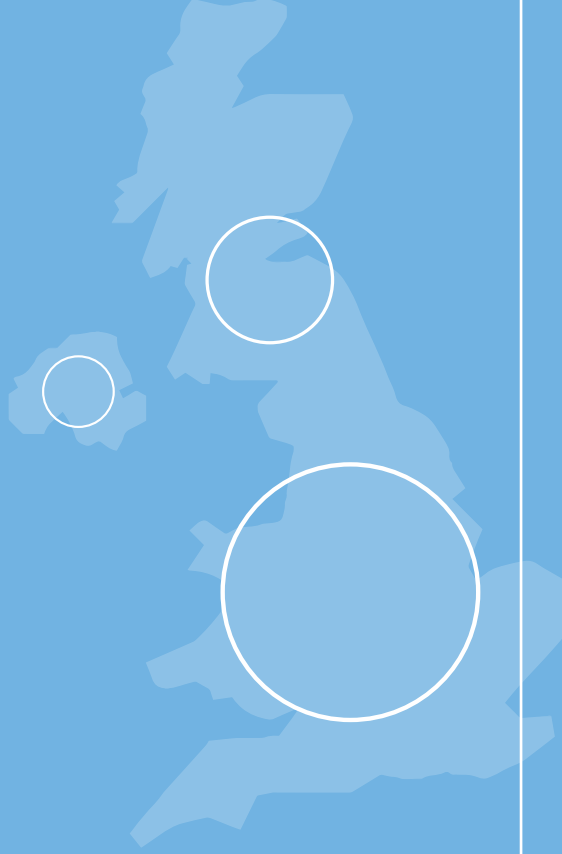
Initiatives like the Mental Health Crisis Care Concordat and increased investment in community services demonstrate Northern Ireland's resolve to improve mental health care. While it is too early to assess the overall success of the strategy, it has been accompanied by a significant financial investment and a commitment to reforming existing provision. The collaborative method of developing the policy is progressive as is the distinct emphasis on reform and innovation.

📍 WALES

Wales has also established a ten-year cross-governmental strategy for mental health.^{xcvii}

The strategy relies upon five themes:

- **Experience:** improving the availability of services and transition between services
- **Quality:** improving access to a range of psychological support



In 2020, 5224 people in England and Wales, 805 in Scotland and 219 in Northern Ireland took their own lives

- **Workforce:** improving the support available to those providing compassionate care
- **Prevention:** recognising the importance of informal non-medical support
- **Relationships:** emphasising shared decision-making and the relationship between professionals and people accessing support.

The Welsh Government has prioritised reducing stigma, improving services and promoting mental wellbeing in a variety of settings. The Mental Health Transformation Programme is a collaborative project; aiming to integrate mental health into primary care and strengthen community-based support.

Health Education and Improvement Wales and Social Care Wales have subsequently partnered to design a strategy focused on developing the social care workforce.^{xviii}

It is too soon to assess the impact that these strategies will have but it is significant that Wales has focused on the development of the workforce and the role of non-medical interventions.

ENGLAND

In England, the NHS Long Term Plan has outlined commitment to expand mental health services, increase funding and integrate mental health support into primary care. The vision of the National Institute for Health Research Mental Health Translational Research Collaboration (MH TRC) is to engage in world class translational research in partnership with academics, the life science industry and charitable organisations and to develop the foundations for improved mental health.^{xix}

The UK Government launched Health Missions to design cutting-edge new technologies and treatments; unlock next generational medicines and diagnostics to save lives, transform patient care and ensure that UK patients are best placed to benefit from medical breakthroughs. £40.2 million was ear-marked for Mental Health research that could include technological advances to enable patients to monitor their health at home and report to their doctor if necessary. The funding (which is limited to England) will be spent in the Midlands and the North to strengthen services and level up support geographically. However, in common with the NIHR TRC, the finance for this initiative will support the infrastructure for research to occur rather than covering expenditure on research activities.

To date, there is no ten-year plan for mental health in England and in January 2023, the Secretary of State for Health and Social Care announced the Government's intention to develop a 'major conditions strategy' which would include mental

health support alongside cancer, dementia and cardiovascular disease.^c

As in Victorian times, this step implies that the Government sees mental health in the light of a purely 'medical' issue; in sharp contrast to the approach taken by the other UK devolved nations where there is a much greater emphasis on social care and therapeutic approaches. It is also concerning that the opinions expressed in the 28,000 responses to the 2022 consultation, (raising the need for a ten-year strategy) appear to have been summarily dismissed.^d

The seemingly arbitrary shift from a ten-year strategy for mental health towards a 'major conditions' strategy indicates a lack of understanding in face of the mounting incidence of mental illness in the UK and elsewhere and a composite picture of a service under immense strain in every respect from research capacity to the provision of preventative, early intervention and therapeutic measures and development and training at every level of the mental health workforce.

By working together, the devolved nations of the UK can spur a global impetus toward better mental health support; ultimately improving the lives of individuals both within national borders and throughout the wider world but as of now:

- England is lagging behind the other devolved UK nations. A ten-year strategy for mental health must be introduced as of urgency
- The strategy must acknowledge the breadth of the mental health workforce; ensuring that there is adequate and sufficient training and support for all frontline workers to include mental health professionals, teachers and social workers
- There must be significant and immediate financial investment in Mental Health ensuring that UK patients wherever and however they live can benefit alike from scientific discovery that is truly translational and ensures that they get the diagnosis, treatment and care that they require; delivered in a way that dispels stigma, build trust and is culturally appropriate to all communities.



CHAPTER 8: THE KEY COMPONENTS OF A 10 YEAR MENTAL HEALTH PLAN

‘Poor mental health and poor wellbeing have an impact on every part of society, and every part of society has a role to play in supporting positive mental health and wellbeing.’^{cii}

The Government consultation sought to inquire around the areas of wellbeing and health promotion, prevention, early intervention and service access, treatment type and safety, quality of life for those living with mental health conditions, crisis care and support and stigma with the opportunity to raise ‘other’ areas. The Department received a huge response from over 5,000 organisations and individuals, including thousands with lived experience who fed into commissioned surveys.

Yet in January 2023, Secretary of State for Health and Social Care, Steve Barclay scrapped plans for a specific long-term plan for mental health in favour of making it just one of several conditions in a new Major Conditions Strategy.

Good mental health is essential if individuals are to thrive and communities and nations to be economically and socially productive. The UK and its citizens need and deserve a comprehensive and effective 10-year Mental Health Plan.

What should be in it?

1. Prevention and public awareness

A vital component of a Plan must be prevention. A meaningful and integrated partnership between Ofsted and early years, primary, secondary and higher education settings with national health strategy use is crucial in achieving this aim. In the US, an accessible School Health Index is readily available for nationwide implementation.^{ciii}

A UK ‘whole school mental health approach’ should be implemented systematically with all schools having access to practice and evidence-based targeted mental health support from qualified professionals with expertise in working with children and young people. Mental health and wellbeing

should be an intrinsic component of Teacher Training (ITT) and Continuing Professional Development (CPD) programmes and in an amended curriculum, Preconception Care would be a syllabus requirement with Physical Education acquiring core subject status.^{civ}

Investment in public awareness campaigns and community initiatives empowers individuals to recognise and manage their mental wellbeing and the Plan should focus on local, place-based services. Local authorities are acknowledged pioneers in preventative health/wellbeing strategies and established evidence suggests that for every £1.20 spent on preventative services, a further £1 saving accrues to the NHS.^{cv} Councils must now be given the budget security to continue developing preventative community services that are less costly, more likely to be effective and can deliver savings to other parts of the public sector.^{cvi} They are ideally placed to take a lead in promoting inclusiveness, instigating positive mental health education campaigns, challenging stigma and stereotyping and encouraging people to seek early help without fear of discrimination or judgement.

2. Early intervention and timely access

The Plan should prioritise early intervention and timely access to mental health services across the age range to ensure that effective support is made available as soon as problems occur. From 2010, government cuts have seen public health spending reduced by 24% in real terms with deprived communities faring worst.^{cvi}

Responding to the 2022 Government call for evidence, the Mental Health Policy Group (an informal coalition of six national organisations working together to lobby for improved mental health policies) suggested that 4% of public health spending should be ring-fenced for public mental health.^{cvi}

Early intervention would involve establishing comprehensive screening programmes, training professionals in early detection and integrating mental health support within primary care and educational settings as appropriate. Conditions would include anxiety, depression, self-harm, eating disorders, children and young people presenting with neuro-divergence and those affected by adverse childhood experiences (ACEs).

Support and guidance should be early at any stage in life, accessible and not subject to undue bureaucracy but obtaining help is a lengthy process and conditions can sometimes reach crisis levels before support is given. A House of Commons report on Mental Health Statistics: prevalence, services and funding in England states that waiting times for NHS talking therapies (IAPT) vary from 4 to 229 days depending on geographical location and social grouping.^{cix}

Reduction of waiting times and improving access to practice and evidence-based treatments and therapies are essential to avoid the escalation of mental health conditions. In the case of severe mental health illness such as psychosis; early intervention is imperative.

3. Integrated, holistic service provision and addressing health inequalities

A 10-year Mental Health Plan should ensure that services are both integrated and holistic; addressing the diverse needs of individuals with mental health conditions.

This includes a multidisciplinary approach involving psychiatrists, psychologists, social workers and other healthcare professionals acting collaboratively to provide care that is person-centred. Integrating mental health with other healthcare services such as physical health and social care will encourage the formation of a comprehensive and co-ordinated support system.

The Plan should also ensure that health inequalities are faced and addressed. People suffering financial stress are at particular risk of mental health issues and poor mental wellbeing.^{cx} Problems from existing poverty, the historical 2008 recession and the Covid-19 pandemic leave these same groups more vulnerable to mental ill health.^{cx}

It is essential that a 10-year Mental Health Plan should be cross-governmental and include co-ordinated action to reduce child poverty and inequality whilst simultaneously recognising the corroding effect of institutional racism. The plan should include action to be taken by NHS England to reduce barriers to ensure that statutory funding linked to the rollout of the Community Mental Health Framework reaches organisations working with black and minority ethnic communities (including infrastructure funding) so that organisations have sufficient capacity to engage their communities in systems change.

4. Sustainable funding for research, mental health services and workforce development

Allocating funding for research, clinical trials and technology-driven solutions can facilitate the development of evidence-based practices, improved treatment modalities and innovative interventions. Dynamic collaboration between academia, industry and healthcare providers can accelerate progress in understanding mental health conditions and developing more effective interventions. It is also essential that mechanisms for monitoring and evaluating the effectiveness of funds allocated must be established in the interests of transparency and accountability.

5. Developing the workforce and capacity building

A robust 10-year Mental Health Plan requires investing in workforce development and capacity building. The entire mental health workforce needs secure long-term investment involving increasing the number of mental health professionals at every level and across the sector; enhancing their skills through specialised training that is regularly updated and providing ongoing support and supervision. Creating a positive and well-resourced working environment and stimulating career development opportunity is crucial for retaining skilled professionals in the mental health sector and attracting talented people to join it.

The children and young people’s mental health workforce in particular needs the security of long-term investment. This should include financial support for the voluntary sector as a provider of training, qualification and as an employer. The potential of bursaries and training subsidies with voluntary sector providers should be investigated and financial assistance provided for the training of counsellors and play and creative arts therapists who work in school and community settings.

6. Partnership working and collaboration

Effective and dynamic collaboration among government agencies and departments, healthcare and education service providers, community organisations and individuals with lived experience is fundamental for a successful 10-year Mental Health Plan. Establishing formal partnerships, involving service users and their families at the heart of all activity and decision-making processes and engaging with the voluntary and community sectors can lead to mental health services that are effective, efficient, person-centred, responsive and responsible.

Such a Plan will only work if it wins the collective support of policymakers and all stakeholders working together to make it happen – but if this can be achieved, the UK will have systems in place that value and prioritise mental health and a society in which those who have mental health conditions can walk tall throughout every stage of their journey through life.

RECOMMENDATIONS FOR A 10-YEAR MENTAL HEALTH PLAN

1. **Prioritising prevention and increasing public awareness**
2. **Facilitating early intervention and timely access to services**
3. **Promoting integrated, holistic services and addressing health inequalities**
4. **Guaranteeing sustainable funding for research, mental health services and workforce development**
5. **Growing the workforce and capacity building**
6. **Partnership working and dynamic collaboration**



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