Mental Health Foundation submission to

DHSC: Mental Health and Wellbeing Plan Discussion Paper Call for Evidence

The Mental Health Foundation

Our vision is for a world with good mental health for all.

The Mental Health Foundation works to prevent mental health problems.

We drive change towards a mentally healthy society for all, and support communities, families and individuals to live mentally healthier lives, with a particular focus on those at greatest risk. The Foundation is the home of Mental Health Awareness Week.

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Introduction

The Mental Health Foundation (MHF) welcomes the Mental Health and Wellbeing Plan discussion paper, and the government's commitment to developing a ten-year genuinely cross-government plan with a strong focus on promoting good mental health and preventing mental health problems.

In this submission, we have sought to present our evidence and recommendations for the Mental Health and Wellbeing Plan as they relate to the different age / population groups covered by the consultation. As we are a public mental health charity, the focus of our submission is on the promotion, prevention, and early intervention sections of the consultation.

A referenced version of our online survey submission is also available on request.

Overview of evidence sources for our submission

In our submission we have included evidence from the literature and our own research, combined with insights from MHF's Our personal Experience Network (OPEN), and from our own work in communities.

MHF runs a number of community projects to benefit people whose circumstances mean they are at elevated risk of poor mental health. In this way, we provide evidence of prevention in action. Each evidence-based project utilises one or more of the following approaches, and some will use all of them:

1. Providing information/education about mental health, for example psychoeducation, evidence-based advice.
2. Developing skills/strategies to support people to feel more empowered/in control, for example through problem-solving in the self-management model or sharing strategies around managing difficult emotions.
3. Increasing relational/social contact, for example through peer support, peer education, group work.
4. An activity with some evidence base around positive effect on mental health, for example involving nature, or creative activity which provides a sense of connection through common experience.
5. A systemic component which places individual, family or group mental health in a broader systemic or societal context, for example training, systems change, a policy element.

In this submission we have included the views of some of our project beneficiaries **(including in the Annex)**, evidence from project evaluations and some case studies of our projects.

We would be happy to arrange a visit to one of our current prevention projects if this would be of interest to the Minister or to officials.

Our vision for a Mental Health and Wellbeing Plan

Principles informing the strategy

The Mental Health and Wellbeing Strategy should deliver **better mental health for all**. It should include a major focus on reducing mental health disparities and on levelling up the experience of those who are marginalised, and whose social and economic circumstances mean they are at greater risk of developing poor mental health.

The strategy should take **a preventative approach**, seeking primarily to prevent people from developing mental health problems before they reach the level of clinical need. An important part of this is **providing at scale the many well-evidenced interventions** that are effective in preventing mental ill health, and also cost-effective.

The strategy must be **genuinely cross-government**. Mental health should be the business of all government departments. The social determinants of mental ill health fall within the policy areas of departments across government and cannot be influenced within DHSC alone. This should be formalised by giving the cross-government ministerial board on prevention oversight of the strategy's implementation.

Mental health and wellbeing should be at the heart of every government policy. This should be supported by the **mental health policy tool** that is currently in development by DHSC to provide a common framework for Departments to assess their level of actual and potential mental health impact.

To ensure that departments have a focus on the mental health impacts of policy moving forward, it is essential that the plan includes a **commitment for the mental health policy tool to be fully implemented by all departments**, and utilised and completed in a transparent way for all policy development.

Improving wellbeing should be the central aim of government. This should be formalised by adopting an approach similar to New Zealand's Wellbeing Budget or the approach in Wales enshrined in the Well-being of Future Generations (Wales) Act 2015.

The strategy should have measurable, achievable goals shared across all departments of government, and supported by a publicly available dashboard that tracks progress against the main indicators. This is important for driving joint working at a local level.

The strategy should take **a proportionate universalism approach**, balancing universal provision with resources targeted to those known to be at greatest risk. Those who live in the most deprived areas should benefit the most from the provisions of the plan.

Everyone should be included – new mental health policies and interventions should be informed by **co-production** and **co-design**, at both national and local level.

Mental health support should be **holistic and individually-centred**, while also ensuring that the right conditions are in place for people to thrive, and to receive early, timely, appropriate support when they need it. It should take account of a person's history, experience of trauma, and their social, economic and cultural context.

There should be **no 'wrong door'** to mental health support.

Tackling inequalities

Tackling inequalities must be central to the new strategy.

One way of conceptualising the inequalities at the heart of mental health problems is to break them down as economic, relational, health, and environmental inequalities.[1]

Economic inequalities include poverty, academic achievement, and employment status.

Relational inequalities include race, gender, sexual orientation and gender identity, childhood adversity (in particular emotional, physical and sexual abuse and neglect), domestic violence and abuse, trauma, immigration status, and loneliness.

Health inequalities, as risk factors for mental health, include physical health status, ageing, and disability and long-term conditions.

Environmental inequalities include housing/shelter, neighbourhood safety, access to green and blue spaces, and public infrastructure.

To tackle these inequalities, the Mental Health and Wellbeing Strategy must engage meaningfully with reducing disparities.

The strategy must seek to reduce economic disparities; prevent Adverse Childhood Experiences (ACEs), including domestic and sexual violence and all other forms of child abuse, and discrimination; create mentally healthy environments; and track the socio-economic influences on mental health.

The strategy should seek to build healthy communities by building assets at a community level, such as affordable housing, safe public spaces that promote connections between people, and trauma-informed services. Support and intervention programmes should similarly take a strengths-based to working with individuals, families and communities.

The approach taken should be proportionate universalism: balancing universal approaches that benefit everyone with targeted approaches that allocate resources according to levels of need and risk.

The government should work closely with members of the inequality groups that it seeks to benefit, employing principles of coproduction and codesign.

As an example of a coproduced intervention, we ran a programme called **Comhar** to reach Irish men, a group at elevated risk of suicide in Camden. The project evaluation highlighted the benefit of using targeted, culturally sensitive interventions to ensure they are acceptable to the intended beneficiaries. A well coproduced intervention should give participants a greater sense of choice and agency in their lives, and empowering participants to self-manage their feelings can help to give them a sense of achievement, all of which is beneficial to their mental health.

Tackling trauma

In recent years, understanding of trauma has grown exponentially. There is both a greater awareness of its prevalence in society and deeper knowledge of its long-term effects on survivors. With this has come recognition of the role organisations and institutions often play in perpetuating trauma, inadvertently causing further harm to some of the most vulnerable people they work with.

The government can shift this paradigm by adopting trauma-informed care principles as standard across all its services.

In 2018, the VCSE Health and Wellbeing Alliance, a partnership between the Department of Health and Social Care, NHS England and Public Health England commissioned the Mental Health Foundation and the Centre for Mental Health to produce a report on trauma-informed care for women.[2] Publication of 'Engaging with complexity' followed the 2018 Women's Mental Health Taskforce report,[3] whose recommendations included the wider use of trauma-informed care. The report contains a set of principles for providing trauma and gender-informed care, intended to be used as a high-level, strategic tool to help providers, practitioners and commissioners at a local level consider the specific needs of women with mental illness. These should be widely adopted as good practice, and this should also inform the mental health elements of the Women's Health Strategy.

The Mental Health Foundation ran a series of workshops with the Centre for Mental Health on what trauma survivors thought trauma-informed care should look like. The theme that came across most strongly was that services should put people before protocols. The workshops highlighted the inescapable necessity of services being willing and able to engage with complexity, remaining receptive to the different and changing needs of people who access services, rather than seeking to specify these needs in advance.

From the workshops, four processes emerged as fundamental to trauma-informed care: listening, understanding, responding, and checking. **The Mental Health and Wellbeing Plan must put these processes at the heart of how public services interact with service users, especially where they regularly interact with vulnerable people.**

The government must also focus especially on trauma in childhood. Adverse childhood experiences lead to a substantially higher risk of poor wellbeing, mental ill

health, and other negative outcomes during the whole lifetime of the person affected.[4] For example, analysis shows that 46% of individuals with depression[5] and 57% of people diagnosed with bipolar disorder report high levels of childhood maltreatment.[6] A landmark study found that experiencing a high number of ACEs (four to six compared to zero) increases the chance of depression by 460%, suicide attempts by 1,220% and intravenous drug misuse by 4,600%.[7]

Prevention across the life course

Families and infants

From a prevention perspective, the early years are the most important.

Secure attachment

A crucial component of a mentally healthy childhood is secure parental attachment. The government's approach to the mental health of infants should seek to educate parents from all backgrounds about how to develop secure attachment with their infants, and secure attachments should be considered one of the key indicators for success of this section of the strategy.

Parenting education

There is currently no universal learning offer for parents about good parenting, developing secure attachment, and understanding the normal physical and emotional development of infants. The government's strategy should seek to ensure that all parents, regardless of their circumstances and background, are equipped with the skills and knowledge to raise a mentally healthy infant and protect their own mental health as a parent. We also recommend that healthy emotional development of infants, and the role of good parenting, should be taught in the school curriculum as part of RSHE (Relationships, Sex and Health Education).

In the community, evidence-based parenting programmes should become part of the universal offer to parents. A study of the Triple P programme in Ireland has demonstrated some significant reductions in the prevalence rates of children's social, emotional, and behavioural problems, and shown that a universal parenting programme implemented at multiple levels using a partnership approach may be an effective population health approach to targeting child mental health.[8]

Such programmes also offer excellent return on investment. Our report 'The economic case for investing in the prevention of mental health conditions in the UK' identified 'universal and targeted manualised parenting programmes' as one of the 'best buys' in terms of return on investment.[9] Analysis by the Washington Institute for Public Policy in the US found the potential long-term payoffs from the Incredible Years parenting programme were £5.65 per £1 spent over 50 years, whilst for the Oregon model parent management training programme these long-term benefits were £9.30 for every £1 spent over 50 years.[10] These savings take account of reduced repetition of school years, need for special educational support, as well as less use of health care and reduced criminal justice system involvement for children.

They also account for reduced impacts of major depression on the earnings, mortality, and health of parents.

In England, there are disparities in the groups that access the parenting support that is currently available. Ensuring the inclusion of families who do not readily engage with services is core to supporting families' wellbeing. Working within the community, in well-connected multi-sector settings such as Family Hubs, has the potential to provide a non-stigmatising space for families to seek help early to prevent difficulties from arising. **The Family Hub programme should be expanded beyond the 75 local areas currently receiving funding to set up Family Hubs.**

Barriers to accessing support

The government should also seek to reduce the barriers to families accessing support.

Centre for Mental Health research[11] shows that many mothers do not seek help for their mental health during the perinatal period because:

- 46% Worry that the health professional would think they are incapable of looking after their baby
- 37% Feel embarrassment or shame
- 33% Assume their feelings were normal for a new mother

Proactively reaching families where they feel most comfortable will help to address these barriers to help-seeking. Doing this preventatively, before families reach a point of crisis, is when families can meaningfully engage with guidance, information, and support to manage their own wellbeing and protect the wellbeing of their infant.

Peer support

Using peer-led information, support and education can also reduce barriers to families getting the information they need to support their own wellbeing by making support more approachable and relatable. Again, this is best done early, before families reach a crisis point. Being in a heightened state of difficulty can prevent families from being able to use psychoeducation and similar tools that empower them to manage their wellbeing as a family unit. Providing peer-led information and support helps to destigmatise opportunities for families to be empowered before they deteriorate, enabling prevention of mental health crises through early help-seeking.

The evaluation of the Mental Health Foundation's peer-led **Young Mums Together** project helped young mothers to feel more connected to other mums, increased their parental confidence, built their resilience, and enhanced their confidence in their future prospects.

Joined-up services

Joined-up support and service provision, such as that envisaged in developing Family Hubs, allows families to get wraparound support targeted to their unique needs. Families that have to chase for multiple areas of support from multiple service

or support providers, when they have complex and multiple needs, usually focus just on their immediate needs of clothing, food and housing.

For example, in the Mental Health Foundation's **Young Mums Connect** groups, mums can come for food, peer support, and play opportunities for their baby. They can learn about parenting and wellbeing together, but they can also get support in the group with issues related to housing concerns, gas and electricity, help with food provision, and other practical needs.

This is a critical dimension of the support they need: when parents are fighting to survive, there is no scope to engage with wellbeing services, and their own wellbeing and that of their children is at risk.

Families often feel stigmatised and have a heightened sense of power imbalance and vulnerability when they are struggling for basic necessities such as housing and food. By providing a nurturing environment that enables families to eat as part of a wellbeing initiative, families can feel physically and mentally cared for. Their wellbeing is supported, and they are more ready to engage with wellbeing initiatives in this context.

Care and kindness

Given the importance of kindness to our wellbeing, policies affecting our mental health should not ignore kindness. Rather, they should be fundamentally concerned with what kindness gives individuals and communities, and how the conditions can be created to foster the support and inter-connectedness it offers, including through services that are experienced as being more responsive to people's needs. To quote Anderson and Brownlie: 'Kindness is about social practices and the conditions under which these are more, or less, likely to occur'.[12]

It is therefore a value that should inform both policy intent, and assessment of its impact on our mental health and wellbeing, across the whole of government. There are signs that this is beginning to be recognised. For example, in its 2018 National Performance Framework (NPF), Scotland adopted kindness as one of its values, stating that: 'We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way'.[13]

In England, the 2019 NHS Patient Safety Strategy recognises the important role of kindness and civility in **creating a positive healthcare culture that supports and promotes patient safety, through the valuing of staff and their contributions**, and understanding and addressing factors that might lie behind unkind or uncivil behaviour. Role-modelling kind behaviour is identified as important, giving the examples of: smiling and saying hello in the hallway, saying thank you, recognising what people do and listening with intent.[14]

Our focus groups highlighted the importance of care and kindness in clinical and personal relationships. This is especially true for parents, as parenting can be an isolating experience.

However, for those relying on services, a Centre for Mental Health survey found that a significant minority (27%) of parents reported that that health professionals did not

seem interested in their mental health, such as during home visits.[11] Declining health visitor numbers also mean that remaining health visitors are dealing with an unmanageable workload and are not always able to give parents the quality of care that they need.

The new strategy should also recognise that public mental health extends beyond providing programmes and services. **Local authority policies should** also **be informed and guided by the value of kindness**, and creating the physical conditions for kindness and connection to grow and thrive. **Financial, architectural and planning decisions about the built environment affect our social environment, and can create or inhibit opportunities for incidental social interaction,** as well as longer exchanges in 'third places' such as libraries and community centres.[15]

Strong and positive family links can also be a protective factor, and these need to be promoted and supported by employers, for example through flexible working practices and carers leave policies in workplaces:

"I got married and I had my first child and my mother helped me through that… because I didn't know anything about having a baby, but my mum guided me. She showed me how to hold a baby, how to do everything… Fortunately for me, we had our mum and she guided us, she supported us, and she loved us dearly".

Targeted interventions

We can further improve the wellbeing of infants and their parents and primary care givers by targeting support to those at the highest risk of experiencing mental ill health.

For example, single parents are at higher risk of poor mental health.[16] Our Creating Connections programme aimed to develop self-management skills and offer peer support for single parents in Wales. The programme evaluation found a significant increase in wellbeing from baseline to six months after the project finished, and 76% of single parents (30/40) surveyed had achieved their goals within six months. These goals were far-ranging but included employment, education and volunteering, self-improvement and relationship improvement.

Single parents also said that attending Creating Connections benefitted them because it increased their confidence and helped them to understand the importance of looking after their own health and wellbeing, gave them advice on where to get support locally, and they valued sharing experiences and making friends:

'It is easy to get into a really negative rut and think of only the negative things about my situation. The course helped me to think of all the positive things of being a single parent and to enjoy being more in control.'

'I was having a problem with my ex and getting on with him. I knew how important it was that I managed to 'get on' with him for my son but I was finding it really difficult, as he was sometimes really challenging, and I would rise to it. Sharing this with the group helped me to get some ideas on how to deal with this problem and now I don't

rise to him and take the upper hand. It has really helped us with our relationship, which I know is important to my son.'

'I enjoyed the fact that some of the other people in the group had come through this and were OK. When I first came to the group, I had felt that nothing was ever going to be OK again, but to see other people who had managed made me feel like "I can do this too".'

Health visitors

The government should invest in increasing health visitor numbers: our report on the economics of prevention identified universal health visitor-delivered identification of risk of perinatal depression in women, followed by provision of psychological therapies, as one of the 'best buys' in terms of their effectiveness and return on investment.

Reaching out, building positive relationships with parents and showing genuine interest in their wellbeing, will encourage parents to proactively seek help and trust that services will be there to support them when things are not going so well. Another critical element of this must be evidence-based parenting programmes, as recommended above.

Families, children and young people

The most important thing we need to do to reduce the number of children and young people who experience mental ill-health is ensure that the places and settings in which they grow, live and study support their mental health and do not harm it.

In particular, this must include addressing issues such as poverty, consideration of the culture of schools and other educational settings, providing early support for difficulties in family functioning and relationships, including working with families in which a parent has mental ill-health, and ensuring that every looked-after child has the support of at least one good adult in their lives, for example through well-evidenced mentoring schemes.

School experience

We ran a focus group with young people to inform our answer to this question. The young people were drawn from the Mental Health Foundation Young Leaders group, hosted by Leaders Unlocked. The group is comprised of 14–25-year-olds from diverse backgrounds and a range of different lived experiences of mental ill health.

Our Young Leaders focus group felt that improving school experience was the most important thing we can do to address the number of children and young people who experience mental ill health. A survey we ran with MHF's Our Personal Experience Network also found that 48% of participants felt that education was one of the three most important areas to address.

With this in mind, the government should work towards putting the whole-school approach to mental health wellbeing on a statutory footing so that all schools implement the approach and benefit from it. DfE and Ofsted should review

accountability systems to prioritise wellbeing and to ensure that the incentives to perform well in exams are not at the expense of child wellbeing.

The young leaders also felt that there is a noticeable lack of mental health support in secondary schools and not enough mental health education. They found it particularly difficult to engage with counsellors – where they were available – who were not representative of their background and experience. There is a clear need to ensure that mental health support staff are available in all schools and particular attention should be paid to improving the diversity of the workforce.

Case study: Becoming a Man

Becoming A Man (BAM) is a secondary school based social and emotional learning programme, licensed from the US. This programme has an excellent evidence base, including two randomised control trials (RCTs) showing reduction in offending and violent crime and improvements on academic measures.[17,18] The Early Intervention Foundation in England gives this programme an evidence rating of 4, the highest available.[19]

The programme aims to help young people to reach their full potential, make effective decisions in their lives and instil the values and skills necessary to succeed and contribute to society. Young people develop skills surrounding a positive identity, resilience, and a sense of belonging through group sessions led by a 'pro-social' male councillor.

The Mental Health Foundation is currently delivering BAM in schools in Lambeth to young people aged between the ages of 13 to 17, with the programme spanning two years. Evaluation data from year one of our programme has revealed that young people have reported positive social-emotional development during their time in BAM, specifically, of 51 students we surveyed: 75% improved on empathy; 63% improved on reflection; 59% improved their relationships with adults; and 57% improved on emotional control.

The programme typically works with pupils that reside in deprived, racially segregated, areas and come from lower socio-economic backgrounds, and therefore usually aims to benefit those who have been identified as needing support with social and emotional wellbeing, and the utilisation of healthy behaviours. Central to the success of the programme is the relationship between the young people and the counsellor; the counsellor is a male role model whom the young person can personally relate to, specifically in regard to race.

Our interim findings for delivering the programme in England show that:

- 97% say their counsellor always listens to them.
- 76% say they always trust their counsellor.
- 100% say their counsellor always believes they will be a success
- 91% of young people would recommend BAM to other people of their age

According to Social Identity Theory, individuals can experience a collective identity based on their membership in a group (such as racial/ethnic gender identities). Groups give us a sense of belonging to the social world, and affiliation with a group confers self-esteem. It is therefore not surprising that our interim findings have found that young people have formed positive relationships with their BAM counsellor, given that individuals are more likely to experience a sense of belonging and acceptance, with and from those they can personally relate to.

While the roll out of Mental Health Support Teams is welcome, the pace is not quick enough, and many schools remain without support. The introduction of a trained Senior Lead for Mental Health in schools is also a welcome development, but it is important that mental health training and knowledge should not exclusively be the responsibility of this member of staff and that the position should support the ethos of a whole-school approach to mental health and wellbeing. The young people we spoke to felt that all teachers needed better training to be able to recognise the signs of mental distress and to have the knowledge and confidence to intervene.

This sentiment was echoed in other focus groups we held to inform our evidence submission:

'When I was in school there was no support at all and there [were] such obvious signs of mental health decline that weren't being picked up on… As far as I'm aware, I don't believe that teachers…and other support workers are trained enough to pick up on those little signs, those absences we're seeing, and instead of penalising that young person, why aren't we asking: "Look, is there something else that you need to talk to us about?"'

The suggestion that young people feel 'penalised' at school also came up in the Young Leaders focus group in the context of behaviour: the Young Leaders argued that behaviour was often an expression of poor mental health, and a punitive, disciplinarian approach could be counterproductive. Behaviour management should take a more relational approach and be mindful that poor behaviour is regularly indicative of one or more deeper issues that need to be resolved.

The young leaders also reported that there were other aspects of the school system that were not conducive to good mental wellbeing. Many felt that there was inadequate support around transitions and at exam times. Schools appear to prioritise exam results over young people's wellbeing and this is likely due to the competitive system of accountability surrounding exams, combined with a lack of accountability and transparency around supporting mental wellbeing in schools. **Ofsted should add the whole-school approach to mental health and wellbeing to its inspection framework to demonstrate that mental wellbeing is a priority, on a par with academic achievement.**

Whole-school approach to wellbeing

While the phrase 'whole-school approach' to mental health and wellbeing has appeared in a number of government publications, the concept is not yet fully apparent in actual policy. **We recommend the introduction of a statutory 'mental**

health and wellbeing policy' in schools which would publicly set out the ways each school is promoting a whole-school approach to mental health. This would be a low-cost intervention that would help to codify the concept of a whole-school approach in practice.

Mental health literacy

Children and young people can improve their own wellbeing if they have a good understanding of their own mental health, their emotions, and healthy coping strategies. There is already an expectation that schools should teach some of these topics through the Relationships, Sex and Health Education (RSHE) curriculum. However, the current curriculum errs too far on the side of providing schools with flexibility, likely resulting in a wide variation in what schools teach and how schools prioritise time for the RSHE curriculum. **We recommend that there should be clearer expectations on how much time schools dedicate to different aspects of the curriculum and a more detailed core curriculum – especially for mental health – that is sequenced by year group and key stage.**

Peer support

The government, schools and local councils can also support children and young people to improve their own mental health by facilitating greater access to peer support and peer education. In our engagement work with young people for this consultation, we heard that peer-led interventions are seen as more acceptable and relatable than those offered by adults.

Case study: Peer Education Project

The MHF Peer Education Project (PEP) is a school-based peer-led programme aimed at supporting young people to develop the skills and knowledge they need to safeguard their mental health, and that of their peers. Year 12 students are trained to deliver five sessions to Year 7s aimed at building an understanding of how to maintain mental health, knowledge of sources of support, confidence to support peers and more.

The Anna Freud Centre's evaluation of the project, which runs in UK schools, found that a majority of trainees (57%) found it helpful to learn about mental health from peer educators instead of from their usual teacher.[20]

"I was really delighted at how much more receptive Year 7s are to comments from Year 12s than from people of my generation, and I think I had underestimated the very positive nature of that." – Staff implementer from our MHF programme.

Both student trainers and trainees experienced a 'significant improvement in their understanding of key terms and skills related to mental health and wellbeing'. Specifically:

- 50% of trainees and 20% of trainers improved their understanding of 'stigma'

- 28% of trainees improved their understanding of ‘discrimination’
- 27% of trainers improved their skill of ‘knowing when to ask for help’, and 18% improved their skill of being able to ‘talk openly’
- 22% of trainees improved on their ability to ‘talk openly’ and 21% improved on their ability to ‘knowing how to keep well’

These findings are encouraging, given that a high proportion of students in our sample already endorsed these areas of knowledge/skills prior to participating. As scores were already high, there was less room for them to substantially improve over time. Despite this, we still saw areas of improvement, illustrating the effectiveness of the programme. In line with this, more student trainers and trainees agreed they were confident to talk about mental health and feelings at school and outside of school, after completing the peer education sessions, compared to before, illustrating the effectiveness of a peer education approach.

The success of the programme is further illustrated by the fact that 75% of student trainers reported that they would definitely recommend this programme to others, and 23% said they would maybe recommend it. Additionally, 43% of trainees stated that they would definitely recommend other students taking part and 45% said they would maybe recommend it.

Bullying

Bullying is a direct and well understood risk factor for poor mental health.

Persistent bullying can adversely affect mental health at all ages, although most initiatives that have looked at ways to counter this issue have focused on impacts on young people. UK evidence suggests that young people who are frequently bullied are more than 2.5 times more likely to use mental health services, both in childhood and adolescence, than other young people. Even in midlife up to age 50 they have a 30% higher likelihood of using services compared to their non-bullied peers.[21] For school-aged children, bullying may mean greater use of school and specialist child mental health services.

Persistent bullying can also affect school performance and can increase truancy; this may also mean that the police, social welfare services and families have to spend time either looking for or supporting young people outside of the school system. There are also impacts on educational attainment, which in turn may ultimately lead to poorer employment prospects in adulthood and lower earnings when in employment.[22,23]

Being the victim of bullying in childhood is associated with significantly increased levels of psychological distress as an adult, at ages of 23 and 50, compared with young people who were not bullied. Children who had been frequently bullied were significantly associated with greater rates of depression, anxiety disorders, deliberate self-harm, suicidality and poorer cognitive health at age 45.[23]

There is strong evidence that measures targeted universally at school populations to address bullying help reduce the incidence of bullying and have positive benefits for

mental health. These interventions can also lead to better outcomes for the perpetrators of bullying. Such programmes can also deliver significant returns on investment.[24]

Our recent report with the LSE on the economic case for investing in the prevention of mental health conditions in the UK[9] found that in-school anti-bullying programmes emerged as one of the best evidenced, cost-effective interventions. A Finnish anti-bullying programme, KiVa, achieved a short-term return on investment (ROI) over four years of £1.58 for every £1 invested. This rose to £7.52 ROI for every £1 invested over the longer term once reductions in lost adult earnings and use of mental health-related services were accounted for. This analysis is still conservative, as other impacts, such as potentially higher rates of teenage pregnancy and contacts with the criminal justice system seen in some longitudinal studies, are not included in this model.[25]

Anti-bullying programmes can also have wider positive effects within schools. There can be immediate benefits from better school atmosphere and less school disruption, as well as longer term benefits if educational outcomes improve. A recent trial in England of Learning Together went further, and also focused on changing the school atmosphere; this was found to have had a significant, albeit small, impact on levels of bullying in schools[26] as well as less classroom disruption and truancy.[27] The latter has important relevance for consideration of behaviour in schools.

We therefore recommend that the whole-school approach to mental health and efforts to address behaviour should include the introduction of evidence-based anti-bullying programmes, which can help to reduce mental health problems among children and young people, and longer term, in adulthood. This could represent an expansion/extension of existing joint working between DHSC and DfE to address mental health problems in the school setting.

Benefits of physical activity

In the same report, we found that increased physical activity at all ages improved mental wellbeing and provided a positive return on investment.[28]

Family context

Outside of school, it is essential to consider children and young people's wellbeing in the context of their families. Children live in a context of family homes and communities (including most children who are 'looked after'). We can make a significant impact on child wellbeing by reaching their parent(s) or their primary caregiver(s), who are often the people who know the child best and are most consistently involved in their lives. If the family environment is not one that is conducive to good wellbeing, mental health interventions in other areas will not be successful. Family Hubs are a good model that situate interventions in a family context. Schools should also consider how they engage parents as part of their whole school approach to mental health and wellbeing.

Some of the most important things to address in the family context are the number of children living in poverty, the number of children experiencing abuse and violence,

and the number living in substandard housing. These children are also more likely to experience a number of other adverse childhood experiences, greatly increasing their chances of experiencing mental health problems.

Addressing these mental health risks needs to be a shared responsibility across government and different types of service.

Youth services

Children and young people also need opportunities outside of schools to help them develop hobbies/interests and fulfilling social connections with peers, both of which are important protective factors for their mental wellbeing. However, spending on youth services has decreased significantly. In 2010/11, local authorities spent an estimated £1.36bn in real terms on youth services in England. By 2018/19, spending had reduced by £959m in real terms to just under £429.[29] As a result, over that period, 760 youth centres closed and 4500 youth work jobs were cut, drastically reducing provision for young people. **The government must reverse these cuts and invest in this community provision for young people.**

Body image

The mental health and wellbeing strategy should also seek to support initiatives to improve young people's body image. Research shows that body dissatisfaction is linked with a poorer quality of life and psychological distress,[30] greater likelihood of depression,[31,32] and the risk of developing unhealthy eating habits and eating disorders.[33] Research we carried out for Mental Health Awareness Week 2019 showed that 37% of teenagers had felt upset about their body image in the past week and 31% had felt ashamed.[34]

We asked young people to identify the sources of their body image distress.[35] They identified the following influences:

Social media:

"Social media makes young people think it's a realistic goal to get the perfect image: lots of younger boys and girls that's what they should look like. Before, people didn't talk about the filters they, but now they are starting to."

Advertising:

"We see celebs and influencers advertise things on their social media, but they are not always going to help an individual look like that person."

Family influences:

"My girlfriend's parents constantly commented on her weight when she was overweight, and it had a negative impact on her."

and School:

"BMI [Body Mass Index] *has a negative impact on individuals' mental health. School students have had a lot of anxiety around going back to school due to the emphasis on looking at your BMI. This even [has] an impact on education."*

The Mental Health Foundation recommends that, in the new plan:

1. The Department for Education should promote body positivity in the Health Education curriculum
2. Building on the welcome progress we have seen from the government over the past few years, DCMS should work with the Advertising Standards Authority, social media companies, and app stores to increase regulation of advertisements, especially on dietary products and filters.
3. The Advertising Standards Authority should expand its definition of body image beyond 'images that appear unhealthily thin'.
4. Image-editing apps and filters should be age-restricted to young people aged 16 and above.
5. The Government should review the psychological impact of its obesity campaigns and increase access to exercise, sports and healthy food options, especially in disadvantaged communities, promoting these as beneficial for everyone's physical and mental health, without any emphasis on tackling obesity etc.
6. The Government must involve young people in decisions on these and other body image-related matters that directly affect them, and work with influencers relevant to them, to address these commercial practices and devise such campaigns, and their associated or potential mental health harms.

Nature

Connection with nature is an important protective factor for mental health,[36,37] and one that children and young people should be able to experience on a regular basis to support and improve their own wellbeing. As well as improving access to nature and the quality of available nature, it is important for young people specifically to build and maintain a lifelong relationship with nature.

There currently exists, however, a 'teenage dip' in engagement with nature that lasts into a person's thirties,[38] meaning that people are not gaining the wellbeing benefits of nature during this period. Secondary schools, therefore, should be a priority for targeted action.

We recommend that nature should be brought back into secondary schools as a way of teaching, and not just something to be taught. Classes should be taken on outdoor activities that support their learning of curriculum subjects: nature should be a part of the learning process.

Our review of the literature on nature and mental health for Mental Health Awareness Week 2021[37] found that education outside the classroom could promote social wellbeing, particularly for pupils of low socioeconomic status, who may not live in neighbourhoods with safe, clean green spaces.

This needs to be accompanied by changes to the design of school estates to prioritise, protect, and build new wild areas and green spaces for such purposes. All new schools should be planned with nature in mind and the government should review the amount and type of green space available in and

around secondary school premises and develop a plan for building up nature in schools whose environment currently lacks natural spaces.

Child and family social care

Local authority child and family social care services have an important role to play in providing early help and support for families experiencing difficulties that are affecting their relationships and children's development and mental health. Investment in prevention and early intervention must therefore include resourcing these early support services for children and families, vital for providing help at an early stage when families are encountering adverse circumstances, or when potential risks to children are identified early enough to reduce them.

In recent years local authorities' funding has shifted markedly to statutory child protection and children in care services[39], and the Early Intervention Grant fell from £2.8 billion in 2010/11 to £1.1 billion in 2018/19 [40]. This trend must be reversed, to reduce the risk of enduring poor mental health for children in these circumstances, and to reduce the costs of more intensive long-term social care - in particular children entering the care system when problems have become acute and they can no longer live safely at home.

Children of parents with substance misuse

In this regard, the Family Drug and Alcohol Courts (FDAC) model, created in 2008, has shown that it is possible - even at the point where the developmental and welfare risks to children have reached a late stage – to work with parents to address their substance misuse problems, and for children to remain at home instead of being taken into care.

The 2011 evaluation[41] found that FDAC may offer a better way than ordinary care proceedings of ensuring that the court system can help improve outcomes for both children and parents in cases involving parental substance misuse. The tracking of 41 FDAC cases (56 children) and 19 comparison cases (26 children) showed that, at final order:

A higher proportion of FDAC than comparison parents had ceased misusing substances by the end of proceedings: 48% of FDAC mothers (19 of 41) were no longer misusing substances, compared to 39% (7 of 19) of comparison mothers. - 36% of FDAC fathers (8 of 23) were no longer misusing substances, compared to none of the comparison fathers ceasing.

A linked finding is that more FDAC parents engaged with substance misuse services in the first six months, and a higher proportion remained engaged throughout the proceedings. More FDAC parents had plans to continue in treatment after the proceedings concluded.

More FDAC than comparison families were reunited with their children. The children of 39% of FDAC mothers (16 of 41) were living at home at final order, compared with children of 21% of comparison mothers (4 of 19).

Also, more FDAC than comparison children had improved well-being at the end of proceedings, but the authors say this may have been related to the younger age of the FDAC children.

To date, FDAC has been rolled out across 14 sites in England, with eight sites expanding existing services and six sites setting up their own new FDACs. DfE's Supporting Families: Investing in Practice programme has commissioned an impact evaluation of these FDAC services, involving 31 local authorities and around 430 families, which is led by NatCen Social Research Group.[42] **The findings from this study are due in November 2022, and we recommend that the government extends this model to all parts of the country if the evaluation is positive.**

Social care and the voluntary sector should also work with health to provide programmes that work with families in which a parent has a mental health problem, as these children have an elevated risk of developing poor mental health themselves.

Children of Parents with Mental Illness

A review of 13 RCTs for the What Works for Children's Social Care group of the evidence for interventions for Children of Parents with Mental Illness found that preventative interventions showed a positive effect on children's mental health and reduced the risk of a child developing the same mental health condition as their parent by 40%. The length of the follow-up period varied between six months and 15 years. (This finding is based on moderate strength evidence from six research trials involving 919 participants, though many of the studies are from the US).[43]

Further, the preventative interventions tended to show a positive effect on children's internalising behaviours, such as symptoms of negative emotions, depression or anxiety. Children who received an intervention had significantly lower scores for internalising symptoms than children allocated to a control group. (This is based on moderate strength evidence from seven research trials involving 750 children).

Case study: KidsTime Southwark

KidsTime workshops are currently delivered in various boroughs in the UK, with the majority being in London. These groups offer a space for children of parents with mental illness to be children and have fun, normalise mental health difficulties, and remove the stigma of being a family affected by parental mental illness.

Workshops offer a preventative and supportive approach by educating children and young people about parental mental illness; providing explanations that can help a child to understand their parent's disordered behaviour. This has the potential to free children from taking on inappropriate responsibility for the parent's disorder and feeling guilty for their parent's illness, and to challenge parental behaviour and thinking patterns that they may otherwise automatically adopt. The project contains both 'family' and 'parent' sessions, and therefore also involves directly working with the parents of the children and young people participating in the project.

The Mental Health Foundation has been running KidsTime in Southwark, London, for the last two years. Due to the onset of the Covid-19 pandemic, KidsTime Southwark was moved from in-person groups to online groups between October 2020-May 2021. Within this timeframe, three groups (15 families) were delivered this project via Zoom. The online delivery of this programme was deemed acceptable to parents and young people as evidenced by the feedback received in the focus groups conducted for the project's interim evaluation.

In a first-year evaluation of our programme by the Anna Freud Centre, over the course of 12 workshops, facilitators reported seeing good interactions between families, an increase in young people's confidence, and reported that KidsTime increased parents' recognition of the impact of parental mental illness on children and young people.

Both parents and children and young people described finding it helpful to meet new people and receive social support. All children and young people said they would recommend KidsTime Southwark to other children and young people because of how fun it was, how much they learnt about mental health and about how to express themselves. All of these are protective factors for children and young people's mental health and reduce their risk of developing poor mental health themselves:

"I know sometimes we just need something to take off that stress and KidsTime is that perfect programme. It's just been like an escape for them. Somewhere to just go and somewhere to make you feel like, "No, you're not weird. You're not weird. Mental health can affect you, even though you're a child. This is how you can deal with it." Which they talk about in KidsTime because it shows how you can deal with it, it doesn't make you strange." – **Parent from KidsTime Southwark programme*]***

One good adult: mentoring programmes

Research has shown that one of the strongest predictors of good mental health amongst young people is the presence of at least 'one good adult', to whom they can dependably turn for guidance and support.[44] A large survey of young people in the Republic of Ireland found that the presence of such an individual was associated with lower levels of anxiety and depression and greater levels of good life satisfaction, high self-esteem, healthy coping strategies and optimism for the future.[45] However, not all young people feel they have a trusted adult they can go to for advice and support, if they are experiencing a problem.

We recommend that all children in care, who are at elevated risk of poor mental health, should have the opportunity to benefit from evidence-based mentoring programmes based on the one good adult model. Ideally, all children living in disadvantaged circumstances should be able to benefit from this approach.

MCR Pathways in Scotland is an example of one such mentoring project, which supports many young people, including young carers, asylum seekers or those who

have suffered significant family bereavement or disruption at home. The project increases their life chances through working with young people from Year 6 until they leave secondary school. The mentoring element begins two years after a period of group sessions for those involved.

A three-year impact evaluation by ScotCen found that 81.6% of mentored care-experienced pupils left school for a positive destination, compared with 56.3% of those young people who were not mentored.[46] For MCR, a positive destination is either progression to college, university or employment.

Working age adults

To support our submission in this area, we ran two focus groups: one with beneficiaries of the Mental Health Foundation's programmes and staff involved in the programmes, and one with members of the Mental Health Foundation's Our Personal Experience Network (OPEN), an online community of people with lived experience of mental health problems whom we engage with to inform our work.

The common themes that emerged from these sessions were:

- The impact of financial struggles on mental health (and vice versa)
- The role of the workplace: the difference between supportive and unsupportive workplaces
- The continuing impact of stigma
- The lack of support and guidance when navigating a complex mental health service
- The need for individualised, tailored solutions to individual's mental health
- The need for consistent support through life's transitions
- The importance of care and kindness, both in personal and clinical relationships
- Doing things that are fun and boost self-esteem can help mental health
- People benefit from talking openly about their struggles
- There is a need for education to support a focus on prevention.

We also ran a quantitative survey with OPEN based on Mind's public engagement questions and found that people said that the following had a positive impact on their mental health:

- 64% surveyed said 'having enough money to enjoy my life'
- 72% said 'having a 'good understanding of my mental health'
- 61% said 'good housing'
- 79% said having 'supportive relationships with friends and family'
- 73% said 'hobbies and interests'
- 72% said 'access to green spaces.'

We also ran a similar exercise as part of our Coronavirus: Mental Health in the Pandemic Study. In the most recent wave (wave 13) of data,[47] when a representative UK sample of more than 4,000 people was asked 'What could be done by the

government to benefit and improve the nation's mental health as restrictions ease and life starts to return to normal?', the top 5 answers were:

- Support victims of domestic abuse (47%)
- Set out a clear vision going forward (46%)
- Provide a statutory living wage (46%)
- Establish a clear single source of public health information (45%)
- Establish a programme to support people to find and to progress in employment (41%).

Poverty

The impact of poverty and financial struggles came through particularly strongly in our focus groups:

'Working in social housing, I work with some of the most impoverished people in our country and, I'm telling you now, they are struggling… We have people… crying to us on the phone to us that they can't afford their rent, they can't afford to take their kids to a park because they can't afford to put petrol in, they can't afford food, we're having to supply food vouchers to families… and I think that's just another stress… as we see a lot in mental health it's just one thing after another after another that leads to mental health decline…'

'When you're brave enough and strong enough to go and ask for help, the last thing you need is to be worrying about is "can I pay my rent"? Or, "can I feed myself and my children"? And, "can I afford to live"? which we can't… and that's just adding to your illness, it doesn't make you feel any better.'

The link between poverty and poor mental health is well established .[4849] Levelling up areas of the country and communities that have benefited less from the UK's economic successes must be central to any mental health and wellbeing plan. We were encouraged to see wellbeing included as one of the twelve missions in the Levelling Up White Paper and recommend that the Mental Health and Wellbeing Strategy provides detail on how this will be achieved, especially with regard to levelling up mental health inequalities.

Given the close link between financial struggles, poverty and mental health, the Treasury should be an important partner in the Mental Health and Wellbeing Strategy, and it is essential that both government departments are incentivised to work towards better mental health for all. **We recommend that the UK government adopts an approach that puts wellbeing at the heart of the economy and of political decision making.** This approach could be based on examples such as New Zealand's Wellbeing Economy[50] or the approach enshrined in the Well-being of Future Generations (Wales) Act 2015.[51]

The mental health policy tool currently in development in DHSC is essential to realising this agenda, and we would like to see it adopted across all government departments, and ideally mandated for use.

Mental health stigma

The government should also ramp up efforts to tackle stigma. Our focus groups were clear that they still felt that mental health stigma was a barrier to getting better:

"There's a massive stigma in the government that they sort of see mental ill-health as, just, laziness; they don't see it as actually the debilitating conditions that they are… We need to change this stigma that is still there".

A trauma-informed approach

There is also a need for public services to adopt a trauma-informed approach to care, to increase engagement with and effective support for people whose mental health problems originate in their experiences of trauma:

"Complex PTSD is like the walls go up and people become scared…"

Talking openly about struggles

The focus groups we held to inform our consultation response suggest that people can better support their own mental health when they can talk about their struggles openly:

'There's lots of things that the government could be supporting with, whether it be community mental health first aiders that aren't clinical professionals, but they have groups that arrange sessions with people that can drop in, they can talk about mental health if they want or they can talk about…anything… But there's just not enough funding; we don't even have community centres anymore; they're getting closed down. There's just no facilities.'

Mental health education

As with children and young people, working age adults also benefit from mental health information and education to improve their own wellbeing. The government's Every Mind Matters campaign is an important tool for people to access preventative mental health advice, and it is important that the government continues to develop and invest in this resource and that it is promoted to the disadvantaged communities who would benefit from it most.

Delphi study on recommendations for maintaining and protecting mental health

In 2018-19, Mental Health Foundation conducted research to explore the most acceptable and evidence-informed individual-level recommendations for maintaining and protecting good mental health.[52]

We have recently published a new guide for the general population based on the results of this study on tips for protecting their mental health. 'Our Best Mental Health Tips – Backed by Research' is an important contribution to the advice literature available to people, and we hope it will be widely used.

The results provide new evidence by consensus on what psycho-educational recommendations should be used in public messaging and campaigns to protect and promote good mental health. We included both an academic and a public panel in

the Delphi process, so the recommendations are both based on academic expertise and judged as acceptable for daily use by the public, particularly by those with lived experience of mental health problems. This suggests that they would be appropriate to use as part of universal mental health promotion interventions and public mental health messaging campaigns.

The top recommendations in terms of academic consensus and public acceptability cover a range of potential risk and protective factors and are good examples of the breadth of influences on mental health. They range from cognitive and psychological traits traditionally associated with mental health (such as understanding and regulating mood) to more external and expansive influences which are environmental (e.g. spending time in green spaces), behavioural (avoid illicit drugs, improve quality and quantity of sleep), social (prioritise fun, remain curious for new experiences) and economic (avoid unmanageable debt).

Though the recommendations are intended as individual actions, the societal and environmental impact on the feasibility for individuals of many of these recommendations must be considered. For example, a person's living environment, such as poor housing conditions and road traffic noise, will affect their ability to obtain good quality sleep, regardless of actions taken by the individual to improve sleep hygiene practices. Similarly, socio-economic status, particularly poverty and low income, may mean it is not possible for someone to avoid unmanageable debt when endeavouring to meet their day to day needs and the needs of those they live with, particularly if good quality and accessible debt advice is unavailable.

To spend time in green spaces, safe, appealing and publicly accessible green spaces must be available, which may not be the case in deprived urban areas. In these cases, individual actions must be enabled and accompanied by effective use of policy levers to create the conditions needed for individuals to be able to benefit from these ways of protecting their mental health. **National, regional and local public mental health and wellbeing policy must consider the action needed to reduce inequalities when promoting these individual actions for promoting and protecting mental health.**

Connecting with nature

Working age adults also need access to nature as a resource to improve their own wellbeing. The Mental Health Foundation's Coronavirus: Mental Health in the Pandemic study found that, in February 2021, the main methods people identified for coping with the stress of the pandemic were going for a walk outside (59%) and being able to visit green spaces (42%).[53]

Crucially, to realise the potential wellbeing benefits of nature, the government must focus on 'connection to nature' as the primary measure for the success of wellbeing and mental health policies, as this has the closest relationship to wellbeing improvements (compared to measures such as cumulative time in nature and the number of visits to nature).[54,55]

To facilitate this closer connection with nature, the government needs to improve access to nature, especially for people in deprived areas who have poor existing

provision. People in the most affluent 20% of wards in England have five times the number of parks and amount of general green space available to them, compared to the 10% most deprived wards.[56] The government also needs to improve access in terms of physical accessibility of public natural spaces and the safety of these spaces.

Nature connectedness is also better facilitated by higher-quality, more biodiverse nature.[57,58] Out of 218 countries in its "biodiversity intactness index", the State of Nature 2016 report places England 189th.[59] **Restoring biodiversity, and ensuring that improvements in nature benefit inequality groups, should be a priority for Defra, DHSC and DLUHC.**

Screening in primary care

There should be routine mental health screening in primary care, just as there is routine inquiry and screening for physical health issues. There should be no 'wrong door' to accessing mental health services.

Similarly, mental health advice and information should be readily available in GP surgeries and other primary care settings, just as information about physical health issues such as cancer, heart disease, immunisation and healthy eating is readily available.

Later life

Older adults experience pressures on their mental health relating to experiences that are unique to – or more common in – their age group. They are more likely to need to cope with life transitions such as retirement, bereavement, declining physical health, developing long-term conditions, and experiencing reduced mobility. People in later life can also be more vulnerable to the adverse mental health effects of poverty, poor housing, and discrimination.

Later life, like all stages of life, encompasses a wide diversity of cultures and experiences. Many people in the later life category may not identify as being an older person and may have a different experience or capacity to other people in their age group, for example their ability to use digital technology. Conversely, the cumulative effects of inequalities may mean that people begin the ageing process earlier than others. Therefore, a great deal of sensitivity is required in approaching the wellbeing of this group and individualised approaches are essential.

Nevertheless, there are some key themes in improving the wellbeing of older adults.

Residents in care homes

Residents in care homes are a group who are known to be at particular risk. **It is essential to treat adults in later life with dignity and respect as they become more reliant on caring services day to day.** This is illustrated by cases such as the Orchid Hill Care Home, a serious case review of the service published in June 2014 which found that of 19 unexplained deaths, five involved neglect.[60] Being treated with dignity and respect in an adult social care setting can include: being given practical help and help with health and personal care needs in an appropriate

and sensitive way, being given choice and control, being provided with pain management, and being given help with eating and nutritional care.[61]

Age discrimination

Age discrimination remains a problem in public services, workplaces and in society in general. The stigma attached to mental ill-health can be more pronounced in certain groups; for example, Black and Minority Ethnic groups, and people who are Gay Lesbian Bisexual Transsexual (GLBT). Moreover, those with poor mental health or living in poverty can feel the impact of age discrimination more keenly, as this intersects and overlaps with other forms of discrimination, which include barriers to services and being treated without dignity and respect.

Mental health services

Mental health services must be made fully accessible to older people. Until the Equality Act came into effect for the NHS in 2012, some IAPT services excluded older people. Even though IAPT is now accessible for those of all ages, IAPT monitoring data indicates that fewer than 5% of people referred to IAPT are over the age of 65.[62] This is despite evidence indicating that older people who do use IAPT tend to show the best outcomes of any age group,[63] and 2011 estimates (based on population size and need) that people aged 65+ should comprise about 12% of IAPT referrals.[64]

Physical health needs

As people get older their mental and physical health needs often become more complex, with increased incidence of comorbidity and long-term conditions. Most people over the age of 65 have two or more long-term health conditions, and most people over 75 have three.[65] For older people who have experienced mental ill health for periods across their life course, there is a cumulative effect on both mental and physical health. **To respond to this mix of health, mental health and social care needs, it is particularly important to take a holistic approach as people get older and to ensure that mental health is treated alongside physical health conditions as standard.**

Protective factors

We have also identified **three protective factors that the Mental Health and Wellbeing Strategy should seek to promote to improve the wellbeing of older adults. These are: connecting, caring and contributing.**

Remaining connected to others is a key factor in remaining mentally healthy in later life. This means connecting socially and in communities, but also actively engaging with people who provide services to avoid becoming a passive recipient of care and/or support.

This is particularly important in the context of the pandemic. Participants in focus groups we held to support our Coronavirus: Mental Health in Pandemic later life briefing told us that:

'The worst thing has been the loneliness...I can spend [so much time] not talking to anybody, fifteen or more hours a day, not talking to a single soul.'

'The loneliness, it's been the hardest part, really'.

For many people, being well supported to care for the people they love is central to their mental wellbeing, but the reality of caring in later years is often tough. There are 1.2 million people in England aged 65 and over who are providing unpaid care to a seriously ill or disabled older relative or friend; many face their own health problems in addition to coping with the needs of the person they are caring for. Nearly half (45%) of carers aged 75 and over are looking after someone who has dementia.[66]

Later life can also be associated with a period of positive wellbeing, a time when people have new opportunities to engage in new leisure activities, volunteer and see families and friends. Volunteering and paid employment have both been shown to have beneficial effects on mental wellbeing. For many, however, a lack of choice impairs wellbeing, such as when working conditions are not flexible enough to meet their changing circumstances, and result in forced retirement. Conversely, people can feel compelled to continue to work for economic necessity beyond their intended retirement age.

Mental health stigma

We also recommend that the Office for Health Improvement and Disparities and NHSE/I should plan specific public information and anti-stigma campaigns on mental health for older people, adapting existing campaigns such as Every Mind Matters. These must reach diverse groups of older people and effectively communicate how they can identify their mental health needs and get the support they need.

Digital technology

We can help older adults to improve their own wellbeing by ensuring that they remain connected to family and friends, regardless of their circumstances.

An important component of this is supporting older adults to use digital technology as a means of communication. While people of any age can be digitally excluded, Age UK reports that 42% of over-75 year olds are digitally excluded.[67]

The government should pay particular attention to guaranteeing access to digital technology in residential care settings. There should also be a greater focus on training and supporting all people later in life to give them the skills and confidence to use digital technologies. Local councils should provide space in public libraries or other community spaces for older adults who want to learn more about using digital technology. While digital technology is an essential tool, the government must not neglect more traditional forms of communication and ensure both that written and landline communication methods are available for those who prefer to use them, and that these are actively offered and positively supported.

The Mental Health Foundation's experience of running a digital access intervention for older adults, **Picture This**, found that:

1) older adults are interested in increasing their communication online

2) there is poor awareness of how to stay safe online

3) older people feel digital skills are something they need to learn in order to access services and there is limited confidence on how to use apps, with participants in our project explaining that they need someone to show them how to do it, and

4) people want to increase their communication with others online: *"I would love to be connected with friends and family".*

From the earliest stage of the project, when a participant first receives a digital device, we have heard how simply owning a tablet and having WiFi access is transformative:

'It [Zoom] is a window to the world. I knew it existed but didn't know how to use it until [the facilitator] explained what it is. I didn't believe it [Zoom] until I saw it for myself.'

Having access to a tablet allows participants to explore their interests and do more of what they love:

"I grew up in Canada and since having my tablet I have gone onto YouTube and found some of the old TV shows that I watched. It's wonderful."

Digital connection also allows people to build relationships with others who live nearby and to maintain relationships with friends and family:

"First session was earlier this week. I got to meet other residents that I didn't know existed - although we lived in the same building. I've made new friends. It is a miracle. I've been here since 2020 (October), and this is the first time I got to meet [them]."

"Speaking to my family and friends online…it has been the best thing for me, especially [with] those ones I have not be[en] in contact [with] for years."

Activity-based groups

Older adults can also be helped to support their own wellbeing by building activity-based groups.

Case study: Creating Communities

The Mental Health Foundation ran a peer support participatory arts-based programme called 'Creating Communities' to help improve the emotional wellbeing and community connections of older people. The programme ran for six weeks for up to 25 older people per group living in extra-care, supported and retirement housing schemes in Hackney, East London.

The groups were focused around creative activities and access to the outdoors (e.g.: painting and drawing, musical workshops, gardening and revamping outside areas), and allowed individuals to form social connections with others. Findings from our

project evaluation highlight the importance of hobbies and activities in later life for older people, and the positive effects they can have on their wellbeing.

The project evaluation found the participatory component of the programme to be effective. Residents expressed that even if they were not creatively gifted, they enjoyed participating in the "mixture" of activities. Participants enjoyed the outdoor activities, including potting plants in the space outside their housing. The sessions offered a refreshing change to residents' days, which were often spent alone, and served as a "highlight" to their routine: **"*Well I find it helps me quite a lot, it breaks up my day because I don't go out a lot, I don't have visitors, I really don't have friends visiting me… this has broken up my day so it's something else to look forward to."* – Participant from Creating Communities**

According to feedback provided by staff, the participatory arts component of the programme also improved the self-confidence of many residents: ***"So, definitely, there's a couple of residents that I can think of in particular [whom] I felt it did really [benefit]. As I say, they've got such a low confidence in themselves and their abilities. It was great when they were doing the group sessions, you know, the arts and crafts sessions".* – Staff member**

Furthermore, the participatory nature of the project, encouraged residents to come together and build friendships; this helped to combat loneliness by strengthening a feeling of social connectedness and belonging. One facilitator described how larger group-based drawings encouraged groups of people, who were very isolated and initially did not speak to each other, to build genuine connections with each other.

Our project is further evidence that older adults can be helped to support their own wellbeing by building activity-based groups, giving them the opportunity to participate in meaningful activities and develop hobbies. Involvement in such activities can have positive effects on older adults' wellbeing by: giving them something to look forward to in their routine, building self-confidence, and increasing opportunity for social connection.

Suicide prevention

Children and young people

The level of suicide amongst under-20s has been increasing for the last 12 years.[68] Research conducted by the Mental Health Foundation throughout the Coronavirus pandemic consistently found that young people were one of the demographic groups most likely to report suicidal thoughts. In November 2021, 34% of young people aged 18-24 reported suicidal thoughts and feelings; this was higher than the reported figure for adults (12%).[47] Self-harm is also thought to be increasing,[69,70] though this needs to be confirmed with up-to-date figures by the forthcoming delayed Adult Psychiatric Morbidity Survey.

There are a number of important measures that must be taken to prevent suicide in children and young people: the complexity of the problem is such that it requires action from across the public sector, including schools, the private sector (for example, social media firms) and the Government.

We particularly want to emphasise the need to support young people who self-harm, as this is the most concrete predictor of future suicidal behaviour. Doing so is not, though, a silver bullet, and further action needs to be taken across Government departments to prevent suicide in this group.

At least half of people who take their own life have a history of self-harm.[71] Suicide is difficult to predict, and thankfully rare amongst children and young people, despite the number increasing in recent years. But self-harm is one of the strongest predictors of future suicide attempts for young people,[72] and once a person has self-harmed, the likelihood that they take their own life increases 50 to 100 times, compared to someone who has never self-harmed.[73]

There are some clear measures that can be taken to prevent self-harm, taking into account the complexity of it, although preventing self-harm is not straightforward. For example, young women living in the most deprived households are five times more likely to self-harm compared to those in the least deprived.[74] As we have set out throughout this submission, preventing poverty is at the heart of improving mental health, and self-harm prevention is no exception. There are, though, additional clear measures that can be taken to prevent it.

Our recent report The Economic Case for Investing in the Prevention of Mental Health Conditions in the UK[9] set out that better use of psychosocial assessment (something already recommended by NICE) when people present to hospital following self-harm could lead to a cost per QALY gained of £9,980 from a societal perspective.[75] This analysis is conservative as it does not include the long term consequences of self-harm to individuals and their families; these costs are substantial and would further strengthen the economic argument for such assessment.

We also know that services for people who self-harm are often poorly set-up to deal with them. A report from the APPG on Suicide and Self-Harm Prevention found that mental health services often ignore self-harm, or even ban children and young people from using services because of it (on the basis that are ‘too high risk’).[76] The Health and Social Care Select Committee recently reported that ‘self-harm is one of the key reasons that a quarter of referrals to children and young people’s mental health services are rejected.’[77]

We agree with the Select Committee’s recommendations that ‘it is essential that self-harm is not used as a reason to reject referrals to mental health services.’ We also agree with the recommendation made by both the APPG and the Select Committee that a system of early intervention is needed to prevent self-harm, with educational settings having a particularly important role in this. The roll-out of Mental Health Support Teams must be accelerated to help facilitate this.

Working age adults

Women and men attempt to take their own lives in approximately equal numbers, although women die in smaller numbers.[78] From a strictly suicide prevention perspective efforts should be targeted at middle-aged men, but with two caveats: women must not be ignored, especially given that numbers are increasing, and women's mental health must be prioritised through the Mental Health and Wellbeing Plan and the Women's Health Strategy. This is because the unacceptable level of attempted suicides in this group makes clear the huge extent of distress amongst this group.

Lower-income, middle-aged men are at the highest risk of suicide, and widely available and accessible support targeted to this group would make a real difference in reducing the number of deaths. Whilst important work has been done in engaging men in what they want to see from services,[79] there is a limited evidence base as to what types of services are proven to work.

There are a number of models of public mental health interventions which could help prevent suicide amongst men, for example 'Men's Sheds'. There is also promising evidence from Australia for programmes working with men in the construction industry.[9] The government should review the most likely candidates for effective interventions and roll them out at scale.

GP appointments (and potentially other parts of primary care), present a good opportunity for clinicians to make a judgement about possible suicide risk and to refer on to these sorts of public mental health programmes. Doing so should be routine; this will require developing primary care practitioners' skills but also ensuring that there are funded, well-evidenced programmes operating in every area.

Primary care practitioners should also be trained to understand that asking someone about whether they are feeling suicidal will not increase the likelihood of them taking their life, which is a common fear. In fact, it is more likely to have the opposite effect.

Longer term, we need to move towards a system focused on early intervention. Whilst suicidal feelings may emerge in middle-age, they are subject to various risk factors, including early trauma and experience of childhood sexual abuse. Ultimately, addressing suicide amongst working age adults, including middle-aged men, also means equipping children with the tools to understand their emotions and addressing the social factors, such as child abuse, that increase the chance of experiencing trauma or unmanageable stress.[80]

As in the answer to the previous question, suicide is ultimately an inequality issue, with higher levels of suicide generally being seen in areas of higher socioeconomic deprivation.[81] Ultimately, therefore, as important as support in the community and through clinical services are, the reduction of poverty and inequality must not be ignored.

Older adults

The government can do more to increase the number of people aged over 65 with depression who benefit from psychological therapies through the IAPT programme. We have already noted that this age group has the best recovery rates for IAPT, yet people aged 65+ have consistently made up only 6% of IAPT referrals [82], despite the fact that DHSC indicated in 2011 that they should comprise an expected rate of 12% of all IAPT referrals, based on population levels and level of need [64].

To increase the numbers of people in later life who benefit from IAPT, the DHSC and NHSE/I should agree and set a new target rate for referrals of people in this age group. This should be accompanied by innovative actions to promote the programme, including targeted communication plans and effective sharing of best practice among mental health commissioners.

IAPT referrals decreased for all age groups during the initial outbreak of the pandemic [83]. [84]. In England, reduction in IAPT services corresponded with a large fall in GP appointments and referrals during the first lockdown, suggesting that fewer people accessed GPs, and/or that fewer IAPT referrals were made following GP appointments [83].

Those at greatest risk

The previous government strategy did not reach its modest target of reducing suicides by 10% from the 2015 baseline.[85]

This is likely in part to be because it consisted primarily of a list of tasks to be carried out, rather than approaching suicide prevention in a rigorous way driven by a theory of change that could be tested and continually re-evaluated.

The most important thing that the government needs to do to reduce the number of people that are at greater risk of dying by suicide is to develop a much clearer strategy, which addresses the substantial gaps in evidence head-on, commits to tackle them, and sets out a credible plan – backed by investment – for rolling out across the country the interventions shown to be most successful.

We have set out some of the areas where there is already good evidence for interventions in our answers to other questions, and there is further detail in our report The Economic Case for Investing in the Prevention of Mental Health Conditions in the UK. Key effective interventions, such as better self-harm prevention and support, should be rolled out straightaway. Other promising interventions should be piloted and evaluated rigorously as a matter of urgency.

The strategy needs to include a new target, but this should be determined by what is achievable, rather than a ‘round number’ like 10%. When developing this target, policymakers should consider the resources available, where they can be deployed in an evidenced manner for particular groups, and within those groups what reductions in deaths we can expect to see as a result. From there, an achievable overall target can be determined.

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Annex: Themes from focus groups

Financial struggles can worsen mental health and vice versa

- Cost of living (people struggling with rent, food prices), PIP and DLA being taken away from people as a source of stress which has a cumulative negative impact on mental health:
    - **“Working in social housing, I work with some of the most impoverished people in our country and, I’m telling you now, they are struggling… We have people… crying to us on the phone to us that they can’t afford their rent, they can’t afford to take their kids to a park because they can’t afford to put petrol in, they can’t afford food, we’re having to supply food vouchers to families… and I think that’s just another stress… as we see a lot in mental health it’s just one thing after another after another that leads to mental health decline…”**
- Finances being an additional issue when people already struggling with mental health - not being “ill” enough to receive PIP and sick pay / UC inadequate:
    - **“When you’re brave enough and strong enough to go and ask for help, the last thing you need is to be worrying about is can I pay my rent? Or, can I feed myself and my children? And, can I afford to live? which we can’t… and that’s just adding to your illness, it doesn’t make you feel any better”.**
- Anxiety associated with not knowing what to do or where to turn (suggestion that education around finances - budgeting and where to go for help – would be beneficial).

The role of the workplace: the difference in supportive vs unsupportive workplaces

- Lack of understanding and support in the workplace in relation mental health. Ongoing stigma, for example, mental ill-health being perceived as laziness, or blame/responsibility being attached:
    - **“…there was also a certain attitude of, you kind of deserved any mental health issues you got because you chose to do that particular job any issues you have as a result of it, well, if you can’t handle it, you shouldn’t have done the job”.**
- Resources on the intranet and yoga workshops are only helpful for people who are not so stressed by work that they are able to access them (*related to theme on stigma – easier to offer support around improving wellbeing than support with mental ill-health. Also relates to theme of getting the right support at the right time*).

- While there is more mental health awareness, there is a need for organisations to be more proactive, e.g., MH first aiders, and lead by example – i.e. the focus on wellbeing and mental health should filter down from the top to more junior members of staff.
- Participants spoke about the benefits of an understanding and supportive workplace:
    - **"I did do some part time work - and that was at a time when I was suffering a lot from anxiety - and what really surprised me was how supportive the workplace was. I had expected them to say, well, if you can't come in today well really that's not very good… but actually, they were really understanding so that's one thing where I benefitted. It should be possible for workplaces to be understanding, be supportive of people who are struggling, because that's how you can get better rather than getting worse".**

Stigma still exists

- Need to take mental health as seriously as physical health. Gap perceived in terms of understanding importance of mental health, in comparison with physical.
- Stigma impacting on the type of support and treatment received. People not comfortable discussing / supporting with more complex diagnoses. Stigma in the government is particularly evident:
    - "**There's a massive stigma in the government that they sort of see mental ill-health as, just, laziness, they don't see it as actually the debilitating conditions that they are… We need to change this stigma that is still there".**
    - **"Complex PTSD is like the walls go up and people become scared…"**

Lack of support and guidance when 'navigating a very complex mental health service':

- Difficulties accessing and navigating mental health support (particularly at the point of crisis / being unwell):
    - **"…you're diverted down paths that somebody who was very well would have difficulty dealing with. "Fill in this form", "Go this way", then you have to be approved for that, then you have to fill in this form. It becomes so daunting that you end up being just completely flawed and eroded".**
- Sense of having to start from the beginning in terms of trying to access care when mental health deteriorates – lack of continuity of care.
- Lack of agency over support and treatment.

- Need for support that is appropriate for where you are at (i.e., you are ready and able to engage). Therapy can be triggering or finding time to do yoga can be an additional stress when struggling at work.
- Not knowing how and where to go for support for self or others.
    - Wanting someone to **"walk with you"** to show you what is available and how you can help your mental health. **"When I was walking on my journey to navigate the world I made so many mistakes. It literally was like a jungle, I felt like it was out to get me."**

Need for tailored solutions; no "one size fits all approach"

- Whilst medication can be suitable for some, participants felt there should be a move away from just prescribing medication for mental health problems as the first port of call.
- There should be a greater availability of talking therapies, with consideration to match the therapist with the participant (e.g. in terms of sensitivities to culture and faith).
    - **"I know for myself my mental health only started getting better when I started talking about it, the medication never did anything, I always weaned myself off it, there needs to be more talking therapies"**
- Participants felt that not everyone is aware they can self-refer for counselling – could be promoted more. Also emphasised that if the therapy isn't working for you, people should be informed that they can always see someone else.
- Difficulties if you don't fit into a particular "box" / "category" for diagnosis and subsequent treatment: **"If somebody helps you when you're asking for help, it won't cost so much for that long-term thing [but] because you don't fit into a certain box, you're not helped".**

Consistent support through life's transitions:

- Participants spoke about various life transitions, e.g., moving schools, bereavement, changing mental health services (the suddenness of the change was described as being a particularly difficult factor). Sometimes people don't seek help during these times because they don't think that it is 'serious' enough to warrant seeking help.
- Differentiation was made between being guided through these transitions with consistent support, e.g., from family, friends and mental health professionals versus the additional difficulty of doing this alone / without consistent support:
    - **"I got married and I had my first child and my mother helped me through that… because I didn't know anything about having a baby, but my mum guided me. She showed me how to hold a baby, how to do everything… Fortunately for me, we had our mum and she guided us, she supported us, and she loved us dearly".**

- **“So, they told us over the weekend that Monday would be the last day of school… I was very anxious about moving to a public school… It was quite hard for me to navigate that, as well as doing my GCSEs . What kind of helped me with it, is that I had a twin brother… us both going through the same experience and being able to share that with each other”.** (Importance of peer support)

- On the other hand, lack of consistency in relation to MH services and staff was described as being a further source of distress for those already experiencing mental health difficulties:
  - **“…with mental health, there’s never the sense that there’s one person who is going to be there for you… or… see you through whatever treatment you need… and certainly for my daughter, who has been struggling with anorexia and depression for years, there has never ever been any consistency. Particularly, actually, was one of the hurdles when she went from being 18 to a bit more than 18, and she’s all of a sudden no longer in the child bit, but in the adult bit”.**

The importance of care/kindness (both in personal and clinical relationships):

- Participants spoke about the impact of going without nurturing / care:
  - **“When you haven’t had nurturing, your whole being is different to what those who had had the right nurturing. So, your look out is kind of… scared and all you want is for someone to show you, not take over and make you, but to show you, to walk with you and show you…”**

- In contrast, care from friends/family was described as a protective factor:
  - **“I had a very happy growing up. We never knew our dad, he died in the Second World War, and my mother brought us up single handed. And she was loving, she was caring, she was a lovely mum, very very nice… she cooked for us, she made clothes for us, she took us to church and she was a real mum”.**

- A distinction was made between being treated with a genuine sense of care on the part of those offering support, including kindness and sense of investment in the person’s journey:
  - **“That was one of the good things about Blue Prescribing compared with CBT… CBT I had to go and be there in the class, learn the lesson and go away, but the Blue Prescribing [project] was: “come and be our guest”, “have a drink”, “be welcomed”. There’s a subtle difference about making you feel that, actually yeah, somebody wants to be nice to me and wants to be kind to me and wants me to get better”.**

Doing things that are fun and that boost self-esteem can help mental health

- Activities that are fun, that build people's confidence, that involve being around others (e.g., sports, arts, programmes) are good for people's mental health as they allow people to focus on something positive:
    - **"I did do the Blue Social Prescribing course, which I really enjoyed… engaging with nature, getting away from things that were worrying me and trying to focus on things that were making me feel good"**
    - **"I set up the art groups on evenings and weekends because people were going into A&E at those times. It minimised that because they were interacting with something that was positive for them. We think too much when we're struggling, and it mounts when we are all alone"**

People benefit from talking openly about struggles

- Importance of having someone to speak to, at an early stage. The ability to speak openly about issues / mental health, regardless of complexity.
- Non-clinical professionals, drop-in sessions where people can talk (about mental health or general conversation) as something that has improved MH:
    - **"There's lots of things that the government could be supporting with, whether it be community mental health first aiders that aren't clinical professionals, but they have groups that arrange sessions with people that can drop in, they can talk about mental health if they want or they can talk about…anything… But there's just not enough funding, we don't even have community centres anymore, they're getting closed down, there's just no facilities".**
- In contrast, holding in feelings perceived as leading to more problems (including physical health problems) in the long-term.

Need for education to support focus on prevention

- Need for early cues to be picked up on by people in the community who have access to those in need of support - specifically GPs and teaching staff.
    - **"When I was in school there was no support at all and there was such obvious signs of mental health decline that weren't being picked up on… As far as I'm aware, I don't believe that teachers…and other support workers are trained enough to pick up on those little signs, those absences we're seeing, and instead of penalizing that young person, why aren't we asking: "Look, is there something else that you need to talk to us about?""**

- Need for greater expertise and focus on determining root cause of mental ill-health. This involves the need for better understanding around things like children's wellbeing, race, and hidden disabilities
- Not waiting until people are deemed to be "sick enough" for support to be offered (when in crisis - self-harm or suicide attempt)
- Supporting people to be self-aware - more education and awareness in primary schools around mental health for children – interactive conversations and discussions:
    - **"If somebody has had a diagnosis of an illness that can affect the mental health of the individual, as well as the family members… That should be discussed, it should be a safe space for children to be able to have those discussions, to learn more themselves, so that they can be armed with information and be able to overcome anything that comes their way, using the right avenues. I think when something happens to an individual, they just don't know where to go, and they just don't know what to do".**