THE MENTALLY HEALTHY SOCIETY

The report of the Taskforce on Mental Health in Society

January 2015

About the Taskforce

The Taskforce on Mental Health in Society is an independent taskforce that met from Spring 2013 to Autumn 2014. The Chair was Sir Stephen O'Brien and the Deputy Chair was Liz Meek.

The Taskforce was established by Ed Miliband in his speech to the Royal College of Psychiatrists in late 2012, and was asked to set out a roadmap for how society needs to change to prevent mental health problems and promote good mental health and to look at how we can support fuller integration into the wider community of those affected by or recovering from mental health problems.

This report therefore forms a submission to the Labour Party, though we hope it will be of interest to policymakers and practitioners across society.

During its work, the Taskforce has consulted and learned from a wide range of people, too numerous to name, including patients, health and education professionals, campaigners, academics and policy experts. We have benefitted greatly from this expertise and would like to thank them all.

The Taskforce

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Foreword

For centuries mental health has been the poor relation of physical health. But it is rising fast up the policy and political agenda as more and more evidence emerges not only of the scale of mental health problems – affecting one-in-six of us at any one time – but also the huge costs of them. These costs manifest themselves in terms of our health and our life chances, and also as very real costs to the economy and the public finances too.

I agree with Ed Miliband that mental health is "the biggest unaddressed health challenge of our age", which is why I was delighted when he asked me to establish this Taskforce to look at how we can do better at promoting good mental health, preventing ill health and supporting those living with mental health problems. I have been privileged to have been joined in this project by colleagues with a huge range of expertise and wisdom and my heartfelt thanks go to the other members of the Taskforce.

This report sets out some of the key next steps we need to take towards becoming a mentally healthy society. Our starting point has not been NHS services to treat mental illness – crucial though they are – but the places where we live our lives: our homes, schools, communities and workplaces.

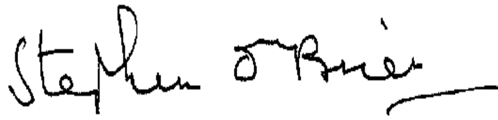
While public health policies like sanitation systems and vaccines have revolutionised our physical health and life expectancy over the last 150 years, there has not been an equivalent set of measures for mental health on anything like the same scale. As well as needing healthier schools and workplaces, a central finding here is that our social life is key. That is why our very first recommendation is that we should take supporting our communities' social infrastructure just as seriously as we do our economic infrastructure.

This report also finds that the logic of early intervention and action is as strong when it comes to mental health as it is in other areas of life; indeed, because mental health problems impact so profoundly on our wider lives – on physical health, on education, on employment – it is arguably stronger. Yet we are currently wasting vast resources by failing to act early and instead waiting until problems become serious and entrenched. This is why expanding and improving access to services such as parenting programmes, school-based counselling, talking therapies and early intervention services is a financial no-brainer. It will not only help prevent a great deal of human distress and suffering; it will save us billions in the costs of failure and is essential if the NHS is to remain sustainable for the long term.

Another key focus of this report is how we can ensure much better opportunities and support for those living with mental illness. Important life outcomes for those with mental health problems lag far behind the population as a whole, and while there are some inspiring examples of how people with mental health problems can be supported to recover and live fulfilled lives, far too often the support and opportunities available aren't good enough. Addressing this will require action across a wide range of areas beyond health and care. To take one example, when employment rates for those with mental health problems are so much lower than for everyone else, it is clear that we need employment services to do far better at helping those with mental health problems achieve their ambitions.

Finally, all of this must be underpinned by a wider generational shift in attitudes and behaviour towards mental health. Recent years have shown some encouraging signs of improvement, but negative attitudes and discrimination are still widespread. So if we want a society where no-one is left out or written off on the grounds of their mental health then there is still much further to go.

Becoming a mentally healthy society will be a challenge, and will require a contribution from everyone – public services, businesses, charities and citizens themselves. But rising to the challenge is essential to building a fairer, more prosperous country where everyone can play their part.



Sir Stephen O'Brien CBE
Chairman, Barts Health NHS Trust

List of recommendations

CHAPTER 1 – POPULATION MENTAL HEALTH

RECOMMENDATION 1: A plan to improve our 'social infrastructure',
The government should develop a social infrastructure plan to help catalyse public and private investment in social infrastructure across our communities, in support of strategies developed and led by communities themselves. As part of this, a new funding pot should be introduced, drawn from a mix of government revenue, lottery funding and contributions from businesses and individuals, to support a range of social platforms, initiatives and activities that help encourage and maintain social participation and social support within communities, such as community centres and events, community organisers, online forums, peer support groups and befriending and mentoring schemes.

RECOMMENDATION 2: A national campaign to support people to get more physically active
A new national campaign should be created to encourage more physical activity, with the aim of significantly increasing the proportion of the population who are physically active, including among groups that can face barriers to being more physically active, such as older people and those with mental health problems.

RECOMMENDATION 3: Mental health considerations should be embedded in planning and design
Mental health and wellbeing must be at the heart of planning, architecture and design. We endorse the proposals of the Farrell Review for entrenching good design in architecture and the built environment through the proposed PLACE reviews and it is important that mental health considerations are embedded in these processes.

RECOMMENDATION 4: All children should have social & emotional learning, or resilience training
All children should have the opportunity to benefit from social and emotional learning in primary and secondary school, and it is important that social and emotional development is embedded in Personal, Social, Health and Economic (PSHE) education and across the whole school community.

RECOMMENDATION 5: A zero-tolerance approach to violence, abuse and bullying across society
Strong action to tackle behaviours such as violence, abuse and bullying is essential and will make an important contribution to preventing mental health problems. That requires a zero-tolerance approach across society, backed up with effective policies and actions.

RECOMMENDATION 6: Give young people education to combat cyber-bullying
The computing curriculum and Sex and Relationships Education should contain a stronger focus on young people using technology safely, so they know who to contact if they experience online bullying and understand that their behaviour online should be as responsible and respectful as their behaviour in the classroom. Technology businesses should also play their part in helping to educate young people about online safety and in supporting teachers with training and guidance on staying up to date with developments in technology and computing.

RECOMMENDATION 7: An expectation that line managers have training in mental health issues
Professional management standards and employer accreditation schemes should reflect the expectation that all line managers should have training in the management issues and communication skills relevant to ensuring a mentally healthy workplace and supporting staff who become unwell. Employers should embed these standards in their organisational policy and practice. The public sector should also take a lead here, ensuring that it becomes routine for line managers to receive this as part of their training.

RECOMMENDATION 8: Communities should assess the need for social support in their local areas
As part of their strategic needs assessments, Health and Wellbeing Boards should assess the need for social support in their communities, and map existing support schemes; where such schemes are needed but are not available, they should be encouraged.

RECOMMENDATION 9: Social prescribing to tackle isolation and loneliness
Health and care services must see it as a core part of their mission to assess whether individuals are isolated or lonely and, if so, link them up with social activities and support. GPs and other health professionals should routinely use 'social prescribing' to signpost people to peer groups and other social activities and support.

RECOMMENDATION 10: Major policies should undergo a Mental Health Impact Assessment
Major government policies should undergo a Mental Health Impact Assessment to ensure that mental health is reflected in policymaking across government.

CHAPTER 2 – EARLY INTERVENTION AND ACTION

RECOMMENDATION 11: Health visitors should have mental health training
Health visitors should have the training and support they need to identify and respond to issues relevant to mental health promptly. Looking out for mental health problems and linking people up with the right services and support should be central to their remit.

RECOMMENDATION 12: Every family who needs to should be able to access a parenting programme Every family who needs specialist parenting support should be able to access a parenting programme free of charge in their local area. While it might not be possible to achieve this overnight, there is a strong economic as well as a health case for making this support available to families who need it.

RECOMMENDATION 13: All teachers should have training in mental health
We should strengthen the training on young people's mental health in initial teacher training so that all teachers are equipped to identify, support and refer children with mental health problems. This topic should also be a focus for programmes of continuing professional development.

RECOMMENDATION 14: A universal 'health check' at 13/14 when children have their vaccinations
The contact with a health professional that all children have at age 13/14 for booster or HPV vaccinations should be developed into a universal 'health check', including questions about wider wellbeing, which would provide a structured opportunity for a young person to raise mental health issues in a non-stigmatising context, and an opportunity to ensure they have information about sources of support in their local area.

RECOMMENDATION 15: Restore funding for Child and Adolescent Mental Health Services
Funding for Child and Adolescent Mental Health Services needs to be restored in real terms to 2009/10 levels as an immediate step, and subsequently strengthened further. One way to ensure that CAMHS is protected and strengthened for the future would be to put in place a target to ensure that services are available for a certain proportion of the population in need.

RECOMMENDATION 16: Every school should have a named CAMHS worker
Every school should have a named CAMHS worker, who can be the primary point of liaison between the school and CAMHS; where suitable, they might also deliver mental health services within the school.

RECOMMENDATION 17: All children able to access counselling services through their school
All children should be able to access professional, qualified counselling and therapy services in their school or college in age-appropriate form. The Government should set out a strategy to achieve this, with schools, local authorities and the NHS working together to deliver it.

RECOMMENDATION 18: The option to remain with CAMHS until 25
To ensure access to services and continuity of care is not disrupted, young people with special educational needs and disabilities and young people who are looked after should have the option to remain with CAMHS until they are 25. Where young people are receiving Tier 3 CAMHS provision or above but are not classed as having special educational needs and disabilities, they should also have the option to remain with CAMHS until they are 25.

RECOMMENDATION 19: A minister for child development
There should be a minister of state with responsibility for child development and health issues, sitting in both the Department for Education and the Department for Health, to ensure that child development policies are joined up, and that child health and wellbeing is placed at the heart of children's policy and services once more.

RECOMMENDATION 20: The coverage of talking therapies should be doubled by 2020
The IAPT programme should be expanded so that more people have access to it. As a first step, the programme should be doubled in size to cover 25% of those with depression and anxiety disorders by 2020, while maintaining and improving quality to achieve average recovery rates of 50% or over.

RECOMMENDATION 21: A 28-day waiting-time target for access to psychological therapies
At least 80% of those referred for psychological therapies should start treatment within 28 days. In introducing this new standard, alongside the expansion of service coverage recommended above, it is essential to ensure that quality is protected and recovery rates maintained. The aim should therefore be to phase this in by 2020 or as soon as possible thereafter.

RECOMMENDATION 22: A 28-day waiting-time standard for CAMHS
Government should also commit to a waiting-time standard of 28 days for therapies within Child and Adolescent Mental Health Services, and set out a strategy and timetable to deliver this.

RECOMMENDATION 23: Better occupational health support for small businesses
Once it is up and running, the new Health and Work Service should be strengthened so it can provide businesses who need it with free advice and support on occupational health issues, including on line management and HR practices, job design and work organisation to help promote mental health in the workplace and on the best interventions when problems occur. This strengthened remit should also include expanding support for those who are self-employed.

RECOMMENDATION 24: Better information for employees to self-refer
We would like to see more small businesses promoting early intervention by making employees aware of the help available locally which they can access by self-referral, for example by posting IAPT service literature on the company intranet or notice board. Local Authorities should provide small businesses with information and display materials about local sources of support and treatment, which they could display in the workplace.

RECOMMENDATION 25: Encourage businesses to join schemes for supporting mental health
We want to see as many businesses as possible joining schemes to accredit employers for supporting mental health, which are also a good way to access expertise and proven solutions. Local

Authorities, Health and Wellbeing Boards and local Chambers of Commerce could play a valuable role here in encouraging businesses in their area to sign up. More generally, government should work with employer organisations such as the CBI and the FSB and with trade unions to proactively promote the role of good employers in improving and maintaining mental health.

RECOMMENDATION 26: Access to talking therapies for those out of work
Everyone on sickness absence or out-of-work benefits because of a mental health problem who would benefit from access to psychological therapy should be automatically offered it, whether through the new Health and Work Service or through Jobcentre Plus. In addition, psychological therapy services should include more specialist employment-related support for those who would benefit from it.

RECOMMENDATION 27: Providing enough Early Intervention in Psychosis services
The NHS should provide enough Early Intervention in Psychosis services to meet demand. This would improve health and save money. Existing EIP services should not be cut, as this not only harms health outcomes but increases NHS costs.

RECOMMENDATION 28: Protecting early action and early intervention spending
Government should put mechanisms in place to protect early action and early intervention spending in a similar way to capital spending. To discourage short-termism, which can store up significant social and financial costs for the future, whenever central funding for early action or early intervention services is reduced, the responsible department should be required to publish an economic impact assessment

CHAPTER 3 – BETTER OPPORTUNITIES AND SUPPORT FOR THOSE LIVING WITH MENTAL HEALTH PROBLEMS

RECOMMENDATION 29: Health & Wellbeing Boards to include a housing & planning representative
Health and Wellbeing Boards should include a housing / planning representative, such as the Head of Housing / Planning or a relevant Director.

RECOMMENDATION 30: National planning guidance should be revised to have regard to mental health
National planning guidance should be revised to ensure planning officers have regard to mental health needs and the supply of specialist housing options in drawing up their local plans.

RECOMMENDATION 31: Support projects to create more specialist accommodation
A rapid review is needed of how to tackle barriers to utilisation of the NHS estate, to ensure that existing estate and assets can be used to best effect for patients and the NHS as a whole. To get momentum behind this, ten 'trailblazer' projects should be identified – Trusts or CCGs working in partnership with Housing Associations and other providers specialising in care for people with mental illness – that would get a small grant towards the cost of working up plans to get projects underway quickly. These projects would demonstrate models that can be implemented more widely and provide further intelligence on the barriers that exist.

RECOMMENDATION 32: Housing needs should be considered as part of integrated care packages
Clinical Commissioning Groups, local authorities and NHS trusts should include housing organisations in designing their care pathways for those affected by mental health problems. Housing needs should be identified early on and care plans should include an accommodation section.

RECOMMENDATION 33: Improve the Work Capability Assessment
The Work Capability Assessment must be reformed to take better account of the nature of mental health problems. Providers need to invest in the right training for their staff to get decisions right first time and should be held to account with financial penalties for getting assessments wrong.

RECOMMENDATION 34: Better employment programmes for people with mental health problems
Providers bidding to deliver government employment programmes must demonstrate they have specialist knowledge of mental health and that they can offer access to evidence-based employment programmes, including condition management and, where relevant, supported employment.

RECOMMENDATION 35: All health professionals should have training in mental health
All health professionals should have training to be able to recognise signs of mental ill-health and refer patients to appropriate care and support. This should include proactively looking out for common mental health problems among people with long-term conditions.

RECOMMENDATION 36: Coordinated care for all with serious or co-morbid mental health problems
All people with serious or co-morbid mental health problems should have a personal care plan, designed in partnership with them and built around their goals, and a personal care coordinator to organise their care and link them up with wider services and support.

RECOMMENDATION 37: A national strategy to tackle race inequality in mental health services
The Department of Health should develop a new national strategy to tackle race inequality in mental health services, including on workforce development and leadership, and to improve outcomes for BAME communities. It must be clear about what indicators will be used to measure progress and what success will look like. This should include a national framework through which commissioners and providers at local level can be held more accountable for developing and delivering their own plans to achieve this.

RECOMMENDATION 38: People with mental health problems should be offered access to social support
People with mental health problems should be offered access to social activities and support if they need it, such as befriending or peer support. For those with complex needs, assessment and referral to social support should be a standard part of care plans.

RECOMMENDATION 39: Time to Change should continue for the next Parliament
The Time to Change campaign should be continued for the next Parliament, beyond 2016 when its current funding runs out. Alongside other funders, the Government should fund a third phase of the campaign until at least 2020.

RECOMMENDATION 40: Mental health awareness should be integrated into teaching in schools
Mental health awareness and understanding should be integrated into what children learn about health in schools. This is also an area where young people living with mental illness could play an important role in helping educate peers about the impact of stigma and discrimination.

Introduction: Why Mental Health in Society?

- Mental health is central to everything we do: it goes to the heart of who we are, our sense of agency and our ability to participate in society – all issues that underpin the most basic political values of equality, liberty and citizenship.
- Mental ill health is the single largest cause of disability in the UK, 23% of the total disease burden, and one in four of us will experience a mental health problem at some point in our lives. The World Health Organisation estimates that by 2030 depression will overtake heart disease and cancer as the leading global burden of disease.
- Mental health problems can not only be disabling and distressing in their own right, but can also have a profound impact on wider life outcomes, including on physical health, education, employment and income – no other health condition has such a profound impact.
- Mental ill health costs the country a lot of money. The estimated cost to the economy is £105bn, including £26bn to businesses in the costs of sick leave, reduced productivity and increased staff turnover, while the estimated cost to the NHS of untreated mental health problems is over £10bn.

All of these are reasons why it is vitally important to look at how we can improve the mental health and wellbeing of our nation and better support those living with mental health problems.

In setting up this independent Taskforce, Ed Miliband said: "Good mental health doesn't start in hospital or the treatment room. It starts in our workplaces, our schools and our communities. So we need a mental health strategy outside as well as inside the National Health Service."

Why is it important to look at mental health across society, rather than simply within health and care services?

We believe there are three particularly important reasons, which have consistently emerged in the work the Taskforce has done, and around which this report is organised.

1. **Mental health is shaped by the environment in which we live, so we should ensure our environment promotes and protects mental health**

Mental health is shaped by the contexts in which we live our lives and for most people that isn't in the NHS but in our homes, communities, schools and colleges and workplaces. These institutions and environments can help or harm mental health, sometime quite profoundly. So ensuring the environment in which we live promotes mental health and helps prevent mental ill-health should be a major focus of policy and action. Yet while this objective has long been the driving force behind public health policy for physical health, there is no comparable body of public policy interventions on a similar scale for mental health.

Chapter 1 looks at these issues of population mental health.

2. **Early intervention is needed to tackle problems before they escalate and need acute care**

By the time a problem comes to the attention of the NHS – and particularly to specialist mental health services – it has usually become more serious. But waiting until this point to address problems is not only worse for the individual concerned but usually more expensive too since it may require more specialist healthcare, as well as input from other services. So there is an economic case

as well as a health case for early intervention. Yet too often, mental health problems are only addressed late, when they have become more entrenched or reached crisis point.

Chapter 2 looks at early intervention and action – both intervention early in the life course and action to tackle problems early on before they get worse.

3. **Mental health impacts on many aspects of life, and so people living with mental health problems must be supported across society**

Many people will experience a mental health problem at some point in their lives – some short-lived, some long-term. If we want a society where everyone can play their part, then we need to make sure we support and promote opportunity for all, including those living with mental health problems. Yet while there are some inspiring examples of how people with mental health problems can be supported to recover and live fulfilled lives, far too often the support and opportunities available aren't good enough.

Chapter 3 looks at improving opportunities and support for people living with mental health problems.

The concluding chapter asks what our vision of the good society should look like when it comes to mental health, drawing out some underlying principles from the report.

Finally, there are a variety of important issues that are beyond the scope of this report, or which it does not seek to address in detail.

- We have not sought to focus on specific mental illnesses or problems, which cover a very wide range of conditions – anxiety disorders, depression, bi-polar disorder, schizophrenia, personality disorders, eating disorders, obsessive-compulsive disorder (OCD), autism, attention deficit hyperactivity disorder (ADHD), and many more – but have looked at some of the common issues faced by individuals across a range of conditions.
- We have not specifically included dementia or learning disabilities, though many of the issues we discuss also apply to these conditions – and in these cases we would certainly hope that our policy recommendations would also bring about much-needed improvements in service provision and quality of life for these groups too.
- This report does make some recommendations for specific mental health services, but because its focus is mental health in society we do not seek to offer a comprehensive programme for reform of NHS services. Nevertheless, we share the concerns of many who work in the NHS about the pressures that mental health services are currently under – described further in the box below – and believe these must be urgently addressed.

Current pressures in mental health services

Although in recent years there have been a number of welcome steps taken in mental health, including the House of Lords introducing an amendment to the Health and Social Care Act 2012 on parity of esteem between mental and physical health, the passing of the Mental Health (Discrimination) Act 2013, and the new 'Crisis Care Concordat' between the NHS, the police and other national bodies for improving crisis care, there have also been very concerning reports of pressures and problems within mental health services that must urgently be addressed. For example:

- *In 2012, the Department of Health confirmed that spending on mental health had fallen for the first time in ten years, and recent analysis by the Health Service Journal shows that mental health trusts have suffered a 2.3 per cent real terms funding cut between 2011-12 and 2013-14.*

- *In 2014, Monitor and NHS England recommended a 1.8% reduction in the amount of money paid for non-acute care services, including mental health, significantly higher than the 1.5% reduction in the budget for hospital-based medical services.*

- *Analysis by the Royal College of Nursing in November 2014 showed that there are now 3,300 fewer posts in mental health nursing, and 1,500 fewer beds, than in 2010.*

- *An investigation by the Health Service Journal in February 2014 found that uncertainty following the split in mental health commissioning in April 2013 led to a pause in the commissioning of new inpatient services which has exacerbated bed shortages. NHS England itself has acknowledged "weaknesses in commissioning" as a reason for bed pressures and patients being inappropriately admitted to specialised units.*

- *An investigation by the BBC and Community Care earlier this year found a growing number of children are being admitted to adult psychiatric wards and many sent hundreds of miles for hospital care as a result of bed shortages.*

Chapter 1 – Population Mental Health

A. The key argument of this chapter

This chapter focuses on the importance of public health for mental health. A variety of social and environmental factors affect our mental health and policy interventions can address these.

It is hard to overstate the importance of public health. Despite the overwhelming focus of health policy on services for diagnosing, treating and managing health conditions, analysis suggests that some 80% of the increase in life expectancy since 1900 has in fact been due to public health measures – clean air and water, unadulterated food, vaccination against diseases – and just 20% to health services.[1]

Yet while public health interventions in terms of physical health are well-established building blocks of healthcare systems all around the world, no comparable set of public health interventions has been developed for mental health at anywhere near the scale of those for physical health. This must change if we are to tackle the increasing prevalence of mental health problems in the 21st Century.

Thankfully, recent advances in epidemiology make this possible. Science has advanced our understanding of how the environment in which we live can affect our mental health in a way that is enabling the development of a modern field of public mental health.

Mental health problems can of course have a wide range of causes and triggers – including factors as varied as genetic susceptibility, negative life events such as bereavement or separation, physical illness or injury, or drug use. But there are factors that can make it more or less likely that a person develops a mental health problem. These include what we describe here as *resilience factors* that are beneficial to mental health, or protective of it at times when people experience threats, promoting resilience in the face of environmental stressors and reducing our susceptibility to mental health problems. They also include *risk factors* that are potentially harmful to mental health and can contribute to the onset or recurrence of mental health problems. Some of these factors are sometimes described as 'social determinants' of mental health: characteristics of our environment, such as social relationships or the workplace, that can help explain the pattern of health outcomes across the population. Addressing these 'social determinants' will require a far greater understanding of how lifestyle changes in the 21st century – such as increased use of new technology and social media, or changes to employment patterns and greater job instability – affect our mental health.

The key message of this chapter is that improving mental health can't just be about the treatment of existing disorders, but must also be about promoting health and wellbeing, and preventing ill-health, in the population as a whole. In the 19th Century, advances in our understanding of how disease was caused by microorganisms and our understanding of immunity enabled radical public health improvements such as the development of sanitation systems and vaccines. Today, recent advances in our understanding of risk and resilience factors for mental health can help us to make changes in 21st Century society to help reduce the prevalence of mental ill-health.

The mental health of societies

One of the most interesting findings of epidemiological studies is that there are sometimes significant differences in the prevalence of mental health problems between different societies or between different groups within societies. For example:

- *Studies have found an inverse relationship between the strength of social capital and the presence of mental disorders in populations. One of the most striking demonstrations of this actually comes from studies of the impact of war on civilian populations: for example, a study by Edgar Jones of civilian morale in the Second World War found that community cohesion was one of the factors explaining why some British communities that were bombed during the Second World War fared better than others in terms of mental health problems, and other studies of conflicts around the globe highlight the role of social support in explaining differences in mental health outcomes.*

- *Kate Pickett and Richard Wilkinson, in their work on the impact of inequality, find that rates of mental illness in developed countries vary substantially depending on how equal or unequal they are, with a higher prevalence in more unequal countries. The authors argue that greater inequality harms the quality of social relationships within a society and, through this, mental health.*

Such differences in the mental health of whole countries or communities highlight the role of social and environmental factors. They show that we cannot simply understand mental health problems in terms of individual pathology, but also need to see mental health as a product of the environment in which we live.

B. Resilience factors

i. Social networks

Social networks are protective for mental health: the stronger an individual's social networks, the less likely they are to develop a range of mental health problems. Studies have found strong associations between lack of social contacts and experience of depression and other mental health problems.[2]

The connection between social networks and mental health runs in both directions: on the one hand, social networks play a protective role in preventing mental health problems; on the other, people living with mental health problems can find it harder to form or maintain social networks. Chapter 3 looks specifically at the issue of improving social opportunities for people living with mental health problems. But enough is known about how social networks and social participation can promote and protect mental health for this to be a focus of public health in its own right.

How social networks influence mental health

There are several ways in which social networks can influence mental health. For example, they can influence related health behaviours such as drinking or smoking, or they can be a route to accessing information and advice about health.

But there are two specific 'psychosocial mechanisms' through which social networks can influence mental health, which have been analysed by the psychologist Sheldon Cohen.

The first is the act of participating in social relationships and activities, which can reinforce a sense of identity, purpose and belonging and aid emotional self-regulation.

The second is the provision of social and emotional support to help individuals cope with stress ('stress buffering'). In particular, the perception that others will provide support if needed can bolster one's perceived ability to cope with demands of a situation, lowering its stress. So social support can have a protective effect on mental health by mediating the body's reactions to stressful events.

The landscape of social interaction and social networks is complex. It covers a whole continuum of contexts ranging from family, friends and neighbours at one end, through various kinds of 'platforms for association' – including physical spaces like the school gate and civil society organisations like the sports club or allotment group – through to 'light touch' support schemes such as buddying and mentoring, all the way to formal public services, including care services and mental health services. Moving along this continuum takes us from support which is primarily informal and voluntary, and where the social support is often a by-product of everyday interactions with others, to support which is increasingly formal and funded. In each case, the type of 'infrastructure' underpinning the activity may be different – sometimes a public space or institution, sometimes the internet or telephone, sometimes volunteers, sometimes paid service professionals, and so on.

Supporting social networks is an area of life where government and public policy necessarily have a limited role; government cannot make individuals form social relationships. But along with communities themselves, government, public services and the voluntary sector do have a potential role to play in helping support the social life of communities and removing barriers to social activity where possible.

Examples of initiatives that could make a real difference here include:

- Providing information about activities within a community, and ensuring public services and other organisations can signpost people towards these activities where appropriate
- Supporting community groups and community events such as the Big Lunch
- Supporting the development of online forums, which may be of particular benefit for those who are physically or socially isolated
- Supporting and training community organisers who can mobilise activity
- Helping fund community centres and other physical spaces that support social activity
- Co-locating services such as children's centres, libraries or day centres, to support social activity in these settings

The current Government has sought to catalyse public and private investment in economic infrastructure through a national economic infrastructure plan.[3] We think the time has come for an equivalent ambition for national *social* infrastructure, to help fund and facilitate the development of social infrastructure and networks in communities, and provide momentum to initiatives that support this important area of our national life.

*** The government should develop a social infrastructure plan to help catalyse public and private investment in social infrastructure across our communities, in support of strategies developed and led by communities themselves. As part of this, a new funding pot should be introduced, drawn from a mix of government revenue, lottery funding and contributions from businesses and individuals, to support a range of social platforms, initiatives and activities that help encourage and maintain social participation and social support within communities, such as community centres and events, community organisers, online forums, peer support groups and befriending and mentoring schemes.**

ii. Physical activity

One way to enhance and protect mental health is through physical activity – which could be sport or exercise, play, or just everyday activity like walking to the bus stop. Studies show physical activity can enhance mood, reduce the likelihood of developing depression and anxiety, and ameliorate the symptoms of depression and anxiety.[4] It can also reduce the likelihood of developing dementia and slow the progression of the disease.[5] Physical activity has these effects through a range of mechanisms, both physiological mechanisms (like the release of neurotransmitters in the brain or the long-term benefits of exercise for brain plasticity) and psychological mechanisms (such as fostering a sense of purpose and improving confidence).[6]

So measures to encourage physical activity have an important role to play in improving mental health.

*** A new national campaign should be created to encourage more physical activity, with the aim of significantly increasing the proportion of the population who are physically active, including among groups that can face barriers to being more physically active, such as older people and those with mental health problems.**

This could involve initiatives in schools, such as measures to promote physical education, and initiatives in workplaces and in community leisure facilities and parks, as well as promoting cycling and safe walking routes. Another opportunity is the wider use of 'social prescribing' by health professionals, where individuals are linked up with and encouraged to participate in physical activities – which is discussed in more detail further below.

iii. Well-designed buildings and urban spaces

The design of our buildings and urban spaces can have a huge impact on our health and wellbeing. Housing quality, density, natural light, noise, access to green spaces – all of these can influence our mental health. For example, one recent study found that individuals who move closer to green spaces in urban areas exhibit immediate improvements in mental health, with the impact sustained for at least three years.[7] On the other hand, poor housing and neighbourhood attributes such as overcrowding, feeling unsafe and lack of access to community facilities can have a harmful impact on mental health.[8]

The same is true for the design of buildings. For example, studies of the design of care homes have identified a variety of factors that can benefit mental health, such as soft landscaping and grouped seating spaces.[9]

A range of mechanisms mediate the impact of the built environment on mental health. In some cases, the impact will be through stress – such as stress caused by living in crowded buildings – or disrupted sleep patterns. The built environment can also have a large impact on mental health via its impact on other behaviours – such as whether an urban space encourages or discourages social interaction or physical activity.

So housing isn't just about bricks and mortar, but about places and communities where people want to live and be and where all citizens can find environments appropriate to their needs. Well-designed communities and buildings are therefore an important public health intervention.

The recent Farrell Review looked into architecture and design in the built environment and made powerful recommendations for entrenching better design through better planning and encouraging greater focus on the quality of place.[10] It recommended replacing Design Reviews (where professionals join panels to review projects) with PLACE reviews – planning, landscape, architecture, conservation and engineering – with experts from each of these professions being consulted by local planning authorities. Farrell suggests that these reviews should assess not just the quality of new developments but the quality of existing places.

*** Mental health and wellbeing must be at the heart of planning, architecture and design. We endorse the proposals of the Farrell Review for entrenching good design in architecture and the built environment through the proposed PLACE reviews and it is important that mental health considerations are embedded in these processes.**

This will not be achieved by regulation or guidance alone. Ultimately, well-planned and designed areas are those that derive from a vision of place focusing on the right mix of land uses and tenures, transport, the need to plan for and protect informal spaces, parks and a sustainable environment and perhaps most of all the health, safety and pleasure of both residents and visitors. So our culture must also value quality places, with political leaders, stakeholders, residents and citizens collaborating and involved in their design and creation.

Recent proposals to increase the supply of new homes, along with the development of New Towns and Garden Cities, are a real opportunity to demonstrate commitment to creating mentally healthy homes and communities. For example, Garden City principles require a commitment to sustainable development to improve quality of life, health and wellbeing, and this will include the good design and access to green spaces that are so important to mental health.

iv. Social and emotional skills

Social and emotional learning, including resilience training, helps people understand the links between their thoughts and feelings and develop skills in controlling and managing them. It also helps build interpersonal skills and a better understanding of how we relate to others. These are all qualities that build character, enable us to be more resilient in coping with adversity, and more ready and able to seize new opportunities. Social and emotional learning has been shown to improve mental health and reduce the likelihood of developing mental health problems such as anxiety, depression or conduct disorders.[11]

The most common context for social and emotional learning programmes is in schools, though it can benefit people in all walks of life; for example, it has recently been introduced by the US military to prepare soldiers to face the stress of combat and prolonged separation from their family.[12]

There are a variety of school programmes used around the world that have had positive evaluations, such as Roots of Empathy, Kidsmatter and Positive Behaviour Interventions & Supports.[13] But the key point is how programmes are delivered: they need to be structured, with sufficient time allocated to them, and they need to be delivered by trained staff. In the UK, the SEAL programme has been used in recent years; evaluations of the early phase of the programme suggested that this was more effective for primary children than secondary, with the issue at secondary level being lack of structure and guidance on how to deliver it.[14]

Evaluations of successful programmes show they have many benefits beyond improving mental health, including improving educational attainment, behaviour and school attendance.[15] One meta-analysis of programmes in the US found that children who took part in them not only increased their emotional well-being but improved their academic performance by an average of 11 percentile points.[16]

During the last decade, considerable progress was made on improving mental health within schools, including expanding social and emotional learning. However, in recent years it has been squeezed out of the picture, even being described as 'peripheral'.[17] We think that child mental health is fundamental, not peripheral, and that to try to separate academic attainment from mental health and wellbeing is to misunderstand the nature of child development.

*** All children should have the opportunity to benefit from social and emotional learning in primary and secondary school, and it is important that social and emotional development is embedded in Personal, Social, Health and Economic (PSHE) education and across the whole school community.**

The government should look at the best set of levers to make this happen. But we think the most important factor will be encouraging schools to adopt a 'whole-school' approach to mental health, with a culture of valuing mental health and recognising it is the responsibility of everyone in the school, and with effective school policies to tackle problems, strong links to learning in the curriculum and leadership from the head and governors, including in supporting training in mental health issues for staff.

One important step in achieving this is to encourage schools to work towards a benchmark of provision and to ensure that those who do valuable work with children and families to tackle mental health issues are properly recognised. The Healthy Schools Programme, which ran from 1999 to 2011, was a popular programme for encouraging and supporting schools to improve the health and wellbeing of children and young people. We would like to see a successor to this programme, which includes a way of accrediting and recognising schools for their work in promoting and protecting children's health and wellbeing.

C. Risk factors

i. Violence, abuse and bullying

Negative life events are a common trigger for mental health problems. Some events such as bereavement or separation may not be preventable and when they happen the priority is to ensure that effective support is available for individuals and families.

However, there are other types of traumatic life events involving violence, abuse and threatening behaviour that can and should be prevented. While it is beyond the scope of this report to make detailed recommendations for tackling them, we wish to highlight two important issues in this section that can have very harmful effects on mental health: domestic abuse and bullying.

Domestic violence and abuse

The scale of violence and abuse in our society is shocking. The 2011/12 Crime Survey for England and Wales found there were two million victims of domestic abuse over the previous year and 536,000 victims of sexual assault.[18] A recent NSPCC survey has found one in five children reporting serious physical abuse, sexual abuse or severe physical or emotional neglect at some point in their lifetime.[19]

Violence and abuse have a devastating impact on mental health. Being a victim of sexual or domestic violence is associated with the onset and persistence of depression, anxiety, eating disorders, substance misuse, psychotic disorders and suicide attempts.[20] Childhood abuse also has long-lasting impacts on mental health; it is estimated that between a quarter and a third of the disease burden of adult psychiatric disorders is attributable to the effect of childhood abuse.[21]

A range of important interventions are needed to prevent violence and abuse against children and adults encompassing law enforcement, safeguarding, education and supporting troubled families. Detailed recommendations in this area are beyond the scope of this report.

The Labour Party has committed to a new Bill to help tackle domestic violence, including to establish a Commissioner for Domestic and Sexual Violence, new national standards for policing, a National Refuge Fund, compulsory sex and relationships education in schools and FGM protection orders to stop young girls at risk from being taken out of the country.

This should also provide an opportunity to put renewed focus on the mental health needs of those who have suffered or witnessed domestic abuse and their experience of health services. Priorities here include ensuring that counselling services and other psychological treatments are available and are offered to survivors of violence and abuse, and that staff who work in mental health services are trained to handle issues of abuse or violence when someone chooses to talk about their experiences. Domestic violence is under-detected in both primary and secondary care, and the recent annual report of the Chief Medical Officer highlighted that most mental health care professionals and GPs have little or no relevant training and may find it difficult to facilitate disclosure and to manage the issues after disclosure.[22] NICE guidance recommends training clinicians to ask about experiences of violence in a sensitive, non-judgemental way, with signposting to appropriate local referral and care pathways that ensure safety and promote recovery.[23]

Bullying

Bullying is experienced by between a third and half of British school children and young people,[24] and people of all ages can be victims of bullying.

As well as the distress it causes, bullying is an important factor in the development of depression, anxiety and eating disorders. People who are bullied may be more likely to self-harm or turn to drugs or alcohol, and children who are exposed to frequent bullying are at higher risk of developing mental health problems.[25] A recent study found that nearly two-thirds of Child and Adolescent Mental Health Service (CAMHS) users reported being bullied, and of these nearly two thirds identified bullying as an important reason for their CAMHS attendance.[26]

Identity-based bullying can be particularly harmful, such as homophobic bullying or racist bullying. And where such bullying is accompanied by other disadvantage, such as learning disabilities, the

effects may be compounded. The effects can also be long-term, with victims of childhood bullying having an increased risk of depression, anxiety and suicidal thoughts up to 40 years later.[27]

It is important that anyone being bullied has someone they can speak to and that organisations such as schools, colleges, universities and businesses have explicit anti-bullying policies and programmes in place and staff trained to deal with bullying.

*** Strong action to tackle behaviours such as violence, abuse and bullying is essential and will make an important contribution to preventing mental health problems. That requires a zero-tolerance approach across society, backed up with effective policies and actions.**

Homophobic bullying in schools and mental health

Stonewall's recent School Report reveals some shocking statistics about the prevalence of mental health problems in LGB young people and the links to homophobic bullying:

- *More than half (55%) of LGB young people experience homophobic bullying at school - and nearly half of these have symptoms consistent with depression.*
- *Almost half (46%) of LGB young people who experience homophobic bullying have symptoms consistent with depression.*
- *More than half (56%) of LGB young people have self-harmed (compared to an estimated 10% of young people as a whole), and those who have experienced homophobic bullying are more likely to self-harm.*

The mental health consequences of homophobic bullying can be particularly bad for LGB young people because many may feel unable to turn to family and friends for support if they are not 'out' to them.

Tackling homophobic bullying in schools requires action on a range of fronts, including:

- *Ensuring those who do suffer homophobic bullying are able to turn to someone and get proper help and support - both from staff within the school, and organisations in the wider community.*
- *A zero-tolerance approach, dealing with incidents swiftly and clearly; there is less bullying in schools which explicitly state that homophobic bullying is wrong, for example through a charter posted visibly in classrooms and corridors.*
- *Teachers having training in tackling homophobic bullying as part of their initial teacher training and continuing professional development.*

One specific issue that has risen to prominence in recent years, and which particularly affects young people, is cyber-bullying – when someone uses digital media to send insults, threats or information designed to damage someone's reputation. As the recent annual report of the Chief Medical Officer observes, cyber-bullying can be particularly harmful because it lacks time or space boundaries so young people have no respite from their persecution, while the use of technology provides anonymity which can result in greater cruelty compared with face-to-face bullying.[28]

Cyber-bullying can be difficult to tackle because of the lack of established legal frameworks for intervention and difficulties in tracking the originators of anonymous messages. So it is important

that all young people are made aware of issues of online safety and responsibility, and what do to if they experience cyber-bullying.

*** The computing curriculum and Sex and Relationships Education should contain a stronger focus on young people using technology safely, so they know who to contact if they experience online bullying and understand that their behaviour online should be as responsible and respectful as their behaviour in the classroom. Technology businesses should also play their part in helping to educate young people about online safety and in supporting teachers with training and guidance on staying up to date with developments in technology and computing.**

ii. Work-related stress

There were an estimated 487,000 cases of work-related stress, depression and anxiety in Great Britain in 2013-14, accounting for 39% of all cases of work-related illness, and resulting in a total of 11.3 million working days lost.[29]

Studies have looked at the specific factors behind work-related stress and how they are related to mental health.[30] It is important to emphasise that 'stress' in this context is not simply saying someone has a large workload; high demands can be a good thing, motivating people and enhancing performance. Rather, stress comes from the combination of high demands with factors such as:

- lack of control over one's job, such as lack of involvement in decision-making or lack of opportunity to use one's skills. The combination of low control with high demands predicts a range of illnesses, including mental health problems, independently of the personal characteristics of individuals.[31]
- lack of appropriate support from supervisors or colleagues, such as lack of ability to talk about work-related problems, or receiving inconsistent information from supervisors. These factors are associated with a two-fold increased risk of poor mental health, while good levels of support have a protective effect on mental health and reduce sickness absence.[32]

So the work environment and the opportunity that it gives individuals for control can be an important factor in mental health.

Good mental health is the responsibility of everyone in a workplace, from chief executives and board members, who can promote a healthy workplace culture and support employees during periods of change, to employees, who need to look after their own mental health and communicate needs and concerns to managers. But in terms of avoiding work-related stress, it is clear that line managers can play an especially important role.

Good line management and HR practices that increase employee input and control, and that offer a supportive environment in which work-related problems can be discussed, can help reduce work-related stress and subsequent mental health problems. Yet surveys suggest that many managers have poor knowledge of mental health and of the extent of mental ill-health among their employees;[33] the Parliamentary Office of Science and Technology has suggested an important reason behind this is the failure to support people who are promoted to management positions on the basis of technical skills to develop as people managers.

A variety of management standards currently exist to support mental health in the workplace, which include ensuring employees have a degree of control over their work and that appropriate support is available. These include standards set out by the Health and Safety Executive[34] and also recommendations from the National Institute for Clinical Excellence[35] – and a variety of other important resources exist for employers to draw on in improving workplace mental health, such as

those by Acas, Mind and the Centre for Mental Health. The best employers already conform to and exceed these kinds of standards. To improve workplace mental health across the country, however, we need more employers to do so.

*** Professional management standards and employer accreditation schemes should reflect the expectation that all line managers should have training in the management issues and communication skills relevant to ensuring a mentally healthy workplace and supporting staff who become unwell. Employers should embed these standards in their organisational policy and practice. The public sector should also take a lead here, ensuring that it becomes routine for line managers to receive this as part of their training.**

Given that poor mental health costs business an estimated £26bn a year – comprising some £8.4bn due to sickness absence, £15.1bn due to 'presenteeism' (employees attending work but not functioning at full capacity) and a further £2.4bn in staff turnover – there are strong incentives for employers to promote mental health and help prevent mental health problems.[36] Adherence to these management standards could not only make a significant contribution to improving population mental health, but generate significant benefits for their business, improving productivity and performance, reducing absenteeism and increasing staff retention.

National Institute for Clinical Excellence recommendation for employers on the role of line managers in promoting mental health in the workplace

[Employers should] strengthen the role of line managers in promoting the mental wellbeing of employees through supportive leadership style and management practices. This will involve:

- *promoting a management style that encourages participation, delegation, constructive feedback, mentoring and coaching*
- *ensuring that policies for the recruitment, selection, training and development of managers recognise and promote these skills*
- *ensuring that managers are able to motivate employees and provide them with the training and support they need to develop their performance and job satisfaction*
- *increasing understanding of how management style and practices can help to promote the mental wellbeing of employees and keep their stress to a minimum*
- *ensuring that managers are able to identify and respond with sensitivity to employees' emotional concerns, and symptoms of mental health problems*
- *ensuring that managers understand when it is necessary to refer an employee to occupational health services or other sources of help and support*
- *considering the competency framework developed by the Chartered Institute of Personnel and Development, the Health and Safety Executive and Investors in People as a tool for management development*

Work-related stress can also be a product of factors beyond the immediate work environment. One source of stress can be difficulty in juggling work and family life, which is why promoting and extending flexible working initiatives can be important for mental health. Job insecurity can also have a significant detrimental effect on mental health, so actions such as tackling the use of exploitative zero-hours contracts would be positive steps forward in improving mental health and wellbeing.

iii. Social isolation and loneliness

An earlier section looked at the protective role of social networks for mental health, but there is a case for viewing social isolation as a harm in its own right – not simply the absence of the benefits of social relationships, but something that is actively detrimental to mental health. Studies show the positive association between social relationships and health isn't 'linear': once you have a few social ties, having more does benefit your health, but not by nearly as much as the benefit of someone who has no social ties gaining one or two.[37]

Social isolation can lead to loneliness, and evidence suggests that both isolation and loneliness can be harmful to mental and physical health:

- In terms of physical health, isolation and loneliness heighten metabolic responses to stress and increase the risk of blood pressure problems and heart disease.[38]
- In terms of mental health, isolation and loneliness increase the risk of a wide range of illness, including depression.[39] Studies also show that it is also linked to cognitive decline, increasing the risk of Alzheimer's disease.[40]
- Social isolation also has a very powerful impact on mortality – reducing your chances of survival to the same extent as smoking 15 cigarettes a day.[41]
- Isolation can harm health in wider ways too, for example by hindering a person's ability to access services or get information and advice.

The facts about isolation and loneliness in Britain today are shocking, particularly among older people. Around 10% of people over 65 – some 900,000 people – say they feel lonely all or most of the time; among ethnic minority older people, this rises to 15%.[42] In terms of social contact, 11% of older people say they are in contact with family, friends and neighbours less than once a month,[43] while six per cent of older people report that they leave their house once a week or less.[44]

Specific interventions exist to tackle isolation and loneliness – often with a strong volunteer element – that can be applied in a range of settings and for different groups of people:[45]

- Befriending schemes provide additional social support, usually by volunteers or paid workers visiting an individual in their home, but also sometimes on the telephone or in groups.
- Mentoring schemes have something in common with befriending, but are primarily aimed at equipping people with the skills and abilities to achieve goals, and the social relationship involved is a positive by-product of this.
- Gatekeeping schemes involve volunteers who provide vulnerable people with emotional, practical and social support, acting as an interface between the individual and the wider community and public services.
- Social group schemes help people widen their social circle. They cover a range of models, from groups where social participation is the primary objective, to groups with another objective (such as creative activities) where social participation is a natural by-product.

Online networks and forums are also an important means of social interaction, where people can come together around specific activities as 'communities of interest', and online interactions may also be a significant component of the schemes listed above.

Age UK befriending schemes

To tackle the problem of loneliness among older people, many local Age UKs provide befriending services, some by telephone and some where a volunteer visits an older person in their home. The service works by assigning each older person a befriender (a volunteer), who provides friendly conversation and companionship on a regular basis over a long period of time. As well as providing emotional support and a link to the outside world, volunteers can also pick up on the practical or health needs the older person may have and help to make sure they get the support they need.

This relationship not only promotes wellbeing and confidence, but can also help people remain independent in their own homes in later life.

By reducing loneliness, which is a major risk factor for depression, programmes such as these can not only promote emotional wellbeing, but can help prevent mental ill-health too.

Such schemes provide valuable social support and help promote social engagement and participation, with considerable potential health benefits; for example, studies have found that befriending schemes can reduce depression.[46] It is therefore important to ensure that all communities have these kinds of support available for those who might benefit from them.

The proposal earlier for a new funding pot to support the development of social infrastructure across communities could help catalyse such schemes where they are currently not available. What is critically important is that communities themselves develop and lead strategies for tackling loneliness and isolation.

*** As part of their strategic needs assessments, Health and Wellbeing Boards should assess the need for social support in their communities, and map existing support schemes; where such schemes are needed but are not available, they should be encouraged.**

The other key priority is ensuring that those who could benefit from these kinds of activities and support get linked up with them. For example, much greater use should be made of 'social prescribing' by GPs and other health professionals, linking individuals up with peer groups and other social activities and support.

*** Health and care services must see it as a core part of their mission to assess whether individuals are isolated or lonely and, if so, link them up with social activities and support. GPs and other health professionals should routinely use 'social prescribing' to signpost people to peer groups and other social activities and support.**

iv. Poverty, insecurity and disadvantage

One in four people will experience a mental health problem at some point in their life, and anyone can be affected – young or old, rich or poor. But not everyone is equally likely to experience one. There is a 'social gradient' for many types of mental health problem, such as depression, with those in lower-income groups more likely to experience them than those in higher-income groups.[47]

This social gradient is testament to the impact of the underlying social determinants of mental health, highlighting the role of economic and social inequalities in creating health inequalities. It reflects the fact that those in lower-income groups or other disadvantaged groups, such as Black and

Minority Ethnic groups, are more likely to be exposed to the psychological risk factors and stressors that contribute to mental ill-health, as well as being less likely to have access to the support or resources to deal with them. For example, there is a strong social gradient in factors like social isolation and lack of control at work.[48]

There are many other aspects of poverty, insecurity and disadvantage that have a negative impact on mental health, including financial insecurity and debt, housing insecurity, job insecurity and greater risk of being a victim of crime.[49] Improving population mental health is therefore partly a question of tackling some of the most damaging inequalities that exist in society today.

It is beyond the scope of the Taskforce's work to make recommendations across all of these areas of social policy, especially given how wide-ranging the actions required to tackle these issues of insecurity and disadvantage are. To take one example, we know that struggling to pay the rent and resulting debt can be a major contributor to mental health problems; the full set of solutions here would need to encompass not only better debt advice, more sensitive debt-collection practices and more affordable credit, but also more affordable rents and better supply of housing.

Government policy can also be a major factor in its own right, for good or ill. For example, the National Housing Federation estimates that one in seven households affected by the Housing Benefit under-occupation penalty are now at risk of eviction.[50]

Household insecurity and disadvantage impacts on child mental health too.[51] The Chief Medical Officer's recent annual report stated that, "Given known links between economic uncertainty and mental health, as well as the association of childhood psychiatric disorder with both social disadvantage and parental psychological distress, the levels of mental health difficulties in children and young people require urgent reassessment, as austerity may disproportionately impact on their mental health and wellbeing".[52]

Given the wide range of policy areas, well beyond the Department of Health, that have an impact on mental health – including tax, welfare, employment, education, housing, crime and justice – it is important that mental health considerations are at the heart of policymaking. The 2010 Marmot Review of Health Inequalities called for 'health in all policies' and this principle should clearly apply to mental health as well as physical health.[53] However, there is also a need for policies that may have a significant impact on mental health to be subject to particular scrutiny.

*** Major government policies should undergo a Mental Health Impact Assessment to ensure that mental health is reflected in policymaking across government.**

Chapter 2 – Early Intervention and Action

A. The key argument of this chapter

This chapter looks at early intervention and mental health – both intervention in childhood to promote mental health and prevent ill-health ('early intervention'), and intervention to tackle emerging mental health problems before they get more serious ('early action').

The start of life is a time of rapid cognitive, social and emotional development. And early child development, including child mental health, has a huge impact on later life outcomes – both health outcomes and also wider outcomes like education and employment. Supporting children in the early months and years of life is important precisely because it is where the opportunities to improve a child's developmental pathway, and the risks of poor development, are at their greatest. The importance of early intervention has been powerfully demonstrated in a series of recent reports, including those by Frank Field and by Graham Allen.[54]

Unfortunately, the approach we take with mental health is often precisely the opposite of early intervention; as Graham Allen said in his recent report, "Almost without exception, UK policies for the care of children in the social, emotional and mental health spheres are based on the principle of waiting until matters go seriously wrong".[55] More than three quarters of adults who access mental health services had a diagnosable disorder prior to the age of 18,[56] but less than less than half are treated appropriately at the time.[57]

The same logic holds for tackling emerging mental health problems whenever they occur in life: intervening upstream to nip problems in the bud, or treat them early on, is a far better strategy than waiting for problems to develop and become more severe or entrenched, which then requires more intensive support.

This logic means there is a powerful economic case for early intervention too – and this case can be particularly stark when it comes to mental health. While mental health problems are often thought of simply as a 'health' issue, defined by their clinical symptoms, they can have big consequences across many different areas of life, including housing, employment and criminal justice. Because of this, a failure to intervene early can lead to large public expenditures later on. Conversely, because of the huge costs of failing to intervene early, it does not take long for early intervention programmes to pay back their costs.

For example:

- Between the ages of 10 and 28, the additional public sector costs of someone having conduct disorder at age 10 is £40,784, compared to the £1,282 costs of a parenting programme at age 10.[58]

- Accessing treatment can be a critical step in helping those out of work with depression or anxiety move into work, and the average cost of a course of talking therapy in the IAPT programme is less than the cost to the Exchequer of keeping somebody on Employment and Support Allowance for a single month.[59]

- Because of the high costs of being sectioned, Early Intervention in Psychosis services on average generate *in-year* savings of thousands of pounds.[60]

The issue is not simply that we need to expand effective early action and early intervention services because there is currently unmet need. Right now, programmes are being *cut* and this is not only harming health and imposing costs on the economy and wider society, but is actually increasing

costs to the *public sector* – a 'lose-lose' situation. And at a time when deficit reduction still remains a huge challenge, this is simply unsustainable. So while there is much to do to expand and improve services, in the immediate term an equally pressing objective must be to protect the range of successful early action and early intervention services that are currently available.

The neglect of children's mental health

If adult mental health has in policy terms always been the poor relation of adult physical health, then children's mental health has been the poor relation of a poor relation, receiving less priority and less attention than adult mental health, despite the critical developmental importance of childhood and adolescence. For example:

- *NHS spending on Child and Adolescent Mental Health Services (CAMHS) accounts for just 6% of the mental health budget, despite the fact that three quarters of adult mental illness begins before the age of 18*
- *Waits for CAMHS are often longer than for adult mental health services, and the recent Government announcement on waiting-time standards did not apply to services for children and young people*
- *In some areas of the country there are insufficient 'places of safety' and suitable inpatient beds for young people, which has seen a worrying rise in recent years in the number of young people being placed in adult wards, detained in police cells or sent long distances away from home in order to find a suitable place*

The NHS must commission the services needed to meet children's mental health needs and must be as ambitious about standards of access to these services as it is for adult services.

If children and young people's mental health was given the priority it deserves, then over time we would expect the proportion of the mental health budget spent on CAMHS to rise, in the process lessening some of the demand on adult services through better early intervention.

B. Early intervention to support children and young people

i. Mental health around birth and the role of health visiting

Health visiting is a particularly important service for identifying the need for early intervention. Health visitors have contact with families from pregnancy through the first weeks and months of life and up until a child starts school, delivering the Healthy Child Programme development checks after birth and at 2-2½ years, and also providing support during pregnancy, where healthy foetal development is essential for later outcomes. Health visiting is also a universal service, enabling contact with every family whatever their social status. And health visiting is one of the few services that supports families in their home, the critical environment for child development.

So health visitors are in a valuable position to spot issues early on that may develop into more serious problems if left unaddressed, such as a child with emotional or behavioural problems or a parent struggling to cope, and to link families up with wider services such as psychological therapy, relationship support, debt advice, and Sure Start services.

A particularly important factor is parents' mental health. This is important not only for the parent's wellbeing, but the child's too – for example, if a problem impairs a parent's ability to provide stimulation to their child. While the majority of parents with mental health problems are very good parents, it is important that support is in place, as it would be for those with other conditions, to ensure their child's development is not affected. Antenatal and postnatal mental health problems are a particularly significant issue: some 10-14% of new mothers experience depression in the perinatal period, with 3% experiencing severe depression.[61]

There is a chance to make better use of the health visiting service to support mental health. While there are many excellent health visiting services around the country, there is evidence that opportunities to address mental health are sometimes missed; a recent NSPCC survey, for example, found a significant proportion of mothers saying they were not asked about depression.[62]

It is therefore important that all health visitors across the country are supported with the training and skills they need to recognise and respond to the signs of mental ill health. Health visitors currently receive training on postnatal depression, but there is an opportunity to go much further in embedding mental health and wellbeing within their remit.

This could be achieved if the existing standards for professional practice were reviewed and updated to ensure specific relevance to health visiting.[63] Now more than ten years old, these very broadly stated standards are arguably dated, as whilst they outline the principles underpinning health visiting practice, they say little about the specifics as they were originally written to accommodate a broad range of public health nurse roles. As a result, the time devoted to the topic of mental health will vary across pre-registration health visitor education programmes and thus knowledge and practice is not consistent. As the Law Commission indicated in their 2014 report on the regulation of health professionals,[64] the time has come to review how the NMC regulates 'specialist community public health nurses' (the umbrella term for health visitors, school nurses, occupational health nurses and others). A fresh set of professional standards for health visitors should explicitly include a focus on mental health during the early years. Educational programmes working with these standards need to include specific time allocated not only maternal mental health but also infant mental health and wider aspects of child social, emotional and behavioural development. To take one example: language development at the 2-2½ year check can be an indicator for early diagnosis of autism.

*** Health visitors should have the training and support they need to identify and respond to issues relevant to mental health promptly. Looking out for mental health problems and linking people up with the right services and support should be central to their remit.**

Pursuing an expanded role for health visitors on mental health will also require ensuring there is enough capacity to do so, including addressing issues of high caseloads and tackling bureaucracy.

Where new mothers develop serious mental health problems they will need to have access to the wider range of perinatal mental health services – discussed further in the box below.

Perinatal mental health

More than one in ten women develop a mental illness during pregnancy or within the first year after having a baby (the perinatal period). Despite its high prevalence, there is a shortfall in the quality, availability and accessibility of antenatal and postnatal mental health care.

Specialist support such as the Channi Kumar Mother and Baby Unit at Bethlem Royal Hospital plays a critical role in helping the mother to recover, developing a relationship between the mother and her baby, reducing the impact of the mother's mental illness on the child, and providing support for the mother in her community. Yet, this is one of only seventeen mother and baby units across the country. Half of areas across the country have no specialist NHS perinatal services, so women can end up on adult psychiatric wards, separated from their babies and partners, or not receiving any support at all.

Left untreated, perinatal mental illness can have a devastating impact on the women affected and their families. Without appropriate services, perinatal mental illness can impact on a child's cognitive, emotional and social development. And there is not only a moral case for ensuring that all new and expectant mothers experiencing mental illness get the specialist support they need but an urgent economic imperative too; recent research by the Centre for Mental Health shows that untreated perinatal mental illness costs our economy £8bn a year.

More intensive interventions for the most vulnerable young families: The Family-Nurse Partnership

The Family-Nurse Partnership programme originated in the US but was introduced in England in 2007. It is a voluntary programme that consists of intensive home visiting by specially trained nurses for vulnerable, first-time young mothers from early pregnancy until age two. Among other things, it aims to promote attachment and positive parenting through changing behaviour and tackling the problems that prevent some mothers and fathers caring well for their children.

An evaluation of the first 10 sites in England found higher levels of warm parenting, improved self-esteem among mothers, and children developing in line with the population in general – a remarkable result. A large-scale randomised control trial is now underway to gather more evidence.

Evaluations of the programme from the US, where the programme has been running for 30 years, have demonstrated a wide range of benefits including improved parenting, improved language development and academic achievement, reductions in neglect and abuse and increased maternal employment. The programme has also been found to generate considerable financial savings – £3-5 for every £1 invested. The costs of the programme to the public sector are recovered by the time children reach age 4, due to reduced health service use, reduced welfare use and increased earnings, and less involvement with criminal justice.

Despite the potential benefits of this programme, there is still some way to go to ensure that all vulnerable first-time parents who meet the criteria for Family Nurse Partnerships have access to it. Current plans are for the programme to be available to 16,000 families by 2015. The House of Commons Library estimates that each year there are around 23,000 new first-time mothers under 20 in England, meaning that the programme will need to continue to expand.

ii. Parenting and parenting programmes

Warm, positive parenting and secure attachment are crucial for a child's social and emotional development. Of course, the primary responsibility for this lies with a child's parents and carers. But public services and the voluntary and community sector have an important role in ensuring that all parents and children have access to the support they need to get off to the best possible start in life, with additional support for the most vulnerable families.

Parents differ in their parenting capabilities and various factors and pressures can result in poor parenting or a challenging home environment for child development. In these situations, parenting programmes, which help improve parenting skills and the quality of the parent-child relationship, are one tool for addressing the problem.

One example of a problem that can be improved by skilling up parents is conduct disorder, which affects around 5% of children aged 5-10.[65] Conduct disorder is different to normal bad behaviour; it is where problem behaviours and emotions like anger and aggression become so severe or persistent that they impair a child's own functioning and justify diagnosis as a mental health problem. If unaddressed, these problems can persist into in adolescence and adulthood, where they are associated not only with anti-social behaviour and low educational attainment, but also with increased rates of depression and anxiety, alcohol and drug abuse, personality disorder, self-harm and suicide.[66]

There are a variety of parenting programmes available for conduct disorder, some of which have been subject to rigorous evaluation, such as the Positive Parenting Programme and the Incredible Years programme.[67] As with other types of early intervention services, Children's Centres often play a critical role in delivering parenting programmes, and as a universal service provide a valuable, non-stigmatising setting for doing so.

Evaluation by NICE has shown that successful programmes are effective in reducing conduct disorder, with around two-thirds of children showing some improvement in their behaviour, and the majority of these moving below the clinical threshold for a mental health diagnosis.[68] And while there is still a need to gather evidence on the magnitude of the long-term effects, evaluation of the Parenting Early Intervention Programme, which ran from 2008-11, showed that it had a positive effect on children's behaviour and parents' mental health, and that these outcomes were maintained one year on from the end of the programme.[69]

Parenting programmes for conduct disorder are a good example of the economic case for early intervention, and this is explored further in the box below.

*** Every family who needs specialist parenting support should be able to access a parenting programme free of charge in their local area. While it might not be possible to achieve this overnight, there is a strong economic as well as a health case for making this support available to families who need it.**

The economic case for parenting programmes for conduct disorder

The Centre for Mental Health calculates that the cost of conduct disorder to the Exchequer, over and above the normal costs of service use, is around £5,000 per year per child during childhood, and then a further £4,800 per year through adolescence up to the age of 28. These are costs falling on the health service, education sector, social services and the criminal justice system. The wider societal impacts of conduct disorder are considerably larger.

This means that parenting programmes more than pay for themselves when set against the medium- and long-term savings to the public sector. One recent study for the Department of Health found that the average cost of a parenting programme, £1,282 per child, is fully recovered in terms of public expenditure after seven years, with net savings then accruing in subsequent years. It estimated a benefit-cost ratio to the public sector of 2.9:1 – meaning that every £1 spent on a parenting programme leads to subsequent savings of nearly £3.

iii. The role of schools and teachers

Around 10% of children have a mental health problem at any one time. That is around 850,000 children, or three in every classroom.[70] Some of the most common problems are anxiety (3.3% of young people), depression (0.9%), conduct disorders (5.8%) and Attention Deficit Hyperactivity Disorder (1.5%).[71] Moreover, for every diagnosable mental health problem there are many young people needing help with milder problems, such as stress, which can progress to more serious problems if left unaddressed.

Yet mental health problems affecting children and young people are often not recognised. Too many children and young people who are struggling feel that they do not have anyone to turn to. And even

when problems are identified, access to services can be poor: of the 850,000 young people with a diagnosable mental health problem, almost three quarters get no treatment.[72]

Schools are in a unique position to promote child mental health and wellbeing and help address problems because they are where children spend a large proportion of their childhood and also because they are a universal service, where support can be provided in a non-stigmatising way. And being at the frontline, a teacher is one of the first people who can spot the possible signs of mental health problems and offer support, or link a child up with more specialist support.

There was a view among those the Taskforce consulted that better teacher training in mental health should be a priority, in particular that all initial teacher training should include some core knowledge and skills in child development and child mental health, such as: basic knowledge of child developmental stages and awareness of the common factors that affect child well-being and learning; ability to identify mental health problems, spot the early warning signs and understand what is going on; and an understanding of what can be done to support children's mental health within the school, and when and how to list external help. As well as initial teacher training, these are also important areas for continuing professional development too.

Helping to develop mental health awareness and expertise amongst school staff shouldn't just be a concern for schools. External agencies, including CAMHS and the wider NHS, should have a strong incentive to help build schools' capacity through training and support, since if emotional or behavioural issues can be effectively addressed in the early stages within schools, it can prevent an escalation of need to more specialist services. Specialist charities and organisations also play a critical role here; for example, YoungMinds provide training and consultancy services for schools around understanding children and young people's mental health and knowing how to spot the signs that a young person is struggling.

*** We should strengthen the training on young people's mental health in initial teacher training so that all teachers are equipped to identify, support and refer children with mental health problems. This topic should also be a focus for programmes of continuing professional development.**

iv. The missed opportunity for support in adolescence

Adolescence is another critically important phase of development, but one in which opportunities to identify and support children who are struggling are often missed. The peak age for exclusion from school and for admission into care is 14 and Public Health England has identified early onset of risk-taking behaviour at this age (especially with drugs and alcohol) as a key priority in public health. Self-harm affects 1-in-12 young people.[73]

However, unlike early years, there is no current consistent health framework in respect of the health of young people. Some groups can be particularly badly affected by the neglect of this important developmental phase. For example, some children are missing out on diagnosis of lifelong conditions such as autism, especially in teenage years for want of specialist referral for timely diagnosis. And young people with learning difficulties can experience significant difficulty in navigating the interface between children's and adult services despite their lifelong conditions. Schools, parents and young people alike can feel unsupported through the developmental journey into adulthood.

We would like to see more creative thinking about how the Healthy Child Programme and the Personal Child Health Record (the "red book") could be used to improve monitoring of child health into adolescence, including mental health.

We think an important opportunity here could be to use the contact with a health professional that all children have at age 13/14 for booster / HPV vaccinations to create a broader health check.

*** The contact with a health professional that all children have at age 13/14 for booster or HPV vaccinations should be developed into a universal 'health check', including questions about wider wellbeing, which would provide a structured opportunity for a young person to raise mental health issues in a non-stigmatising context, and an opportunity to ensure they have information about sources of support in their local area.**

v. Improving access to services and support for children and young people

During the consultation work conducted by the Taskforce, several barriers were cited to young people's access to Child and Adolescent Mental Health Services. These included:

- high thresholds for access, with less provision available for children with milder problems where early support could make a difference;
- lengthy waits, which can be a barrier to swift intervention; and,
- the fact that attending a clinic can be a disincentive for some children.

Schools sometimes also face communication problems with CAMHS and the links between schools and CAMHS can be patchy, even though information-sharing is important to ensure coordination across interventions.

Among those we consulted, there was an overwhelming view that a twin-track approach is needed to improving access to services for children and young people: (i) protecting and strengthening CAMHS and improving the links between CAMHS and schools; and, (ii) encouraging more school-based provision.

Strengthening CAMHS and improving the links between CAMHS and schools

Some of the problems young people are currently facing in accessing mental health services reflect recent cuts in funding for CAMHS. Funding for mental health services within the NHS has been cut for the first time in a decade, with real-terms NHS spending on Child and Adolescent Mental Health Services falling from £766m in 2009/10 to £717m in 2012/13.[74] And a recent survey by charity YoungMinds found that two-thirds of local authorities have reduced their CAMHS budget since 2010;[75] given that local authorities are likely to fund early intervention services and Tier 2 CAMHS services, these cuts will mean fewer services that stop mental health problems becoming more serious and entrenched.

Such cuts are short-sighted and once again highlight the lack of parity of esteem for mental health in practice. No-one would regard cutting back on child vaccination programmes as acceptable, so why should cutting back on key prevention and early intervention programmes for child mental health be acceptable?

*** Funding for Child and Adolescent Mental Health Services needs to be restored in real terms to 2009/10 levels as an immediate step, and subsequently strengthened further. One way to ensure that CAMHS is protected and strengthened for the future would be to put in place a target to ensure that services are available for a certain proportion of the population in need.**

Second, CAMHS services need stronger links to schools. In some situations, CAMHS may be a provider of services within schools, but even when this is not the case, there needs to be good relationships and liaison between school-based provision and CAMHS.

For schools, better links can offer a chance to draw on expertise within CAMHS. For CAMHS, supporting schools and school-based interventions earlier on could reduce the number of children that end up being referred for more intensive services.

*** Every school should have a named CAMHS worker, who can be the primary point of liaison between the school and CAMHS; where suitable, they might also deliver mental health services within the school.**

Waiting times for CAMHS are also an issue, and this is discussed further in the second half of the chapter.

The voices of young people who use mental health services

The charity YoungMinds works with a range of young people, and some of them provided their personal views on the problems with accessing services.

Stella
"Young people are under so much pressure growing up. It is increasingly hard to get appropriate support for our mental health that is actually helpful! This has got to change so that young people get the help we need when we need it and aren't left to suffer in silence."

Rose
"Being a young person is really tricky, especially when you suffer from mental health problems. At my lowest points, I desperately needed help, but found it extremely difficult to access the support I knew I needed. This is not acceptable, and I believe that something needs to be done so that no young person ever has to suffer alone. Growing up is tough for everybody, but for those of us with mental health issues it can be a disastrous time. With support, we can make it through, but we desperately need better access to mental health services in order to guide us through this minefield."

Cameron
"The pressures young people face today are phenomenal, and are increasingly pushing children and young people to the brink of mental health crises. I know first-hand the debilitating effects of mental illness, and how severe symptoms must become before getting the help of health professionals. Accessing excellent mental health services in a timely manner is crucial to the support and wellbeing of thousands of young people who, without such help, will continue to suffer and be denied a happy, healthy childhood."

Ensuring more school-based provision

Interventions that are embedded within the school and take place on the school premises, such as school-based counselling, can be very effective in enabling issues to be picked up and addressed early on.

First, school-based provision tends to be well-suited to offering the type of lower-level intervention that can be hard to access through formal CAMHS, but which can prevent problems subsequently becoming more serious.

Second, school-based provision is highly accessible, avoiding lengthy or complex referral processes, and waits tend to be relatively short. School is also where young people already are during the day, and – crucially – is where they say they want to access services: over two-thirds say they would rather see a counsellor at their school as opposed to outside.[76]

Finally, because schools are a universal service, accessing provision in schools can help overcome any perceived stigma or reluctance to attend mental health services. For these reasons, school-based services such as counselling tend to have high take-up, and there is evidence that young people are more likely to access school-based mental health services as compared with non-school-based ones.[77]

School-based counselling can also be part of a broader package of mental health support that can include support for parents, carers and families, such as personal counselling or support in developing parenting skills, and coaching for school staff in how to support children's mental health and wellbeing.

School-based counselling in secondary schools

Recent research by Mick Cooper at the University of Strathclyde has looked at the current state of counselling in the UK's secondary schools.

- *School-based counselling is a way of helping young people with personal and developmental difficulties. It allows them to discuss their problems in a confidential and non-judgemental atmosphere, gain a better understanding of them, and develop the personal resources and strategies to manage their situation and cope with change.*
- *School-based counselling can cover a range of therapeutic approaches, from non-directive practices in which the emphasis is on providing the young person with a supportive and understanding relationship and the time and space to find ways of addressing their difficulties, through to a more active therapeutic approaches such as challenging the young person, including in some cases drawing on techniques from approaches such as Cognitive-Behavioural Therapy.*
- *School-based counsellors work with clients at a range of levels of distress. They tend to see more young people experiencing 'borderline' or 'normal' levels of difficulties than specialist CAMHS, who correspondingly see a higher proportion of young people with 'abnormal' levels of difficulties.*
- *Counsellors report that the most frequent issues that children present with are family issues (a third of cases), anger (16%), behaviour (12%), followed by bereavement, bullying, self-worth and relationships in general (each presenting in about 10% of cases).*
- *Studies suggest that school-based counselling is associated with significant reductions in psychological distress. Some recent service evaluations found that 45% of clients demonstrate clinical recovery (moving from the 'abnormal' or 'borderline' ranges at the start of counselling into the 'normal' range by its end), with only 10% demonstrating clinical deterioration.*
- *Users tend to rate school-based counselling highly: a large majority of those young people who participate in school-based counselling rate the intervention as helpful and around two-thirds of young people who used school-based counselling said that it had led to improvements in their capacity to study and learn.*

There are still many children who do not have access to school-based counselling and therapy. A recent survey suggested that somewhere around three quarters of secondary schools in England provide young people with access to counselling.[78] Underneath this figure are considerable regional variations with less than half of secondary schools in some areas providing access to school-based counselling services.

For primary age children, it has been estimated that counselling is currently available in around half of schools.[79] This tends to cover a greater range of interventions because of the varying developmental and emotional needs of children across the primary age range, and recent reviews have highlighted the need to continue to build the evidence base for the most effective interventions at this age. For children at the younger end of the spectrum, interventions often draw on play-based therapies and creative therapies, like art or music therapy, as well as talking therapies, while older children may benefit from counselling to help cope with the transition of moving to secondary school.

School-based counselling is mandatory in many countries, including in the majority of US states, France, Germany and the Nordic countries, and also Singapore, Japan and South Korea.[80] In Northern Ireland, counselling services have been established in all secondary schools since 2007 and in Wales since 2008. Wales has now placed a statutory duty on local authorities to provide school-based counselling services for all secondary pupils, and is expanding this programme to primary schools.

*** All children should be able to access professional, qualified counselling and therapy services in their school or college in age-appropriate form. The Government should set out a strategy to achieve this, with schools, local authorities and the NHS working together to deliver it.**

Because there has been no previous national strategy in England for counselling children and young people, standards of provision and delivery are not consistent across the country. The British Association for Counselling and Psychotherapy is developing an evidence based curriculum for counselling children and young people (5-21). This curriculum, based upon a scientifically developed competency framework, could be used as the benchmark for future training of the workforce.

There are a range of different service delivery models for school-based services. Schools could employ a counsellor or therapist directly or have services embedded in the school via their local CAMHS service. Alternatively, counsellors could be employed directly by the local authority in a managed service or by another agency. Another popular model is that of commissioning external providers to deliver school-based mental health support, such as Place2Be.

Place2Be

Place2Be provides school-based mental health support, reaching a community of 90,000 pupils in 230 primary and secondary schools across Britain, many in disadvantaged areas. This includes one-to-one and group counselling and a range of other services designed to support mental health and wellbeing, building children's resilience and helping them to cope with complex social issues including bullying, bereavement, domestic violence, family breakdown, neglect and trauma.

Place2Be counselling services include individual counselling, a drop-in self-referral service staffed by a counsellor (Place2Talk) and group work ranging from school assembly to circle time to groups focused on specific issues such as self-esteem. Place2Talk is accessed by up to 30% of children in schools with the service. For individual counselling, children are referred from a number of sources including school staff, self-referrals, parents and outside agencies. Children who have Place2Be's one-to-one counselling show significant improvement in their emotional wellbeing and peer relationships and a reduction in behavioural difficulties and classroom disruption. Teachers and parents report that improvements in these areas have a positive impact on children's classroom learning. The charity measures and evaluates the impact of its work continuously.

Place2Be also provides individual counselling to parents, grandparents and carers whose children are being supported by Place2Be, as well as training for school staff in supporting children's emotional wellbeing, on issues like resolving conflict and supporting transitions. Place2Be has a range of professional qualifications and training, including a Newly Qualified Teachers programme, which enhances the skills and understanding of children's mental health for professionals working both in school and other environments and helps support more students to reach their full potential, both academically and socially.

Another increasingly important source of mental health support for young people is online support. Young people spend increasing amounts of time online and often feel more comfortable communicating online. Online support has the advantage of being available anytime, anywhere and also is accessible anonymously, thus helping to avoid any perceived stigma surrounding discussion of mental health problems. So in addition to face-to-face professional support, which is vital, we anticipate online support becoming an increasingly important vehicle for helping mental health, and both public services and voluntary-sector organisations will need to change to reflect that.

vi. Special educational needs and disabilities and the transition to adult services

There are 1.5 million children and young people in England who have been identified as having special educational needs and disabilities, of whom around 230,000 have a statement of special educational needs.[81] For these young people, the condition – whether physiological, neurological or psychological – will in many cases remain in some form for life.

Despite the improvements in recent decades, young people with special educational needs and disabilities can still be let down: for example, children with autism are still seven times more likely to be excluded from school and only 15% of adults with autism are in work.[82]

A critical issue for those with special educational needs and disabilities is the transition to post-16 education and to adult services. This is often poorly managed with access to services disrupted or young people slipping through the net completely. Many young people leave supported education

settings to move to little or no support at all and there are breaks in eligibility and in services affecting them at just the time when their needs require particular concern in relation to the prospects for work and independence.

These problems with discontinuity of access also affect another group who have higher-than-average mental health needs: young people from the care system – expected to move at the time of transition to adulthood and often lacking support networks outside the care system.

Some of these issues were recognised in the recent Children and Families Act, which created a unified framework for assessment for special educational needs up until the age of 25, and which gave care leavers the option to stay with their foster families until they turn 21.

There are also some specific issues regarding transition within mental health services. The end point for CAMHS in most areas is either 16 or 18, but given the complexity of adolescent development, age alone can be a poor indicator of readiness for transition to adult services, and so an arbitrary age cut-off can be inappropriate. Furthermore, adult services may not be geared up to cater adequately for some of the disorders that CAMHS routinely does, such as autism, ADHD, anxiety and attachment disorders.

*** To ensure access to services and continuity of care is not disrupted, young people with special educational needs and disabilities and young people who are looked after should have the option to remain with CAMHS until they are 25. Where young people are receiving Tier 3 CAMHS provision or above but are not classed as having special educational needs and disabilities, they should also have the option to remain with CAMHS until they are 25.**

vii. Leadership in government on child development

Strategies for improving child mental health will only work if they are backed up by leadership at national level, with clear signals about the importance of child development, including social and emotional wellbeing.

Sadly, after a decade which saw the creation of the Every Child Matters agenda, the introduction of a universal entitlement to early years education, the creation of a network of Sure Start children's centres and the introduction of a range of early intervention programmes for families, there is a widespread feeling that leadership and momentum in this area has been lost.

In particular, in recent years, the focus on child wellbeing was downgraded within the Department for Education, with the abandonment of successful initiatives such as the Every Child Matters agenda and the Healthy Schools Programme, both of which demonstrated the value of a consistent national framework. The role of a DfE Minister of State with responsibility for 'health issues' has also been lost, and along with it the close joint working arrangements between the DfE and the DH that lay behind previous children's initiatives.

Incredibly, this was done under the banner of a stated desire to focus more on academic attainment, even though evidence shows that good mental health is key to a child's academic attainment: children with emotional problems are twice as likely to have difficulties with literacy and numeracy.[83] So even solely within the context of academic attainment, neglecting child mental health is counterproductive.

*** There should be a minister of state with responsibility for child development and health issues, sitting in both the Department for Education and the Department for Health, to ensure that child**

development policies are joined up, and that child health and wellbeing is placed at the heart of children's policy and services once more.

C. Early action to tackle mental health problems

i. Early access to treatment and support for those with common mental disorders

Only a third of those with depression and anxiety are getting treatment, compared to around 90% of people with chronic physical conditions.[84] This could be down to many factors, including people being embarrassed to admit they have a mental health problem, but a major reason is that not enough services are available.

Starting in 2008, the Improving Access to Psychological Therapies (IAPT) programme began to address this lack of access, delivering a set of NICE-recommended therapies for people with depression and anxiety, including Cognitive-Behavioural Therapy (CBT), interpersonal therapy, couples therapy, counselling and brief psychodynamic therapy. Average recovery rates are around 45% but a substantial number of services are now achieving over 60% and more are likely to do so in the future. This programme has expanded access to therapies, with the proportion of adults with depression and anxiety receiving therapies going from virtually zero to around 13% today. The current target is to reach 15% by 2015, but this is clearly not yet enough.

One important step in protecting and expanding provision will be to ensure that therapies enjoy the same status as other kinds of treatment. Updating the NHS Constitution to ensure that patients have the same kind of right to talking therapies as they currently have to drugs and medical treatments would help ensure psychological therapies are given the priority they deserve – and send a signal to commissioners about the importance of commissioning these services. Beyond this, there should be a specific new ambition to extend access to talking therapies to more of those who could benefit from them.

*** The IAPT programme should be expanded so that more people have access to it. As a first step, the programme should be doubled in size to cover 25% of those with depression and anxiety disorders by 2020, while maintaining and improving quality to achieve average recovery rates of 50% or over.**

It is important that this expansion of the IAPT programme is *in addition to* the range of current provision of psychological therapies, and that evidence-based psychological therapies and treatments that are not part of the IAPT programme are protected and strengthened too. These include important services such as long-term courses of talking therapy, often as part of treatment for those with significant risk issues and difficult-to-treat conditions such as personality disorder, where there is a need for risk assessment, management and a team approach. There is also a need to ensure that models of delivery of talking therapies are consistent with provision of integrated care in multi-disciplinary teams, for example, for people with long-term physical conditions such as diabetes.

The current lack of access to treatment is not only unjust, given that mental health problems can be distressing and disabling, but is also economically damaging, since untreated mental illness involves large economic and financial costs. Recent studies have highlighted two particularly significant issues here:

- **Increased physical healthcare costs**. Around two-thirds of the six million people with depression and anxiety disorders have a co-morbid physical health problem, like heart disease or diabetes. Because mental health problems can exacerbate physical health problems, the impact of co-

morbid mental health problems is to increase physical healthcare costs by at least 45% (£1,750) per person, which is more than double the cost of a course of psychological therapy for anxiety and depression.[85] Studies suggest that when patients with co-morbid mental health conditions receive therapy and recover, the cost of their physical healthcare declines by more than the cost of the therapy.[86]

- **Spending on health-related benefits.** Some 40% of people on Employment and Support Allowance have a mental health problem, compared to around one-in-six of the population as a whole.[87] Yet the average cost of treating someone with depression or anxiety with psychological therapy (£650) is less than the cost of someone being on Employment and Support Allowance for a single month (£708).[88] As Layard and Clark observe, this means that if only 4% more of those receiving therapy are in work for the following 25 months than otherwise would have been, then the treatment pays for itself.[89] In fact, studies suggest that the impact of psychological therapies is greater than this in practice; one study of people receiving cognitive therapy for depression found 18% more in work after two years.[90] This implies the savings from taxes and benefits would cover the cost of access to psychological therapies for those kept out of work by mental health problems.

So expanding access to treatment can not only help people recover and improve quality of life, but in many cases can also pay for itself. The Department of Health has sought to quantify this, and found that talking therapy services save £1.75 for the public sector for every £1 invested.[91] Layard and Clark calculate that if the expansion of access to talking therapies to 25% were to be combined with a particular focus on ensuring that those with co-morbid mental health problems and those out of work with mental health problems are able to access treatment, then the £290m gross annual cost of expanding the programme should be outweighed by the savings within two years.[92]

Waiting times

In many cases, people are having to wait too long for access to talking therapies, and some end up not seeing anyone at all.

- In 2013/14, less than half of the 947,000 patients referred to IAPT finished a course of therapy, with a third giving up partly because of long waits.[93]
- A recent survey of people who tried to access talking therapy found that half waited more than three months for an assessment, with 1-in-10 waiting more than a year.[94]

This is particularly concerning given that problems can become more entrenched or severe if left untreated.[95]

The 18-week waiting-time standard introduced in 2008 applied only to consultant-led mental health services. Extending waiting-time standards to cover other types of mental health service could make an important contribution to tackling long waits, though in doing so it will be important to ensure the quality of those services are protected and recovery rates maintained. Given the importance of early action, we think the appropriate waiting-time standard for talking therapies should be 28 days. (On Early Intervention in Psychosis Services, considered in the next section, we endorse the recent proposal for a two-week waiting-time standard.)

*** At least 80% of those referred for psychological therapies should start treatment within 28 days. In introducing this new standard, alongside the expansion of service coverage recommended above, it is essential to ensure that quality is protected and recovery rates maintained. The aim should therefore be to phase this in by 2020 or as soon as possible thereafter.**

The same waiting-time standard should also apply to Child and Adolescent Mental Health Services. At present, little data exists on the state of access to CAMHS, so it is hard to know what a realistic timetable would be for putting this standard in place in a way that protects service quality and prevents eligibility from being restricted.

*** Government should also commit to a waiting-time standard of 28 days for therapies within Child and Adolescent Mental Health Services, and set out a strategy and timetable to deliver this.**

ii. Improving support for those struggling in work, off work or out of work

The role of employers in early identification and action

Employers have a critical role to play in helping to identify and act on problems as early as possible. They also have an important reason to do so: mental health problems such as stress, depression and anxiety accounted for 15.2 million days lost due to sickness absence last year. Yet there is currently considerable variation in how well businesses manage mental health; for example, a recent CIPD survey found that a third of the employers who identified stress as one of their top five causes of absence were not taking steps to address it.[96]

In terms of sickness absence, Carol Black's recent review, *Health at Work – an Independent Review of Sickness Absence in Great Britain*, identified a demand from employers for independent, bespoke advice on the extent to which a person's illness is compatible with a return to work and on how they can make necessary workplace adjustments.[97] The new Health and Work Service is a welcome development which aims to fill this gap, providing independent assessment of an individual's physical and mental function and advice about how they could be supported to return to work. In most cases, the new service will kick-in when sickness absence reaches four weeks, which was identified as a particularly important point for intervention in order to prevent much longer-term sickness absence.

Given the effectiveness of early intervention, however, it is important that individuals and employers are able to act and draw on support well before the point of four weeks' absence. Indeed, it is often the case that sickness absence for mental health reasons is preceded by a long period of 'sickness presence', where an individual is at work but struggling. So intervention should often take place prior to sickness absence.

The recommendation in the previous chapter to ensure that more line managers have appropriate training is crucial here, as this will help them to recognise when an employee is struggling and respond appropriately before more serious problems develop. There are also a variety of resources available for employers to draw on in improving workplace mental health, including from the Health and Safety Executive, Acas, the NHS, and organisations such as MIND.

However, sometimes more tailored advice is necessary to help businesses act early and stop problems developing.

*** Once it is up and running, the new Health and Work Service should be strengthened so it can provide businesses who need it with free advice and support on occupational health issues, including on line management and HR practices, job design and work organisation to help promote mental health in the workplace and on the best interventions when problems occur. This strengthened remit should also include expanding support for those who are self-employed.**

Another challenge is to ensure that employees who need treatment or support are able to access it. Most large businesses have their own occupational health services, but smaller businesses tend not to, and this is an area where they could benefit from support.

Large employers can show leadership here by sharing experience and solutions with other employers to mutual benefit. For example, we would like to see more large employers making their occupational health expertise and resources available to smaller businesses in their supply chains.

Another potential solution is to make information available to employees about how to self-refer for support or treatment if they are struggling. Very often there will be NHS or voluntary sector services available in the area which individuals can use.

*** We would like to see more small businesses promoting early intervention by making employees aware of the help available locally which they can access by self-referral, for example by posting IAPT service literature on the company intranet or notice board. Local Authorities should provide small businesses with information and display materials about local sources of support and treatment, which they could display in the workplace.**

Some employers have recently taken impressive action to change the way in which mental health is supported in the workplace, improving health and delivering important benefits for the business in the process. And valuable schemes exist to recognise and accredit employers for supporting mental health in the workplace, such as the Workplace Wellbeing Charter and Mindful Employer.

*** We want to see as many businesses as possible joining schemes to accredit employers for supporting mental health, which are also a good way to access expertise and proven solutions. Local Authorities, Health and Wellbeing Boards and local Chambers of Commerce could play a valuable role here in encouraging businesses in their area to sign up. More generally, government should work with employer organisations such as the CBI and the FSB and with trade unions to proactively promote the role of good employers in improving and maintaining mental health.**

Case studies of employer good practice on mental health

There are many examples of businesses who have developed ways to support their staff experiencing mental health problems.

Deloitte has signed a long-term strategy to help tackle issues around mental health and has now trained 10 of its partners as 'mental health champions' to help colleagues and line managers who feel that they or one of their team might be suffering from the symptoms of stress and depression, enabling them to talk about their fears and concerns in confidence. Deloitte also offers a number of training programmes to people at every level of the organisation to help them spot the warning signs of depression and get help early. They have recently announced a partnership with the mental health charity Mind, 'Together with Mind'. Together they aim to reach over four million people by 2016, by expanding helpline provision and using new technologies to reach people in need. Deloitte also aims to empower two thousand employers through their clients and network to develop 'mentally healthy workplaces.'

BT is considered a beacon for implementing many positive changes in its workplace mental health policy and practice. The company has taken a strategic approach to health, safety and wellbeing and has developed a three-tiered mental health framework. Level one focuses on promoting employee wellbeing and preventing mental distress, for example through tips on the intranet and management training around softer skills. Level two is an initiative to identify distress and intervene early to prevent it from escalating, for example through an online stress risk assessment for employees and companion training for line managers about how to respond. Level three includes a range of support and treatments for people experiencing mental health problems. Employees are encouraged to work with their line manager to produce an 'advance directive', to identify early warning signs and establish a plan of action for if they become distressed. BT's focused approach has proved to be very successful, with these areas of the business seeing stress and anxiety sick leave fall by 24%. In 2013/14, 901 managers took part in Managing Mental Health training to improve their ability to support colleagues facing these issues. Since 2009, more than 6,000 people managers have received this training.

Improving access to support for those off work or out of work

Mental health accounts for around 40% of sickness absence, and mental health problems are the most prevalent reason for people being on health-related benefits.[98] Yet over half of people on sickness benefits with a mental health problem get no treatment and access to therapies for those off sick is also patchy.[99]

For individuals off sick because of work-related illness, a return to work may only be possible in tandem with changes to the work environment to tackle the cause of ill-health – or in extreme cases, with a change of employer. But notwithstanding this point, being out of work is generally bad for mental health, and over long periods can have scarring effects on mental health and on feelings of worth and self-confidence.[100] So the expansion of psychological therapy services recommended above could have particular benefits in helping more people off work or out of work because of a common mental disorder access treatment.

Speed also matters for helping people remain in work or move back into work; while 75% of people on sick leave because of mental health conditions do eventually return to work, after 20 weeks of sickness absence the majority will move onto out-of-work benefits permanently.[101] So the proposal above to introduce waiting-time standards for access to services will also be important in this

context. There is a principle at stake here: it is only right that if you are out of work because of a health problem for a certain length of time, you should be able to access the treatment you need to help you move back into work. With physical health problems, where the vast majority of cases have access to NHS treatment, this is less of an issue, but with mental health problems, where there is still large unmet need, it assumes more significance.

Improving access to support for those off work or out of work with mental health problems will also require overcoming the current lack of integration between employment services and health services. This will require improving links between the different organisations involved (Jobcentre Plus, Work Programme providers, GPs, IAPT services, etc.), including strengthening referral routes for treatment. It will also require shared goals, with employment services seeing it as part of their role to help promote an individual's recovery, and health services seeing it as part of their role to support an individual's employment opportunity, for example by including specialist employment-related support where appropriate.

*** Everyone on sickness absence or out-of-work benefits because of a mental health problem who would benefit from access to psychological therapy should be automatically offered it, whether through the new Health and Work Service or through Jobcentre Plus. In addition, psychological therapy services should include more specialist employment-related support for those who would benefit from it.**

Cultural change is also required. The recent review of sickness absence noted that many healthcare professionals seem to believe that work is neither a realistic aim nor beneficial for people with mental ill-health – in contrast to how they would normally approach a patient with musculoskeletal problems.[102] As a result, they may see their role as helping an individual stay out of work, potentially harming their long-term health. So it is important to tackle the assumption that work is neither possible nor beneficial for people with mental health problems, and for health services to see work retention or moving into work as an important *clinical* outcome.

iii. Early Intervention in Psychosis

Around one per cent of people will have a full psychotic episode in their lifetime, and the vast majority of these will experience their first episode between 15 and 30.[103] When someone receives early intervention support their prospects of recovery are significantly improved, but a delay in support greatly reduces their chances and makes it more likely the episode will lead to long-term disability.[104]

Early Intervention in Psychosis (EIP) services, introduced into the NHS in 2001, help people aged 14-35 recover from a first episode of psychosis and gain a good quality of life. EIP is a personalised package of support, usually for around three years, combining clinical services such as a psychiatrist, anti-psychotic drugs and psychotherapy with a wider package of support such family counselling or employment support.

EIP services significantly improve a young person's chances of recovering from psychosis and reduce the likelihood they will relapse. They also halve the probability of them being detained under the Mental Health Act, and dramatically reduce the risk of suicide.[105] NICE now recommends that anyone experiencing the onset of psychosis should be offered EIP care.[106]

As with other interventions discussed in this report, there is a strong business case for investing in Early Intervention in Psychosis. This is unsurprising given that people who have EIP support are less likely to need high-cost in-patient care, which costs an average of £350 per day, compared with the £13 per day cost of support in community settings.[107] For this reason, EIP care translates into

sizeable cost savings for the NHS relative to standard care – some £5,536 per service user in the first year of psychosis, rising to a total of £15,862 in the first three years.[108] Indeed, NICE estimates that if early intervention was available to everyone who could benefit from it, the NHS would save £44 million each year through reduced use of hospital beds.[109] And there are further savings to the public purse in terms of the criminal justice system and extra tax revenue from increased employment.

Sadly, many EIP services have experienced cuts in recent years. A recent survey by Rethink found that half of services providing EIP had experienced budget cuts over the last year, some by as much as 20%, and more than half of services had lost staff.[110] According to the research, these cuts are resulting in many young people having to wait longer to access services, which damages their prospects of recovery and increases the likelihood they will be hospitalised, and also resulting in EIP teams being forced to discharge young people before they have completed the recommended three years of support. Professor Max Birchwood, co-founder of the IRIS Network, has argued that, "after more than a decade of progress and success, EIP care is effectively disappearing in some areas of the country…EIP services are at a tipping point, and further cuts will seriously threaten their capacity to support some of the most vulnerable young people in our society".[111]

*** The NHS should provide enough Early Intervention in Psychosis services to meet demand. This would improve health and save money. Existing EIP services should not be cut, as this not only harms health outcomes but increases NHS costs.**

vi. Protecting early action funding and early intervention funding

There are a variety of important programmes that have been under pressure as a result of recent reductions in early action and early intervention funding and local authority funding, as well as from budget cuts within the NHS. For example, investment in the Early Intervention Grant has been reduced by almost £400m in real terms over the last four years, while the infrastructure through which many early intervention programmes are delivered has also suffered, with 600 fewer Children's Centres since 2010 and services reduced in many more.[112]

It is therefore crucial that governments accept the importance of early action and early intervention funding, and the false economy of cutting such programmes.

Embedding 'long-termism' in public spending decisions requires recognising early action and early intervention spending is a type of investment and protecting it in a similar way to capital spending, to stop such spending from being raided to meet short-term pressures.

*** Government should put mechanisms in place to protect early action and early intervention spending in a similar way to capital spending. To discourage short-termism, which can store up significant social and financial costs for the future, whenever central funding for early action or early intervention services is reduced, the responsible department should be required to publish an economic impact assessment.**

Chapter 3 – Better opportunities and support for those living with mental health problems

A. The key argument of this chapter

Mental health problems can happen to anyone, and while some mental health problems are short-lived and many are responsive to treatment or therapy, others can be lifelong conditions.

As a result, at any point in time there will be many people living with a mental health problem – one in six of us – and for some the mental health problem will be a long-term, possibly fluctuating part of their lives.

Part of addressing mental health in society is therefore looking at how we can better support those living with mental health problems to live fulfilled lives.

People with mental health problems want the same kind of life as anyone else – a secure home, a job, opportunities to spend time with family and friends. The concept of 'recovery' aims to capture this, supporting a person's ability to build a meaningful life for themselves, with or without the presence of mental health symptoms.

For too many people, however, this is not the reality. Important life outcomes for people with mental health problems lag far behind the population as a whole and those with mental health problems say that too often they are not supported to fulfil their ambitions or face barriers to doing so.

- Despite the fact that people with mental health problems have the highest 'want to work' rate among benefit claimants, they are much less likely to be in work (with an employment rate of 42%, compared with 58% for all those with a health condition, and 73% for the total population).[113]
- People with mental health problems are twice as likely as those without to say that they are unhappy with their housing situation,[114] and they are three times more likely to be in debt than those without.[115]
- One third of people with mental health problems report having been dismissed or forced to resign from their job and 70% have been put off applying for jobs, fearing unfair treatment.[116]

So this is ultimately a question of citizenship, of whether or not we are prepared to ensure people with mental health problems are not excluded and can play their part.

Achieving equal citizenship requires action on different fronts. It is partly about legal rights, and the recent Mental Health Discrimination Act was an important step forward in repealing discriminatory laws and ensuring that our public institutions will be enriched by the contributions of all citizens.

It is partly about ensuring that people get the services and support they need and that services treat them as individuals and support them to lead the lives that they want.

And it is partly about culture, ensuring that no-one is left out or written off on the grounds of their mental health, that people with mental health problems don't face stigma and discrimination, and that no-one feels unable to speak out about their mental health.

This chapter looks at some important issues concerning how we can ensure better opportunities and support for people living with mental health problems. In each case there already exist inspiring

examples of how people can be supported and helped to flourish, but we need a further shift in attitudes, policy and practice if we are to make this a reality for all.

B. Improving life chances

i. Housing and housing-related services

Housing and mental health are inextricably linked. Lack of a suitable or settled place to live, or problems paying rent, can be a driver of mental health problems, while mental health problems can lead to loss of a job, housing problems and homelessness.

- Mental health is frequently cited as a reason for tenancy breakdown and housing problems are often cited as a reason for admission to inpatient care.[117]
- The proportion of homeless people with mental health problems (45%) is substantially higher than the population as a whole (25%).[118]
- People with mental health problems are twice as likely as those without to say that they are unhappy with their housing situation.[119]

For those with mental health problems, lack of suitable housing can make access to treatment harder, hinder social participation and impair recovery – and recovery from mental health problems is certainly hard enough without having to cope with homelessness or poor housing. There are also people with serious and enduring mental illness for whom complete recovery is unlikely and who need stable accommodation for a lifetime; many have been looked after lovingly by family members for years but as they get older different arrangements need to be made.

For these reasons, it is essential that health and housing needs are considered together, by both service commissioners and providers. When it comes to mental health, there is a powerful economic case too for ensuring housing needs are met, since this can reduce demand for more expensive services by preventing avoidable admissions and facilitating discharge from acute care.

Joining up commissioning

For service commissioners, the key is collaboration and joint working in responding to health and housing needs, including bringing budgets together where appropriate to commission integrated packages of care and support focussed on improving outcomes and promoting independence.

Health and Wellbeing Boards have a particularly important role to play in ensuring that mental health considerations are at the heart of decision-making and delivery across a wide range of services. However, there is currently no requirement for Health and Wellbeing Boards to include an appropriate housing or planning representative, and currently only a third of them do.[120]

*** Health and Wellbeing Boards should include a housing / planning representative, such as the Head of Housing / Planning or a relevant Director.**

It is also essential that Health and Wellbeing Boards use their Joint Strategic Needs Assessments and their Health and Wellbeing Strategies to develop an understanding of the links between housing and mental health and ensure that this drives commissioning behaviour.

Ensuring an adequate supply of specialist housing

Some people living with mental health problems will require specialist housing, which might be temporary or long-term, depending on their needs.

- Temporary accommodation includes crisis housing, which provides intensive support so that individuals in crisis can manage this period in a residential setting rather than a hospital, and step-down accommodation, which helps to support discharge from acute care, promote faster recovery and prevent unnecessary readmission.

- Permanent accommodation includes extracare housing, which integrates housing with ongoing care and support, often including facilities for rehabilitation or re-ablement, and also models like shared housing, group housing or therapeutic communities.

Because specialist housing reduces the use of inpatient care and wider health services, there is a strong economic case for ensuring there is an adequate supply of it. A recent study by Frontier Economics found that investment in specialist housing for people with mental health problems can achieve a large net benefit of around £4,671 per person per year.[121] Evaluations of step-down facilities in Islington (Ponders Bridge House) and County Durham (St Stephens Close) have found even greater savings due to avoiding institutional care and other reductions in service use, with annual savings per client of around £19,000 and £22,000, respectively.[122]

However, evidence suggests that there is currently not enough specialist housing available for those with health and care needs such as mental health problems,[123] making it harder to meet needs locally and potentially leading to high levels of out-of-area placements.

Currently there is no specific requirement for housing planners to consider specialist housing to meet longer-term mental health needs in their local plans.

*** National planning guidance should be revised to ensure planning officers have regard to mental health needs and the supply of specialist housing options in drawing up their local plans.**

To improve the supply of specialist accommodation, including for people with mental health problems, there are a number of opportunities to use the existing NHS estate better, selling or leasing land for homes and accommodation projects, including as joint ventures between housing associations and NHS trusts.

However, despite the potential financial benefits, providers currently report a range of barriers to developing unused NHS estate in this way; these include the rules applying to management of capital and resource budgets, and conflicting objectives within organisations that can be time-consuming to resolve.

*** A rapid review is needed of how to tackle barriers to utilisation of the NHS estate, to ensure that existing estate and assets can be used to best effect for patients and the NHS as a whole. To get momentum behind this, ten 'trailblazer' projects should be identified – Trusts or CCGs working in partnership with Housing Associations and other providers specialising in care for people with mental illness – that would get a small grant towards the cost of working up plans to get projects underway quickly. These projects would demonstrate models that can be implemented more widely and provide further intelligence on the barriers that exist.**

Integrated packages of care and support

Health or housing needs sometimes go unaddressed because they are not identified. People receiving help for mental health problems need to be asked about housing issues so they can be linked up with the right support. Similarly, mental health problems may be present when someone has housing problems, making it important that those working in housing are able to spot this and respond appropriately.

Needs can also go unaddressed from a broader lack of integration of services – a failure to consider housing needs as an integral part of the care pathway. A good example of the importance of integration is in discharge planning, where mental health trusts, local authorities and housing associations can work together to ensure suitable step-down accommodation is available. Without this, NHS providers may feel there is no alternative but to delay discharge, which can act as a barrier to recovery, as well as impacting on other service users and being extremely expensive. Housing organisations can also help provide a range of services relevant to mental health, such as debt advice and parenting support, as well as linking people up with relevant health services, such as IAPT services or early intervention services. And many people with mental health problems can be sustained in mainstream housing through 'floating' support, preventing the need for specialist housing and helping to avoid hospital admissions or homelessness.

We believe there is a real opportunity for commissioners, NHS providers, housing associations and other housing organisations to work in partnership to integrate provision of services, connecting health with wider services and supporting recovery in the community.

*** Clinical Commissioning Groups, local authorities and NHS trusts should include housing organisations in designing their care pathways for those affected by mental health problems. Housing needs should be identified early on and care plans should include an accommodation section.**

<u>ii. Employment services</u>

When welfare and employment programmes include groups of people with vastly different needs – as our current system does – then it is essential that they can identify and properly cater for these different needs. Indeed, the nature of mental health problems poses some particular challenges for welfare and employment services:

- Mental health problems can sometimes be hard to identify
- The fluctuating and complex nature of mental health problems can make it hard to assess fitness for work and the barriers an individual might face in getting work
- Inappropriate or poorly-implemented conditionality can exacerbate mental health problems, thereby making sustained employment less likely

Yet evidence suggests that the current system is not working well for people with mental health problems, and that not enough is being done to help them achieve their ambitions for employment.

- Currently, some 40% of people on Employment and Support Allowance (ESA) have a mental health problem, and a third of claims are primarily for mental health problems[124] (many people on Jobseeker's Allowance also have depression or anxiety, sometimes linked to their unemployment).
- Despite the fact that people with mental health problems have the highest 'want to work' rate among benefit claimants, they are much less likely to be in work (with an employment rate of

42%, compared with 58% for all those with a health condition, and 73% for the total population).[125]
- A recent report highlighted that people with mental health problems are the fastest growing group of claimants of disability-related benefits.[126]

At the heart of these problems lies the poor performance of the Work Capability Assessment (WCA) and the Work Programme. And these problems don't just stop people fulfilling their ambitions; they also create greater costs for the public purse.

So urgent action is required to improve the employment support available to people with mental health problems.

Real voices from within the welfare and employment system: a sample of views given to local Mind organisations

James
"The whole process of claiming and fighting for my wife left me on the verge of a breakdown myself. When the case was finally won and the DWP admitted that my wife should never have been called in, in the first place, I just sat down and cried."

Joe
"The worst thing [with the WCA] is not knowing what's happening. They just leave you hanging, worrying about your future…"

Lee
"One group session I had to attend every week for six weeks was about pain management. This was useless to me as I have mental health problems, but was forced to go as I would have been sanctioned."

A reformed Work Capability Assessment and a better gateway to employment support

A clear gateway to employment support requires an accurate assessment of people's capability and of the support they require, but the current Work Capability Assessment has not achieved this and as a result too many people are getting inadequate support. It has produced too many wrong decisions – and in the process caused distress and undermined faith in the social security system. A recent report found that decisions were reversed at tribunal for over one in ten of those initially judged 'fit for work'.[127]

The Public Accounts Committee has observed that a key reason for this poor performance is the lack of incentives to get decisions right first time.[128] So in future there must be contractual requirements on the accuracy of assessments, to ensure assessors collect the medical evidence they need to make a decision, listen to what the claimant is telling them and make a decision based on the full facts of the case.

*** The Work Capability Assessment must be reformed to take better account of the nature of mental health problems. Providers need to invest in the right training for their staff to get decisions right first time and should be held to account with financial penalties for getting assessments wrong.**

A related issue is that the information about someone's health passed on from the WCA to Work Programme providers often offers inadequate insight into their mental health problems and the support they require. Disabled people report that too often those who are providing back-to-work support do not have sufficient understanding of their health.[129]

To ensure that the WCA properly identifies the needs and barriers that people with mental health problems face, and provides a more effective gateway to employment support, people should be given a statement of the assessor's view of how their health condition may affect their ability to work, and details of the support needed to help address these issues.

A stronger role for specialist advisers could also make a difference here. Anyone with a mental health problem seeking work should be able to have their needs assessed by a specialist adviser in order to be directed to the right support. So it is important there are properly trained staff to take on this role. Just as importantly, contact with an adviser should be based around a constructive conversation about the support someone needs to access work, rather than, as too often is the case at present, a tick-box exercise around the conditionality they need to fulfil. The rise in sanctions for those with mental health problems in the past few years is extremely concerning, and there have been persistent reports that Jobcentre Plus has been told to meet targets in this area, fundamentally undermining the approach we would wish to see implemented.

A better approach to helping people with mental health problems access work should recognise the fact that they are often experts in their own condition. It is important that an improved system of employment support aims to capitalise on this expertise by involving individuals much more actively in shaping the support they receive.

Access to evidence-based employment programmes

The performance of the Work Programme, the Government's main welfare to work scheme, has been poor: only 6% of ESA claimants with a mental health problem as their primary condition who have started the Programme have found a sustained job through it.[130] Another programme, Work Choice, a specific disability employment programme, is much smaller: only around 20,000 disabled people per year access this, and only a third of those on the programme are ESA claimants. It is also often unclear to claimants why they are referred to one programme rather than the other.

It is essential that people with mental health problems have access to specialist, evidence-based employment support where needed, with clear minimum standards set out for the support that providers must offer. The Labour Party has already said that, once existing Work Programme contracts have terminated, it will commission a new specialist disability employment programme to support those who are further away from work, bringing together resources from Work Choice, the Work Programme and combined authorities. This offers an opportunity to improve employment support for people with mental health problems.

- As part of this, it will be important to look closely at the best model to structure payments, so providers are better incentivised to work with those with more complex needs, rather than casting them aside as too many do now.
- It is also essential that this new programme offers evidence-based programmes based on evaluations of what works. For those with mental health problems, this will in many cases need to integrate work-focussed support with health-focussed support. The strength of contracting and managing new schemes at a combined authority level is that it will enable partnerships to develop that bring health, housing, education and other support together with employment services.

*** Providers bidding to deliver government employment programmes must demonstrate they have specialist knowledge of mental health and that they can offer access to evidence-based employment programmes, including condition management and, where relevant, supported employment.**

For people with more severe mental health problems, the 'gold standard' model is Individual Placement and Support (IPS), a form of supported employment, which some people currently have access to through NHS services. This model has proved effective and it would be welcome to see it used more widely.

Supported employment for people with severe mental health conditions

There is an increasing body of evidence in favour of a 'place, support and train' approach to help people with severe mental health problems into sustained employment. This involvers supporting people to move into work quickly – through an intensive process of vocational profiling, one-to-one support and employer engagement – followed by specialist ongoing in-work support. The approach is characterised by full integration of employment support with mental health treatment and care.

The Individual Placement and Support (IPS) model was first developed in the United States and has since been trialled in a number of other countries, including the UK. Over 16 randomised control trials have indicated that the IPS approach can increase the employment rate of people with longer-term mental health conditions in comparison to other approaches.

Following reviews of the research evidence, NICE has recommended supported employment for those with severe mental health problems, and the NICE guidelines on the treatment of schizophrenia and bi-polar disorder suggest the IPS approach should be provided for those who wish to return to work or gain employment.

C. Supportive communities

iii. High-quality, integrated care

People with mental health problems are more likely to develop a range of physical illnesses, and people with long-term physical conditions are more likely to develop mental health problems.

- Depression is two to three times more common for those with cardiovascular conditions such coronary artery disease and stroke, and also for those living with diabetes. And depression increases the risk of developing cardiovascular diseases such as coronary artery disease and ischaemic heart disease by between 50 per cent and 100 per cent.[131]
- As well as increasing the risk of developing physical illness, having a co-morbid mental health problem carries a higher risk of poorer outcomes; for example, someone with chronic heart failure is eight times more likely to die within 30 months if they also have depression.[132]
- In total, nearly half of people with a mental health problem also have a co-morbid physical condition, and nearly a third of people with a long-term physical condition also have a mental health problem.[133]

There are a range of reasons for these links between mental and physical conditions. In some cases, mental health problems interact with and exacerbate physical illness – for example, chronic stress has a direct impact on the cardiovascular system, while the risks of a physical condition can lead to anxiety. In other cases, mental health problems might reduce a person's ability to actively manage their physical condition. And in addition to these direct effects, there has also been a historic neglect of physical healthcare for those with mental health problems, which has led to shocking health inequalities; people with serious mental health conditions, such as bi-polar and schizophrenia, die of the same conditions as the general population, but they do so 15-20 years earlier.[134]

The links between physical and mental health mean it is important that treatment and support for mental health problems is integrated with treatment for physical conditions. Leaving mental health unaddressed also significantly increases the cost of healthcare for someone with a long-term physical condition – by at least 45% (£1,750 a year), according to a recent study by the Kings Fund.[135] This means around £10bn NHS spending each year on long-term conditions is linked to poor mental health.

There are two particular challenges to ensuring properly integrated care: ensuring mental health problems get identified in the first place, and ensuring that services are joined up around the individual.

Ensuring mental health problems get identified

Too often mental health problems get missed. For example, one recent study suggests that the majority of cases of depression among people with physical illnesses go undetected and untreated.[136] Unidentified mental health problems may also underlie the phenomenon of 'medically unexplained symptoms', which account for a fifth of all GP consultations and cost the NHS around £3 billion each year.[137]

Recent years have seen a number of calls for NHS staff to receive training in mental health, and this is an objective we endorse. It is welcome that the 2014 mandate to Health Education England subsequently set out that all health professionals should have an awareness of mental health problems. It is now important that suitable training programmes are developed and embedded in curricula and in programmes of continuing professional development.

*** All health professionals should have training to be able to recognise signs of mental ill-health and refer patients to appropriate care and support. This should include proactively looking out for common mental health problems among people with long-term conditions.**

There is a particular need to ensure that GPs have specialist training in mental health, given that they are often the first professionals that people with mental health problems come into contact with. Diagnosing mental health problems can be challenging: one study found that GPs correctly identified depression in only 47% of cases,[138] and a recent survey found eight out of ten primary care professionals saying they want more training in mental health.[139] If GP training is extended to four years, this could provide an important opportunity to enhance GPs' skills and experience in mental health.

Improving psychiatric liaison services in acute hospitals

Psychiatric liaison teams work in acute hospitals to provide psychiatric assessment and in some cases treatment, and to be an interface between mental and physical health services, including referral to other services. This can be particularly important for older people who suffer from dementia, people who have self-harmed and are being seen in the emergency department, and people who have an existing mental health problem but who are currently in hospital with a physical illness.

- *Half of all hospital inpatients have a mental disorder such as depression or dementia, often co-morbid with a physical health problem; in addition to those who are admitted with an existing condition, a significant number of patients develop a mental health problem during their stay in hospital.*
- *Among people over 65 admitted to hospital, 60% will have or develop a mental disorder (including dementia) during their admission.*
- *It is estimated that as many as one quarter of people presenting in A&E have a mental health problem, with mental health being the primary cause in around 5% of cases.*

Identifying and managing mental health problems quickly and effectively helps people to recover and reduces their length of stay in hospital. It also generates savings too in terms of reduced admissions and length of stay, saving an average hospital £5 million a year. Further savings accrue from an increase in the number of patients discharged to their own homes rather than residential care.

Despite these benefits, services around the country are currently variable with some areas having few or no liaison services. We endorse the recent call by Centre for Mental Health that every general and acute hospital should have a dedicated liaison psychiatry service.

Joining up care and services for those with complex needs

Another problem is that care is often fragmented. Services tend to respond to each of our needs separately, focussing on the body part or the individual problem rather than the whole person behind it. This is particularly the case with mental health, which suffers from the historic separation of physical and mental – a legacy of the thinking of previous centuries, when the nature of mental health problems and the complex interactions between mental and physical health were poorly understood.

Furthermore, people with mental health problems may have needs that go beyond health and care services, such as housing and employment needs, where there can be important benefits to integrating and coordinating this broader range of services.

Achieving better integrated care will require embedding mental health support within care plans for those with complex needs, as well as better links and joint working between mental health specialists and other professionals. Voluntary sector organisations also play an especially important role here, often working at the interface of different health and social needs.

Multi-disciplinary working already happens in many mental health services. Early Intervention in Psychosis teams, for example, include social workers, occupational therapists, psychologists, psychiatrists and recovery care coordinators, while the Care Programme Approach for those with

more complex problems incorporates care plans that cover a range of needs such as employment and housing. But as a recent report by the Mental Health Foundation observed, "good integrated care for people with mental health needs remains the exception rather than the rule".[140] To take one example, a recent Care Quality Commission report found that less than half of those with complex mental health problems who had a care plan definitely understood it.[141]

*** All people with serious or co-morbid mental health problems should have a personal care plan, designed in partnership with them and built around their goals, and a personal care coordinator to organise their care and link them up with wider services and support.**

The recent report of the Independent Commission on Whole-Person Care, *One Person, One Team, One System,* whose recommendations we endorse, looked at the key systemic changes needed to make integrated care a reality.[142] Some of the major recommendations are listed in the box below.

The wider system reform needed to make integrated care a reality

The Independent Commission on Whole-Person Care was established to make recommendations about how we can integrate health and care services within existing resources and avoiding further structural reorganisation.

The final report, published in March 2014, sets out a vision of integrated services and makes recommendations for how we can ensure the provision of high-quality care for millions of older people and those with complex needs, while at the same time getting better value for taxpayers' money.

Key recommendations include:

- *Integrated, multi-disciplinary care teams working together around the individual, including mental health staff*
- *Maximising user empowerment with co-designed care plans, more information available to patients and more support for self-management*
- *Training and education programmes to be reformed to cover skills such as collaborative care planning and effective multi-disciplinary team working*
- *Health and Wellbeing Boards as the vehicle for collective system leadership for care for those with complex needs, creating a collective commissioning plan that covers the whole resources available for this group*
- *A year-of-care tariff to cover all of a person's care needs, incentivising providers to coordinate care, to deliver care in the best setting and to focus on prevention*
- *The development of accountable, coordinated provider networks collectively responsible for delivering outcomes for defined population groups*
- *People should own their health and care record, with a strengthened duty for providers to share information, and the patient able to opt out of this arrangement if they want*

Dual diagnosis

The term 'dual diagnosis' is used to describe people with mental health problems and problems with substance misuse (which can include tobacco, prescribed medication, illegal drugs or alcohol). The nature of the relationship between the two conditions is well established. Mental illness can lead to substance misuse as a way of supressing symptoms or the side-effects of medication. Likewise substance misuse can lead to psychological problems or act as a trigger in those who are susceptible to severe mental illness.

The 2002 Co-morbidity of Substance Misuse and Mental Illness Collaborative study found that 75% of drug service users and 85% of alcohol service users had mental health problems, while 44% of mental health service users had used drugs or alcohol at hazardous or harmful levels in the previous year. The Annual Report of the Chief Medical Officer 2013 found that high rates of smoking cause much of the excess morbidity and mortality associated with people with serious mental illnesses. The prevalence of daily smoking among people with major depression, bipolar disorder and schizophrenia is 57%, 66% and 74% respectively.

People with a dual diagnosis could present in any number of settings, from A&E units to housing departments to police stations. It is therefore important that staff across different services are adequately trained to spot problems and signpost people to support.

People with a dual diagnosis have a range of complex needs involving a number of different agencies. Therefore providing support for individuals with a dual diagnosis is one of the biggest challenges facing mental health services.

In 2002, the Department of Health published Good Practice Guidance for dual diagnosis management. The guidance recommended that mental health services should be responsible for anyone with dual diagnosis and that integrated care should be the norm for this group. However, care is still often fragmented and patchy.

To avoid further gaps in services CCGs and local authorities will need to work together to jointly commission services which will better coordinate the care of people with multiple service needs. The Health and Wellbeing Board could provide a forum for joining up local services.

Liaison and diversion: Mental health, police services and the criminal justice system

Liaison and Diversion (L&D) services exist to identify offenders who have a mental health problem, learning disability or substance misuse vulnerabilities when they first come into contact with the criminal justice system so that they can either be supported through the criminal system pathway or diverted into a treatment, social care service or other relevant intervention or support service. L&D services aim to improve health outcomes, reduce re-offending and identify vulnerabilities earlier, thus reducing the likelihood that offenders will reach crisis-point.

The importance of addressing this issue is clear. Nine out of ten prisoners have at least one mental health condition, including drug or alcohol dependency or a personality disorder, and two-thirds have more than one. Rates of psychosis in the prison population are ten times the general population. Furthermore, it has been estimated that mental health issues account for at least 20 per cent of police time.

The L&D Programme came about as a consequence of the Bradley Report which was published in 2009, which recommended that the government should develop and improve L&D Services. The Taskforce welcomes the progress made since the publication of the report, but believes that there is a lot more to be done in making sure effective liaison and diversion is available everywhere.

Following the roll-out of nine pilots in 2013, Street Triage services have begun to develop across the country, where police and mental health professionals work together to support people in mental health crisis access safe and appropriate care. Although Street Triage services and Liaison & Diversion services are distinct, with separate commissioning arrangements, they should work to link together. For example, in some areas L&D nurses work on the Triage team, to ensure its integration into standard L&D work.

Last year, the Centre for Mental Health published The Bradley Report five years on: An independent review of progress to date and priorities for further development, which made a number of recommendations for further improvement, including the need to develop an operating model for prison mental health and learning disability care.

The Bradley Report also recommended that the National Offender Management Service and Department of Health produce a strategy for people with mental health problems and learning disabilities leaving prison but not subject to supervision from probation.

Of those subject to probation, it should be noted that here are also very high levels of mental ill-health. It is unclear what impact the Transforming Rehabilitation reforms will have on the mental health of offenders in the year after they are released from prison or those on community sentences. It is vital, however, that they are offered effective mental health support alongside help with housing, employment and substance misuse. The Centre for Mental Health also found that the release experience for prisoners with mental health problems and learning Disabilities who are subject to probation supervision has often been far from satisfactory.

The Taskforce agrees that an 'all stages diversion approach' should be the aim – meaning that people can be diverted at any stage of their route through the criminal justice system – and that the model of diversion should consider people leaving prison as within scope. NHS England is currently piloting and evaluating L&D services throughout England, and subject to successful evaluation, it is important that these services are extended to the rest of the country as soon as possible.

Inequalities in service access and experience: The case of Black, Asian and Minority Ethnic (BAME) communities

Ensuring access to high-quality, integrated care also requires tackling some of the inequalities in service access and experience that exist for particular groups. This section looks at an area where these inequalities are particularly marked – the case of BAME communities.

People from BAME communities living in the UK are more likely to be diagnosed with a mental illness than the population as a whole. For example, they have a three-fold increased risk of psychosis, and for Black African and Black Caribbean groups this rises to a seven-fold increased risk.[143] Black African and Black Caribbean groups are also more likely to experience admission under the Mental Health Act 1983 and are over-represented in psychiatric and secure mental health hospitals.[144]

As discussed in Chapter 1, this partly reflects broader socioeconomic inequalities and the increased exposure of some BAME groups to key risk factors for mental health, such as social isolation or financial insecurity. But it also reflects inequalities in service access and experience.

There are significant inequalities in access to talking therapies and to other services, and rates of access to secondary mental health services for BAME groups are lower than previously thought.[145] In general, people from BAME groups are more likely to experience poor outcomes from treatment and are more likely to disengage from mainstream services.[146]

We are clear that there is much work to be done to tackle these inequalities and support frontline professionals and leaders to rethink how they engage with service users from different ethnic and cultural backgrounds. Regardless of ethnicity, faith or heritage, everyone with a mental illness should have decent and equitable access to and experience of mental health services.

A range of interventions are needed, encompassing: recognition of the mental health needs of BAME communities in commissioning services; accessible entry points to services, including through non-clinical routes; more awareness and training for frontline staff in relevant issues, and more culturally sensitive services; health and care services better linked up with relevant voluntary and community organisations in service delivery; and mechanisms through which we can guarantee that the voice of BAME service users and carers influences service commissioning and development.

The previous government's action plan on BAME mental health, *Delivering Race Equality*, ended in 2010 and has not been renewed or replaced.[147] We want to see a renewed focus and leadership on tackling race inequality in mental health services for both young people and adults.

*** The Department of Health should develop a new national strategy to tackle race inequality in mental health services, including on workforce development and leadership, and to improve outcomes for BAME communities. It must be clear about what indicators will be used to measure progress and what success will look like. This should include a national framework through which commissioners and providers at local level can be held more accountable for developing and delivering their own plans to achieve this.**

iv. Social opportunities

Mental health problems can be 'lonely illnesses'. Many people have less social interaction following the onset of a mental health problem, and for some their social circle can become reduced to immediate carers and people working within mental health services. Stays in hospital can mean people become separated from their social networks, while the negative and discriminatory attitudes that many people with mental health problems still experience can make forming

relationships harder. Many more of those with mental health problems report feeling isolated than the population as a whole.[148]

As a result, those living with mental health problems can find themselves excluded from many aspects of life that many people take for granted, including social life and the opportunity to participate in the community.

This is bad for many reasons. It is harmful for an individual's quality of life. It is harmful for health and can impair recovery. It is harmful in terms of opportunities and life chances. And it means as a society we fail to mobilise the contribution of everyone.

Improving access to mainstream social opportunities

Many people with mental health problems wish to have better access to mainstream social activities.[149] There are various possible avenues for making a difference here. To take one example, given that social activities can improve mental health, where people with mental health problems have a personal budget they may wish to use it to help them access these activities. Another example is 'supported participation' schemes, such as supported volunteering.

Perhaps the most pressing issue, however, is to tackle the public attitudes that many people with mental health problems say is a barrier to greater social involvement, such as fear or a lack of understanding about what mental health problems involve. The broader challenge of public attitudes to mental health is discussed in the next section. But in terms of social activities, local leadership can make a real difference here, such as community leaders or organisers championing involvement in activities by people with mental health problems, or outreach schemes to promote this. The recommendation earlier for a new funding pot to support the development of social infrastructure across communities could help promote such activity.

Social support schemes

A variety of social support models exist for tackling loneliness among individuals with mental health problems – similar to those discussed in Chapter 1 for the population as a whole. Social group schemes help people widen their social circle, including groups where social participation is the primary objective to groups with another objective – such as creative activities or health promotion – where social participation is a by-product. Peer support groups can be particularly important here, linking up those with similar conditions so that they can learn from one another and build social networks that provide support. Users of peer support in mental health services consistently report high levels of satisfaction and recommend that more opportunities be made available.[150]

The Conservation Volunteers

People living with mental health problems can find themselves excluded from social activities and the opportunity to participate in the community and volunteering.

National charity The Conservation Volunteers (TCV) run projects across the country, including in Doncaster, where they support local people with mental health problems to get out and about and to work in teams looking after local outdoor spaces for the benefit of the local community.

As well as improving the local environment, TCV's projects help to improve the quality of life of the people they work with, providing opportunities for them to meet and socialise with volunteers from all backgrounds. Being part of a group and working on a project can be good for mental health too, helping promote a sense of purpose, self-esteem and empowerment and helping develop confidence. It also offers the opportunity for physical exercise, which can also benefit mental health.

Befriending schemes are another option for tackling loneliness and supporting social contact for individuals with mental health problems, especially where they may find it difficult to participate in other activities. Given the lack of understanding that many people with mental health problems can face, dedicated befriending schemes for people living with mental health problems offer an opportunity to provide training and awareness about mental illness for volunteers and dispel some of the myths surrounding it.

Good Companions

Good Companions was set up 15 years ago by the Southend branch of the national charity Rethink Mental Illness to tackle social isolation. All volunteers complete a ten-hour training course which covers mental health awareness, personal safety and group-facilitation skills. The course also gives an overview of treatments, mental health services, and explains the Mental Health Act. The training emphasises the stigma that people with a mental illness might face and dispels some of the myths about psychosis.

There are 100 service users on Good Companions' books, referred by GPs, themselves, community mental health workers, social workers or following a care review. At any one time, there are around 25 volunteer befrienders, who commit to a minimum one hour a week. This hour could include a trip to the cinema, pubs, an outing, or simply going out for a cup of tea and a chat.

Good Companions' work has recently been extended to include outreach and recruitment work in schools, colleges, with the local police and local authorities. The scheme is run under contract from NHS commissioners in South Essex.

Chapter 1 concluded that health and care services must see it as a core part of their mission to assess whether individuals would benefit from social support activities and services and link them up with them. This should be a particular priority for those living with mental health problems.

*** People with mental health problems should be offered access to social activities and support if they need it, such as befriending or peer support. For those with complex needs, assessment and referral to social support should be a standard part of care plans.**

Recovery colleges

Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms. A recovery college is a key element of recovery-oriented practice in mental health services. Recovery colleges complement existing services by offering an educational approach to supporting people in their personal recovery journeys.

The colleges offer mental health service users, family members and professionals opportunities to teach and learn together. First developed in the US, recovery colleges were pioneered in the UK in South West London and Nottinghamshire and in the last two years many more have opened across the country. There are currently 31 recovery colleges open in England. One, in North West London, ran 168 courses for a total of 868 students in 2013/14, of whom 67% were service users and 26% were staff.

The defining features of recovery colleges include co-production between professionals and service users and carers to offer a range of courses that people attend on a voluntary basis, not as a form of therapy but as a way to build up their skills, knowledge and confidence.

Evaluations of recovery colleges show promising results. An 18-month follow up study of students in South West London found that 68% felt more hopeful for the future, 81% had developed plans for managing their health and 70% had gone on to become mainstream students, to get employment or to volunteer.

One such example of a recovery college is Recovery College East which is run by Cambridgeshire and Peterborough NHS Foundation Trust. The college follows an adult education model and aims to deliver a responsive, peer-led education and training curriculum of recovery-focused workshops and courses. The courses are co-produced and co-delivered, involving at least one person with lived experience of mental health challenges. Courses are offered to those over the age of 18 who receive or have received services from Cambridgeshire and Peterborough NHS Foundation Trust. Services are also offered to their friends and family, NHS staff and volunteers. Examples of courses include an 'introduction to recovery', which examines the impact of mental health challenges and diagnosis on people's lives, creative writing courses which use fiction writing skills to assist with the recovery process, and courses that provide people with employment training.

v. Improving public attitudes

As documented throughout this report, the task of improving mental health in society will require some major shifts in policy and practice by government, businesses and public services. But underpinning these changes must be a wider generational shift in attitudes and behaviour towards mental health.

Recent years have shown some encouraging signs of changes in attitudes. Surveys for the Time to Change campaign, which aims to tackle stigma, change attitudes and improve behaviour in relation to mental health, suggest that public attitudes have started to shift for the better, with the biggest annual improvement in a decade taking place in 2013.[151] Educational schemes such as Mental Health First Aid also play an important role here; to date it has helped to teach over 77,000 people how to recognise the signs and symptoms of common mental health issues and better understand people who may be developing a mental health problem.

Public figures prepared to speak out about their own experiences of mental illness have also played an important role – including celebrities like Stephen Fry and Ruby Wax, sportspeople like Marcus Trescothick and Frank Bruno, and politicians like Kevan Jones, Charles Walker and John Woodcock.

The Time to Change Campaign

The 'Time to Change' campaign began in 2007 and is the biggest ever campaign in England to tackle stigma and discrimination around mental health with funding. The campaign is currently in its second phase. Since 2007, it has reached millions of people across England and begun to improve public attitudes, with an estimated 6.4% of the population having improved attitudes towards people with mental health problems.

Evaluations of the Time to Change campaign found a clear and consistent link between awareness of the Time to Change campaign and having more positive attitudes. The Government has also argued that "there have been significant reductions in the number of people with mental health conditions reporting discrimination in some key areas of their lives, including employment, as a result of the Time to Change programme."

Despite these improvements, however, negative attitudes and discrimination against people with mental health problems are still widespread. And stereotyped views about mental illness persist – exacerbated by the media, who often portray people with mental health problems as dangerous or unable to live normal lives.

Such attitudes make it harder for those affected to work, make friends and live a normal life – something that is reflected in high rates of social exclusion among those with mental health problems. People often find it hard to tell others about a mental health problem they have because they fear the reaction – and when they do speak up, many say they are misunderstood, shunned or ignored.[152]

- Almost nine out of ten people with mental health problems say stigma and discrimination have had a negative impact on their lives.[153]

- Two-thirds have stopped doing things because of stigma and two-thirds have stopped doing things because of the fear of stigma.[154]
- Indeed, many people say that being discriminated against in work and social situations because of their mental illness can be a bigger burden than the illness itself.[155]

So if we want a society where everyone can play their part and no-one is left out or written off on the grounds of their mental health then it is clear there is much further to go.

*** The Time to Change campaign should be continued for the next Parliament, beyond 2016 when its current funding runs out. Alongside other funders, the government should fund a third phase of the campaign until at least 2020.**

The Taskforce believes there are still challenges in several areas, including the following groups:

- Employers: There are many success stories on progress with workplace mental health in the UK. However, one third of people with mental health problems report having been dismissed or forced to resign from their job and 70% say they have been put off applying for jobs, fearing unfair treatment.[156] So tackling stigma in the workplace must remain an important focus.

- The media: There is still much work to do to challenge misreporting in the media and ensure the views of people with mental health problems are represented more frequently. Currently almost a third of national newspaper coverage about mental health focuses on danger to others and strange behaviour.[157]

- Black, Asian and Minority Ethnic (BAME) communities: Members of ethnic minorities who experience mental illness often experience double discrimination, based on their race or ethnicity and because of their mental health. The 300 Voices project, working with young African and Caribbean men, aims to reduce stigma and discrimination in mental health services and the police, and we would like to see more such projects in other BAME communities.

- Health professionals: One particularly shocking source of discriminatory attitudes can be healthcare staff themselves. In 2011, 30% of respondents to the Time to Change survey reported discrimination by health professionals.[158] This is worrying because if service users face negative attitudes within health services then it may deter them from seeking help. We want to see all health professionals leading by example to actively challenge stigma and discrimination and promote good mental health as part of what they do. Ensuring all NHS staff have training and awareness of mental health issues, as recommended earlier, will help with this. We would also like to see as many NHS organisations as possible sign up to the Time to Change pledge to demonstrate their commitment to tackling stigma.

- Children and young people: Perhaps the most important long-term impact in promoting tolerance and supportive attitudes will come through ensuring children and young people develop greater awareness of mental health, including tackling some of the myths surrounding it. The first chapter recommended that social and emotional development is embedded in PSHE education; raising awareness of mental health and promoting an understanding of those with mental health problems should be an integral part of this.

*** Mental health awareness and understanding should be integrated into what children learn about health in schools. This is also an area where young people living with mental illness could play an important role in helping educate peers about the impact of stigma and discrimination.**

Conclusion: Our vision of the mentally healthy society

This report has argued for some major policy, practical and cultural steps forward to improve mental health in society, including in the areas of population mental health, early intervention and action, and better opportunities and support for people living with mental health problems.

In all these areas, there are examples of good programmes and practice. But a fundamental shift in approach is needed if we are really to achieve a step-change in the mental health of our nation and in the quality of life of those living with mental health problems. Indeed, when it comes to mental health, rather than seeking a justification for departing from the status quo, in many cases we need to ask whether the status quo can be justified any longer.

That is why this report has sought to do more than simply provide a list of policy recommendations, but to articulate a set of principles with which to challenge the status quo:

- We should not accept a society where people live and work in environments that harm their mental health, but should choose to shape our society in a way that promotes mental health and helps prevent mental health problems
- We should not accept the human and economic costs of failing to intervene to stop problems occurring or becoming worse than they need, but should act early – and have to justify not doing so
- We should not accept a society where people are stigmatised, left out or written off because of their mental health, but should act to ensure that those living with mental health problems have better opportunities and better quality of life than they do now

The report also draws out some cross-cutting issues that have important consequences for policy and politics:

- We need parity of esteem for mental health not just within health services, but across society. Each of the three arguments above was won a long time ago in relation to physical health; it is now time to accept them and act in relation to mental health. This is a wider kind of parity – not simply a campaign for parity for mental health services, but for mental health to be taken as seriously as physical health right across society.
- Mental health is everyone's responsibility, not just the responsibility of those who work in health services. Mental health is shaped by the environment in which we live and mental health problems are manifest in a wide range of contexts. And the benefits of good mental health, or the burdens of mental ill-health, don't just impact on the NHS but on employers, schools and wider communities. So all of these actors and institutions have both a responsibility to protect mental health, just as they do physical health, and also a strong incentive to do so too.
- Neglecting mental health and failing to tackle problems early enough is wasting billions and storing up huge costs for the future. For want of getting people the support they need, when they need it, we are having to pay billions dealing with problems when they reach crisis point. This doesn't just mean avoidable suffering; it is financially irresponsible too.

If we were to act on the logic of the arguments presented here, it would help create a society that looks very different, one where mental health would take centre stage in supporting people across the lifecourse:

- Before and after birth, support for mothers, babies and families through family services, health visiting and perinatal services;

- In the early years, help for families to enable a safe and stimulating home environment for child development, including through parenting support if needed;
- At school, help to develop social and emotional skills and convenient access to counselling and wider services, benefiting health and wellbeing, academic attainment and employability;
- In adolescence, someone to talk to if you are struggling and services there when you need them;
- In the transition to adulthood, supporting young people through this period of change by supporting mental health and ensuring continuity of care;
- At work, a supportive environment which helps protect mental health, and provides information about how to get help if you are struggling, helping employees and businesses to thrive;
- For those off work or out of work, quicker access to assessment and treatment along with integrated employment and health support;
- For those who develop a long-term condition, integrated physical and mental healthcare and wider support on housing, employment and other issues to aid recovery and promote independence; and,
- For older people, integrated care delivered by staff who can recognise, understand and help to address mental health issues, and more support for social activities and participation for those who are isolated or excluded.

Ultimately, this is about a cultural shift in how society treats mental health, including politicians and policymakers, the NHS and wider public services, businesses, charities and community groups, and citizens themselves.

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