

## Overview

The Academy of Medical Sciences is the independent, expert voice of biomedical and health research in the UK. Our mission is to help create an open and progressive research sector to improve the health of people everywhere. In April 2022, the Department of Health and Social Care (DHSC) opened a call for evidence to inform a new cross-government, 10-year plan for mental health and wellbeing for England. Our response to this call for evidence<sup>1</sup> is based on our previous policy work across a broad range of topics with relevance to mental health, as well as evidence from Academy programme participants and grant awardees, people with lived experience of mental health issues, and members our elected Fellowship, which includes some of the UK's foremost experts in clinical and academic psychology, psychiatry and neuroscience (Annex I).

This consultation response was submitted to DHSC via an online questionnaire and is therefore structured in the order that the questions appeared in the form. Many of the questions ask for responses to be broken up into different target groups: infants and their caregivers, children and young people, working age adults, older adults, and those at greater risk of mental ill-health.

The summary below highlights the main issues that we raise throughout our response. The summary is exclusive to this public version and was not submitted to DHSC, as the call for evidence asked only for answers to a specific series of questions.

## Summary

Across the potential stages of intervention for mental health, from promoting wellbeing and prevention to treatment and crisis support, there are several common themes that we believe should be central to the Government's mental health and wellbeing plan:

### **Research as an integral part of the 10-year plan**

Research that is innovative, inclusive and collaborative is key to understanding the causes of mental health issues at an individual and population level, and for finding new effective ways of preventing and treating them. It is imperative that research is central to the development, evaluation and implementation of the Plan, and that the Plan sets out how research related to all stages of intervention will be supported. Research must not only be considered in relation to treatment, as it is in the discussion paper, but must underpin the Plan from start to finish.

We highlight priority areas for research throughout our response, including:

- An update of the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) survey

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<sup>1</sup> Department of Health and Social Care (2022). *Mental health and wellbeing plan: discussion paper and call for evidence*. <https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence>

- Longitudinal cohort studies to study environmental and genetic mental health risk factors and the effectiveness of interventions
- Quantitative and qualitative research to identify the causes of increasing rates of mental ill-health in children and young people
- Research to evaluate the effectiveness of social interventions
- Basic and clinical research to develop and evaluate new innovative treatments and interventions, including digital and technological innovations for treatment and service delivery
- Research to understand the interactions between mental and physical health
- Implementation research for translating research into practice
- Research to identify the most effective ways to promote mental wellbeing and prevent poor mental health in young children

The Government, research funders, regulators and the NHS all have a role to play in supporting mental health research and ensuring research is translated into benefits for patients. Key priorities should be boosting investment in mental health research, building capacity for research in the healthcare system, improving data sharing, linkage and access, increasing the involvement of people with lived experience, and strengthening interdisciplinary and multi-centre collaboration. The Academy has identified a specific need for an integrated national training scheme for mental health to encourage and support healthcare workers to partake in academic training and research.

### **Taking a holistic approach to prevention and tackling inequalities**

There is ample evidence that economic and social factors, such as poverty, unemployment and housing and/or food insecurity, have some of the biggest impacts on a person's mental wellbeing and mental health. The Plan, and the Government's broader health agenda, must look to address these determinants and the vast inequalities in mental health that derive from economic and social inequality. The plan must place a focus on building healthy and resilient communities that promote good mental and physical health, instead of placing the onus on individuals. This will involve working with communities as equal partners, empowering them to design and deliver interventions tailored to the communities they serve.

The environment within which a child is born and raised is a strong predictor of child mental and physical health, and subsequently their health in later life. Prevention must therefore start early in life, focussing on how to ensure that all children are raised in an environment that promotes good mental health and considering the role of all individuals and organisations that will have contact with a child from conception through to adolescence. Greater investment is needed in support for families and prevention in schools.

### **Investing in services and building workforce capacity**

Mental health services and their workforce (including the research workforce) are working at capacity, with a number of our Fellows referring to it as a 'workforce in crisis'. Both early intervention and harnessing the benefits of research for patients and the workforce are dependent on relieving workforce pressure and boosting capacity in the system. This means recruiting, training and supporting staff across all services within and outside of the NHS, from psychiatrists, psychologists and psychotherapists to mental health nurses, school nurses and counsellors and members of the voluntary and community sector. Priority areas for increased investment include Child and

Adolescent Mental Health Services, perinatal services, Improving Access to Psychological Therapies (IAPT), and acute hospital care and crisis support.

## **A cross-Government, cross-sector plan**

As many of the causes of mental ill-health fall outside of the control of the healthcare system, many different systems and parts of society will need to come together to prevent and treat mental health issues. The Plan should set out the structures that will be put in place to enable a cross-Government and cross-system approach that coordinates efforts across the education, work, health and social care, justice, public health and voluntary and community sectors. A key facilitator of this approach will be data linkage between systems to enable service delivery and research.

## **Involving people with lived experience, their families, caregivers and communities**

Meaningful involvement of patients, their families and caregivers must be central to the development, implementation and evaluation of the Plan and any subsequent actions, and mental health policy and research more broadly. This will ensure that interventions are designed with the needs of those they serve in mind, and to foster trust in service providers. Attention must be paid to involving all individuals and communities, particularly those who experience poorer mental health outcomes such as people of Black and ethnic minority backgrounds, men, and younger people.

The voluntary and community sector plays an invaluable role in prevention and treatment of mental ill-health, taking pressure off public services and delivering interventions that are accessible and tailored to the needs of their communities. The Plan should consider how voluntary and community organisations can be better supported and linked with other sectors, including the health and social care and education systems.

## **Championing a personalised and integrated approach to health**

People with the same mental health diagnosis can experience different symptoms and require different interventions. We must therefore move towards a targeted and personalised approach to prevention and care. As well as being critically dependent on workforce capacity, this also requires interdisciplinary research to develop new treatments, new modes of service delivery and a better understanding of which interventions work best for which people. Given the impact of physical health on mental health and vice versa, there is also a need to enable services and the workforce to deal with physical and mental health issues in an integrated way.

## Section 1: How can we all promote positive mental wellbeing?

### How can we help people to improve their own wellbeing?

- 1.1. In 2008, the Government Office for Science Foresight Project on Mental Capital and Wellbeing identified five evidence-based ways to achieve mental wellbeing.<sup>2</sup> In addition to forming **positive social relationships** and making a **positive contribution to society** (two factors mentioned in the discussion paper), the project also stressed the importance of **physical activity, mindfulness, and learning new things**.
- 1.2. The importance of nutrition was also emphasised to us. Long-term lack of nutrients is associated with damage to the brain, while a good quality diet can lead to a larger brain volume.<sup>3,4</sup> Our report, 'A healthy future – tackling climate change mitigation and human health together',<sup>5</sup> highlighted the environmental and health co-benefits of improving nutrition at the population level. Population adherence to WHO dietary recommendations is predicted to result in a 17% reduction in greenhouse gas emissions and save 6.8 million years of life lost prematurely over 30 years.<sup>6</sup> **Improving population nutrition** should be a key cross-Government priority to promote mental wellbeing and tackle other public health challenges.
- 1.3. Despite the existing evidence on factors that promote wellbeing, **further research** is still required to identify and validate those that have the most significant impact. A recent review found that the quality of evidence for the efficacy of many wellbeing interventions is still low.<sup>7</sup> The Government should therefore be careful not to invest resource in interventions that not well-evidenced.

### Children and young people

- 1.4. Brain development begins soon after conception and is shaped by genetic and environmental factors (and the interaction between the two) throughout early childhood and into adolescence.<sup>8</sup> The 10-year mental health and wellbeing plan (referred to as 'the Plan' hereinafter) must define how **each institution that has contact with a child from conception to early adulthood** can contribute to a child's mental wellbeing and prevention of mental ill-health (**section 2**). As well as schools, health and social care and universities, this also includes the role of parents and caregivers (**2.8 – 2.13**), health visitors (**2.9**), social services, private childcare and community organisations.
- 1.5. There are several examples of interventions that show evidence of promoting mental wellbeing in young people.<sup>9</sup> Out of these, **psychoeducation** (learning about mental health

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<sup>2</sup> Government Office for Science (2008). *Mental capital and wellbeing*.

<https://www.gov.uk/government/collections/mental-capital-and-wellbeing>

<sup>3</sup> Dewey KG & Begum K (2011). *Long-term consequences of stunting in early life*. *Matern Child Nutr* **7**, 5-18.

<sup>4</sup> Croll P, et al. (2018). *Better diet quality relates to larger brain tissue volumes: The Rotterdam Study*. *Neurology* **90**, e2166-e2173.

<sup>5</sup> Academy of Medical Sciences and Royal Society (2021). *A healthy future – tackling climate change mitigation and human health together*. <https://acmedsci.ac.uk/file-download/11365167>

<sup>6</sup> Milner J, et al. (2015). *Health effects of adopting low greenhouse gas emission diets in the UK*. *BMJ Open* **5**, e007364.

<sup>7</sup> Solanes A, et al. (2021). *Can we increase the subjective well-being of the general population? An umbrella review of the evidence*. *Rev Psiquiatr Salud Ment* **14**, 50-64.

<sup>8</sup> Academy of Medical Sciences (2019). *The developing brain in health and disease*. <https://acmedsci.ac.uk/file-download/9487768>

<sup>9</sup> Salazar de Pablo G, et al. (2020). *Universal and selective interventions to promote good mental health in young people: systematic review and meta-analysis*. *Eur Neuropsychopharmacol* **41**, 28-39.

and wellbeing) was identified as the most effective for promoting mental health literacy and cognitive skills.

- 1.6. However, there is a need for more **rigorous evaluations of interventions aimed at mental health promotion**, particularly **large cluster randomised trials that study longer-term outcome measures** with a focus on **primary school-aged children**. One of our Fellows suggested that such studies should take a holistic approach to targeting and evaluating the impact of interventions on both children and their parents, carers and teachers.
- 1.7. One example of an intervention aimed at primary school children is CUES-Ed, an 8-week clinician-led **cognitive behavioural programme**.<sup>10</sup> The programme encourages children to look after their physical health, recognise cues for when things may not be right with their mental health, and identify helpful ways of responding to cues. Preliminary evaluation of the programme found that vulnerable children improved on measures of wellbeing, distress, and emotional and behavioural difficulties, but more long-term and extensive evaluation is required.<sup>11</sup>
- 1.8. The INCLUSIVE randomised controlled trial showed that low-cost interventions aimed at **reducing bullying, aggression and violence** reduced student reports of bullying and had positive effects on psychological function, wellbeing and quality of life among secondary school students.<sup>12</sup> However, other studies have shown that antibullying interventions only have a small impact on internalising (e.g. anxiety and depression) symptoms.<sup>13</sup> Further development and evaluation of antibullying interventions should focus on identifying the aspects of these programmes that both promote wellbeing and reduce mental ill-health.
- 1.9. Other activities that enable children to build social and emotional skills include **volunteering, holiday clubs, active citizenship and social action projects and arts or sports-based activities**.<sup>14</sup> Children should have access to multiple types of activities, and for some, being able to access community-based support away from school-related pressures and judgements is important.
- 1.10. To improve student wellbeing, universities need to ensure that all aspects of the student experience promote mental wellbeing – a **whole-university approach**.<sup>15</sup> This includes supporting students to make the transition to university and form social connections, ensuring students feel equipped to succeed at university and making systems across the university easy to navigate.
- 1.11. In schools and universities, **peer support programmes** have been shown to have a positive impact on the wellbeing of both students with low baseline levels of mental

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<sup>10</sup> <https://cues-ed.co.uk/>

<sup>11</sup> Underwood R, et al. (2021). *Identifying and changing cognitive vulnerability in the classroom: preliminary evaluation of CUES-Ed, a school-based universal cognitive behavioural early intervention service for 7–10 year olds*. Child Adolesc Ment Health. <https://doi.org/10.1111/camh.12524>

<sup>12</sup> Bonell C, et al. (2018). *Effects of the Learning Together intervention on bullying and aggression in English secondary schools (INCLUSIVE): a cluster randomised controlled trial*. Lancet **392**, P2452-2464.

<sup>13</sup> Guzman-Holst C, et al. (2022). *Research Review: Do antibullying interventions reduce internalizing symptoms? A systematic review, meta-analysis, and meta-regression exploring intervention components, moderators, and mechanisms*. J Child Psychol Psychiatry. <https://doi.org/10.1111/jcpp.13620>

<sup>14</sup> Sehmi R, et al. (2020). *No man is an island: social resources, stress and mental health at mid-life*. Br J Psychiatry **217**, 638–644.

<sup>15</sup> Byrom NC (2017). *Student Voices: Student Voices in the development of a whole university approach to mental health and wellbeing*. Student Minds. [https://kclpure.kcl.ac.uk/portal/en/publications/student-voices\(029c05ab-5bc3-4efb-b99d-017fcb1a44dc\)/export.html](https://kclpure.kcl.ac.uk/portal/en/publications/student-voices(029c05ab-5bc3-4efb-b99d-017fcb1a44dc)/export.html)

wellbeing and student facilitators.<sup>16,17</sup> An example is the Positive Peers programme at Kings College London.<sup>18</sup>

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<sup>16</sup> Byrom N (2018). *An evaluation of a peer support intervention for student mental health*. J Ment Health **27**, 240-246.

<sup>17</sup> Crisp DA, et al. (2020). *Implementing a peer support program for improving university student wellbeing: The experience of program facilitators*. Aust J Educ **64**, 113-126.

<sup>18</sup> <https://www.kclsu.org/help/wellbeing/positivepeers/>

## Section 2: How can we all prevent the onset of mental health conditions?

### **What does the Government need to address to prevent the onset of mental health conditions and reduce the numbers of people who experience mental ill-health?**

- 2.1. A person's risk of poor mental health is determined by a combination of their genes and the environment within which they are raised, develop, live and work. The social and economic determinants of mental ill-health include poverty and deprivation, income inequality, housing insecurity and food poverty.<sup>19</sup> Other risk factors for mental illnesses include adverse childhood experiences and trauma, tobacco smoking and cannabis use, insufficient physical activity, and job strain.<sup>20</sup>
- 2.2. Public health approaches that **target the social and economic determinants of mental health** hold the greatest potential for reducing the incidence of mental disorders across the whole population. Most of these determinants lie outside of the control of the health domain, the Department of Health and Social Care (DHSC) and NHS England. The Plan must therefore take a **cross-Government and cross-system approach** to prevention. It should **outline the role of all relevant government departments**, including the Department for Education, Department for Work and Pensions, DHSC, Department for Business Energy and Industrial Strategy, Ministry of Justice and the Office for Health Improvement and Disparities, and detail the structures that will be put in place to ensure **coordination**. It should also indicate how different systems – including education, health and social care, justice, public health and the voluntary and community sector (VCS) – will be joined-up to achieve common goals, whether that be through better data sharing, pooled budgets, or existing structures such as Integrated Care Systems and Primary Care Networks.
- 2.3. As one person with lived experience explained to us: '**Prevention must be embedded within the communities and settings within which people live their lives**'. The VCS should be empowered to become a central part of prevention and health promotion, with programmes designed and delivered by the communities they are made to serve.
- 2.4. To prevent mental health conditions and reduce mental health inequalities, steps must be taken to **reduce poverty and financial inequality**.<sup>21</sup> In the following sections we give multiple examples of opportunities for prevention. However, many of these initiatives will be ineffective if people don't have the time, money and means to engage with them. Many of our contributors raised concerns over the impact of the cost of living crisis on poverty, inequality and mental health. Financial support must be available to mitigate the impacts of this crisis on vulnerable individuals and families.
- 2.5. There is strong evidence for inequalities in experiences of poor mental health across different demographic groups, with gender, ethnicity, sexuality, geography, and

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<sup>19</sup> Lund C, et al. (2018). *Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews*. *Lancet Psychiat* **5**, 357-369.

<sup>20</sup> Dragioti E, et al. (2022). *Global population attributable fraction of potentially modifiable risk factors for mental disorders: a meta-umbrella systematic review*. *Mol Psychiatry*. <https://doi.org/10.1038/s41380-022-01586-8>

<sup>21</sup> Centre for Mental Health (2022). *Tackling mental health disparities*. <https://www.centreformentalhealth.org.uk/publications/tackling-mental-health-disparities>

socioeconomic factors all having an impact on risk of mental ill-health.<sup>22</sup> Given the impact of poor mental health on education, employment and productivity, in addition to health and wellbeing more generally, socioeconomic and geographic mental health inequalities present a barrier to achieving the Government's levelling up missions. Reducing mental health inequalities should therefore be a key priority for the Government's strategy to level up the country. Prevention can play a key role in reducing these inequalities and should be **focussed on the populations with the biggest prevalence of mental health issues and worst mental health outcomes.**

- 2.6. To develop effective prevention strategies, we need to be able to **predict who is at greatest risk** of poor mental health, and the **circumstances in which mental health conditions arise**. This in turn requires an understanding of the molecular, genetic, epigenetic (describing the effect of environment on gene expression) and environmental drivers of different conditions throughout the life course. The **funding and coordination of longitudinal research (7.43)** to study these drivers, and the **collection and sharing of anonymised data from patients**, is therefore vital. Priorities for data are addressed in **7.41-7.54**.
- 2.7. It is also important to acknowledge and consider the impact of our **genetics** on our mental health. Understanding of the genetic risk factors for mental health conditions, and how the interaction between genes and environment modifies this risk, is incomplete but rapidly evolving. Knowledge of the combinations of genetic and environmental factors that yield the highest risk could offer an opportunity for **identification of vulnerable individuals** and consequently **targeted and personalised prevention and intervention**.

### ***Infants and their parents or primary caregivers***

- 2.8. Perinatal maternal mental health issues can have long-term impacts on the mental health of the mother and predispose children to mental ill-health. Two- to four-year-olds are 2.9 times more likely to show signs of a mental health disorder if they have a parent who has poor mental health.<sup>23</sup> Strategies for prevention of perinatal mental health issues include the **prediction of mental health risk and early intervention for women around childbirth** and **improving access to midwives and health visitors**. There is a need for targeted prevention and support for families at greatest risk of parental and child mental health issues, such as those experiencing poverty, those where there is a family history of mental ill-health, and single-parent families.
- 2.9. There is strong evidence for the cost-effectiveness of health visitors and their impact on the mental health of mothers and child outcomes.<sup>24,25</sup> It is estimated that at least 30% of the health visitor workforce has been lost since 2015, attributed to public

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<sup>22</sup> Centre for Mental Health (2022). *Inequalities in mental health: the facts*. [https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMH\\_Inequalities\\_Factsheet.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMH_Inequalities_Factsheet.pdf)

<sup>23</sup> NHS Digital (2017). *Mental health of children and young people in England*. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017>

<sup>24</sup> Homonchuk O & Barlow J (2022). *Specialist Health Visitors in Perinatal and Infant Mental Health*. <https://ihv.org.uk/wp-content/uploads/2022/01/SPHV-report-Final-version-January-14-2022.pdf>

<sup>25</sup> Bauer A, Tinelli M & Knapp M (2022). *The economic case for increasing access to treatment for women with common mental health problems during the perinatal period*. <https://maternalmentalhealthalliance.org/wp-content/uploads/economic-case-increasing-access-treatment-women-common-maternal-mental-health-problems-report-lse-2022-mmha.pdf>



health funding decreases and difficulties in recruitment and retention.<sup>26</sup> We welcome the Government's commitment to ensure that health visitors are trained and retained as part of the Start for Life offer,<sup>27</sup> and would like to see this commitment supported by **measurable targets for increasing access to health visitors**.

- 2.10. We heard support for the idea of Family Hubs to provide high-quality, joined-up and whole-family support services as part of the Start for Life offer.<sup>28</sup> One contributing Fellow stressed the importance of ensuring that these are **backed up by sufficient investment** and **joined up with the healthcare system** through Primary Care Networks.
- 2.11. A number of Fellows informed us of evidence for the positive impact of parenting programmes on child behaviour, parent-child relationships, and parental mental health,<sup>29,30</sup> with one example focussing specifically on multi-ethnic communities.<sup>31</sup> Although parenting programmes are recommended by the National Institute for Health and Care Excellence (NICE) for parents of children who have or are at high risk of developing antisocial behaviour or conduct disorders,<sup>32</sup> we heard that access to these programmes is highly variable. **Increasing access to parenting programmes** and further **research into what makes the most effective parenting programmes**, should be a priority.
- 2.12. A recent Nuffield Foundation report provides a review of the evidence base around parenting programmes and identifies priorities for research relating to parenting.<sup>33</sup> The report found that parenting programmes, despite their benefits, are less likely to succeed if not **combined with action to reduce pressure on families**, such as reducing poverty.
- 2.13. Two of our contributors stressed the importance of equitable parental leave policies that are easy to navigate and ensure all parents can afford to take parental leave, regardless of their financial position. Increasing the duration of paid and unpaid parental leave is associated with beneficial effects on the mental health of mothers and children.<sup>34,35</sup> The Government should consider whether **more generous and equitable parental leave policies** are necessary to help all parents and infants get off to a secure start and support children's future mental health.

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<sup>26</sup> First 1001 Days Movement (2022). *Why health visitors matter*. <https://parentinfantfoundation.org.uk/wp-content/uploads/2022/05/Why-Health-Visitors-Matter.pdf>

<sup>27</sup> HM Government (2021). *The best start for life. A vision for the 1,001 critical days*. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/973085/Early\\_Years\\_Report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973085/Early_Years_Report.pdf)

<sup>28</sup> *Ibid*

<sup>29</sup> Vlahovicova K, et al. (2017). *Parenting programs for the prevention of child physical abuse recurrence: a systematic review and meta-analysis*. *Clin Child Fam Psychol Rev* **20**, 351-365.

<sup>30</sup> Morpeth L, et al. (2017). *The effectiveness of the Incredible Years pre-school parenting programme in the United Kingdom: a pragmatic randomised controlled trial*. *Child Care Pract* **2**, 141-161.

<sup>31</sup> Scott S, et al. (2010). *Impact of a parenting program in a high-risk, multi-ethnic community: the PALS trial*. *J Child Psychol Psychiatry* **51**, 1331-41.

<sup>32</sup> National Institute for Health and Care Excellence (2013). *Antisocial behaviour and conduct disorders in children and young people: recognition and management*. <https://www.nice.org.uk/guidance/cg158>

<sup>33</sup> Nuffield Foundation (2022). *Time for parents. The changing face of early childhood in the UK*. <https://www.nuffieldfoundation.org/wp-content/uploads/2022/05/Time-for-parents-Nuffield-Foundation.pdf>

<sup>34</sup> Avendano M, et al. (2015). The long-run effect of maternity leave benefits on mental health: Evidence from European countries. *Soc Sci Med* **132**, 45-53.

<sup>35</sup> Persson P & Rossin-Slater M (2019). *When dad can stay home: fathers' workplace flexibility and maternal health*. National Bureau of Economic Research. DOI 10.3386/w25902.

## **Children and young people**

- 2.14. The psychological and social environment within which a child is raised is a strong predictor of child mental and physical health, in turn affecting their health throughout the life course. This means that **prevention must start early in life**, from the point of conception through to early adolescence.
- 2.15. Our understanding of why the incidence of mental health issues in children and young people is increasing is poor. Possible contributing causes include recession and associated austerity measures, changes to family structures, student debt, academic pressures, the increasing use of social media, predicted gaps in prosperity between young people and their parents/caregivers, and a higher incidence of reporting mental ill-health.<sup>36</sup>
- 2.16. Childhood trauma - defined as events that involve “actual or threatened death, serious injury or accident, or sexual violence” - is associated with poorer mental health, physical health, and social, educational, and employment outcomes across the life course.<sup>37</sup> One in three young people report experiencing a traumatic event by the age of 18 years.<sup>38</sup>
- 2.17. Reducing childhood trauma and addressing trauma-related mental health issues early could prevent a large burden of mental health conditions in adulthood.<sup>39</sup> Although a broad range of interventions for prevention of trauma exist, including home-based health visiting (**2.9**), parenting programmes (**2.11 – 2.12**), school-based programmes and in-hospital and clinic strategies, the effectiveness of most is unknown.<sup>40</sup> There is a need for **more interventions to be assessed in controlled trials**, for both prevention of trauma and prevention of the development of mental health problems in children who experience trauma.
- 2.18. Many of the determinants of childhood trauma sit outside of the control of the health system. For example, parental mental ill-health, domestic violence and substance misuse often co-occur and have a negative impact on the physical and mental health of children.<sup>41</sup> However, interventions to tackle these three issues are largely delivered by separate services and commissioners. Integrated Care Systems could be used to provide a **joined-up multisystem approach** for supporting families where children are at risk of trauma.
- 2.19. We heard that most of the current interventions in schools are centred around treatment rather than prevention and promoting wellbeing. **Greater investment in prevention in schools** is key to ‘turning off the tap’ of the increasing mental health burden in young people.

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<sup>36</sup> Gunnell D, Kidger J & Elvidge H (2018). *Adolescent mental health in crisis*. BMJ **361**, k2608.

<sup>37</sup> Danese A (2020). *Annual Research Review: Rethinking childhood trauma-new research directions for measurement, study design and analytical strategies*. J Child Psychol Psychiatry **61**, 236-250.

<sup>38</sup> Lewis SJ, et al. (2019). *The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales*. Lancet Psychiat **6**, 247-256.

<sup>39</sup> Dragioti E, et al. (2022). *Global population attributable fraction of potentially modifiable risk factors for mental disorders: a meta-umbrella systematic review*. Mol Psychiatry. <https://doi.org/10.1038/s41380-022-01586-8>

<sup>40</sup> MacMillan HL, et al. (2009). *Interventions to prevent child maltreatment and associated impairment*. Lancet **373**, 250-266.

<sup>41</sup> Allen K, et al. (under review). *Family focused interventions that address parental domestic violence and abuse, mental ill-health, and substance misuse in combination: a systematic review*.

- 2.20. **Supporting parents and caregivers to deliver interventions** for mental health prevention in school-aged children has been shown to be effective and is the subject of a study currently underway in England.<sup>42,43</sup>
- 2.21. We were informed that successful school or community-led prevention programmes focus on building a **sense of agency**, a **sense of self**, a **sense of connection**, and **hope for the future**. The Seattle Social Development Project found that enhancing children’s opportunities for **forming healthy bonds with parents and teachers** led to fewer symptoms of mental ill-health, increased health maintenance behaviours and better health and socioeconomic status in later life.<sup>44</sup>
- 2.22. There is a bidirectional association between school exclusion and mental ill-health, and both are associated with lower educational attainment.<sup>45,46</sup> Given the increasing rates of exclusion over the last five years, schools must be supported to follow recommendations from the **Timpson Review of School Exclusion** and the **Education Endowment Foundation guidance report on improving behaviour in schools**.<sup>47,48</sup>
- 2.23. Prevention of mental health problems in young people could be improved through better **coordination between the education, health and social care systems**. This coordination could be supported by school nurses and counsellors (**3.10**) and better sharing of data between the health system and school records (**7.50**). The new NHS Mental Health Support Teams could also play an important role here, but, as described in **3.9**, the rollout of this scheme must be far more ambitious.
- 2.24. Cross-sectional and longitudinal research tends to show that social media has a small negative impact on mental wellbeing, however, research in this field is typically considered to be low-quality and the effect is variable across studies.<sup>49</sup> There is a need for **longitudinal quantitative and qualitative research** that studies the nuances of the impact of social media use - questioning different types of usage, long-term effects and the intersecting environmental risk factors - and how we help people to use and access social media in a healthy way. One way to facilitate this research is by **improving access to anonymised data held by social media companies**.<sup>50</sup> In the

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<sup>42</sup> Rapee RM, et al. (2010). *Altering the trajectory of anxiety in at-risk young children*. Am J Psychiatry **167**, 1518-25.

<sup>43</sup> Reardon T, et al. (2022). *Minimising young children’s anxiety through schools (MY-CATS): protocol for a cluster randomised controlled trial to evaluate the effectiveness and cost-effectiveness of an online parent-led intervention compared with usual school practice for young children identified as at risk for anxiety disorders*. Trials **23**, 1-15.

<sup>44</sup> Kosterman R, et al. (2019). *Effects of social development intervention in childhood on adult life at ages 30 to 39*. Prev Sci **20**, 986-995.

<sup>45</sup> John A, et al. (2022). *Association of school absence and exclusion with recorded neurodevelopmental disorders, mental disorders, or self-harm: a nationwide, retrospective, electronic cohort study of children and young people in Wales, UK*. Lancet **9**, P23-34.

<sup>46</sup> Tejerina-Arreal M, et al. (2020). *Child and adolescent mental health trajectories in relation to exclusion from school from the Avon Longitudinal Study of Parents and Children*. Child Adolesc Ment Health **25**, 217-223.

<sup>47</sup> Education Endowment Foundation (2021). *Improving behaviour in schools*.

<https://educationendowmentfoundation.org.uk/education-evidence/guidance-reports/behaviour>

<sup>48</sup> HM Government (2019). *Timpson Review of School Exclusion*.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/807862/Timpson\\_review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf)

<sup>49</sup> Orben A (2020). *Teenagers, screens and social media: a narrative review of reviews and key studies*. Soc Psychiatry Psychiatr Epidemiol **55**, 407-414.

<sup>50</sup> The U.S. Surgeon General’s Advisory (2021). *Protecting youth mental health*.

<https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html>

meantime, ensuring that high-quality **education on safe social media use and digital literacy** is delivered in all schools from an early age must be a priority.

- 2.25. The social cognitive development of children currently aged 5 and under is likely to have been seriously disrupted by the COVID-19 lockdowns. The first step to mitigate these impacts should be the development of **mechanisms to identify the children who are experiencing delays in their social or mental development** (and are therefore more likely to experience mental health problems), so they can receive extra support.
- 2.26. To reduce the number of university students who experience mental ill-health, the priority must be ensuring continuity of care for those with a previous history of mental ill-health (**4.23**). There is also a need to provide **specialist prevention for sub-groups at a greater risk of poor mental health**. For example, there are strong links between LGBTQ+ identity and mental health difficulties in university students, and young adults who identify as LGBTQ+ report feeling that support services are not accessible or designed to meet their needs.<sup>51</sup>

### **Working age adults**

- 2.27. Prevention of mental health issues in working age adults requires **effective prevention and early intervention in childhood**. Although most people who experience mental health issues will experience symptoms first in their youth,<sup>52</sup> mental health conditions can also be triggered by adverse life events throughout the life course such as bereavement, retirement, changes to physical health, loneliness and isolation.
- 2.28. Building a network of **social relationships** has been shown to help individuals withstand exposure to higher levels of stress resulting from these life events,<sup>53</sup> making the case for ensuring clinicians have the skills they need to **assess an individual's close relationships and broader social ties**.
- 2.29. There are bi-directional links between mental ill-health and financial insecurity. Provision of social security benefits can break this link, however the process of applying for benefits often stimulates or exacerbates mental ill-health. The system is difficult to navigate, especially for people that have existing mental health problems. In addition to **increasing access to and the value of social security (2.4)**, there must be readily available support to **help people navigate the system**.

### **Older adults**

- 2.30. An important priority for medical and social research is understanding **how to protect the mental health of vulnerable older people** who are at risk of poverty, social

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<sup>51</sup> Smithies D & Byrom NC (2018). *LGBTQ+ Student Mental Health*. Student Minds.

[https://www.studentminds.org.uk/uploads/3/7/8/4/3784584/180730\\_lgbtq\\_report\\_final.pdf](https://www.studentminds.org.uk/uploads/3/7/8/4/3784584/180730_lgbtq_report_final.pdf)

<sup>52</sup> Kessler RC, et al. (2005). *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*. Arch Gen Psychiatry **62**, 593-602.

<sup>53</sup> Sehmi R, et al. (2020). *No man is an island: social resources, stress and mental health at mid-life*. Br J Psychiatry **217**, 638-644.

isolation, discrimination and elder abuse, and to **evaluate innovative models of community or financial support**.<sup>54</sup>

## How can employers support and protect the mental health of their employees?

- 2.31. Providing access to **coping skills** or **resilience training** (e.g. mindfulness) has been shown to promote employee mental wellbeing.<sup>55,56</sup>
- 2.32. According to NICE workplace guidelines,<sup>57</sup> individual-level approaches to improving wellbeing should not replace **organisational strategies for reducing work stressors**, such as ensuring adequate staffing and appropriate shift patterns. Resilience should be viewed as a characteristic of a team rather than an individual, and can be developed in environments that foster **safe workplaces and supportive relationships between colleagues**.<sup>58,59</sup>
- 2.33. There is evidence that **psychosocial training for managers** leads to teams performing better at work and taking less sick leave. A randomised controlled trial of a 4-hour manager mental health training programme in an Australian fire service showed reductions in sickness absence and a return on investment of nearly £10 for every £1 that was spent on training.<sup>60</sup> In the UK, REACTMH, an active listening skills training course for healthcare managers, improved managers' confidence in identifying, speaking to and supporting distressed employees.<sup>61</sup>
- 2.34. There is some evidence that mental health disorders are more frequently experienced among individuals working in environments with high exposure to traumatic events (e.g. emergency services and healthcare). Interventions for preventing mental ill-health following exposure to a traumatic event include **training managers to detect signs of distress, peer support systems, group discussions and the TRiM Trauma Risk Management Programme**.<sup>62,63</sup>

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<sup>54</sup> Academy of Medical Sciences and The InterAcademy Partnership (2018). *Challenges and priorities for global mental health in the Sustainable Development Goals (SDG) era*. <https://acmedsci.ac.uk/file-download/48863619>

<sup>55</sup> Greenberg N & Tracy D (2020). *What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic*. *BMJ Lead* **4**, 101-102.

<sup>56</sup> Robertson IT, et al. (2015). *Resilience training in the workplace from 2003 to 2014: A systematic review*. *J Occup Organ Psychol* **88**, 533-562.

<sup>57</sup> National Institute for Health and Care Excellence (2022). *Mental wellbeing at work*. <https://www.nice.org.uk/guidance/ng212>

<sup>58</sup> Greenberg N & Tracy D (2020). *What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic*. *BMJ Lead* **4**, 101-102.

<sup>59</sup> Jones N, et al. (2012). *Leadership, cohesion, morale, and the mental health of UK Armed Forces in Afghanistan*. *Psychiatry* **75**, 49-59.

<sup>60</sup> Milligan-Saville JS, et al. (2017). *Workplace mental health training for managers and its effect on sick leave in employees: a cluster randomised controlled trial*. *Lancet Psychiat* **4**, 850-858.

<sup>61</sup> Akhanemhe R, Wallbank S & Greenberg N (2021). *An evaluation of REACTMH mental health training for healthcare supervisors*. *Occup Med* **71**, 127-130.

<sup>62</sup> Greenberg N & Tracy D (2020). *What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic*. *BMJ Lead* **4**, 101-102.

<sup>63</sup> Greenberg N, et al. (2020). *How might the NHS protect the mental health of health-care workers after the COVID-19 crisis?* *Lancet Psychiat* **7**, 733.

## What is the most important thing the Government needs to address in order to prevent suicide?

### *Children and young people*

- 2.35. There is an urgent need for **research to understand the reason for the year-on-year rise in suicide and self-harm** in children and adolescents, so that the problem can be tackled at the source.
- 2.36. The Plan and the Online Safety Bill must set out **how online suicide and self-harm content will be effectively policed**. Concerns about the Bill as it stands include the lack of clarity over what content will be considered illegal under the offence of 'promoting suicide' and the lack of action over self-harm content.<sup>64</sup>

### *People that are at greater risk of suicide*

- 2.37. Suicide prevention requires strategies for the **assessment of risk and diagnosis of suicidal behaviour**, yet current strategies are inaccurate. In the UK, nearly 90% of mental health patients who died by suicide were rated as no risk or low risk of suicide when they were last seen by clinicians.<sup>65</sup>
- 2.38. There is no single risk factor that is a strong predictor of suicidal behaviour, making prediction challenging. Although potential solutions to this problem include the use of **computerised adaptive tests and machine learning methods with electronic health records**,<sup>66</sup> there is little evidence to suggest that these methods perform better than risk assessments performed by clinicians, and there is concern that their use may interfere with the ability of clinicians to form accurate impressions of their patients. **Qualitative and quantitative research**, including randomised controlled trials, would be required to **evaluate if these methods are effective** in predicting suicide risk and improving clinical outcomes.
- 2.39. Another priority should be the continuous **training of primary care and emergency department staff** in recognising signs of suicidal behaviour. Such training should be **co-designed and co-delivered with people with lived experience**.
- 2.40. Bigger and more representative **multi-centre randomised controlled trials** are required to study the effectiveness of interventions for people who have self-harmed or attempted suicide. There is some evidence for the effectiveness of some psychological interventions for adults (e.g. cognitive behavioural therapy (CBT)), but more **research is required with longer follow up times and a greater use of head-to-head trials** (where treatments are compared directly).<sup>67</sup> There should be a focus on interventions for disengaged groups, particularly men, who are more likely to die by suicide and less likely to seek help.

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<sup>64</sup> Samaritans (2022). *Online Safety Bill: the ins and outs*. <https://www.samaritans.org/news/online-safety-bill-the-ins-and-outs/>

<sup>65</sup> Graney J, et al. (2020). *Suicide risk assessment in UK mental health services: a national mixed-methods study*. *Lancet Psychiat* **7**, 1046–53.

<sup>66</sup> Turecki G, et al. (2019). *Suicide and suicide risk*. *Nat Rev Dis Primers* **5**, 74.

<sup>67</sup> Cochrane (2021). *Psychosocial interventions for adults who self-harm*. [https://www.cochrane.org/CD013668/DEPRESSN\\_psychosocial-interventions-adults-who-self-harm](https://www.cochrane.org/CD013668/DEPRESSN_psychosocial-interventions-adults-who-self-harm)

- 2.41. There is a well-evidenced association between alcohol consumption and suicide.<sup>68</sup> **Alcohol prevention programmes, regulation and taxation** to drive down consumption, alongside support mechanisms for those with alcohol use disorders, may help reduce suicide risk indirectly and improve public mental health more widely.<sup>69</sup>
- 2.42. Suicide rates increase during periods of economic recession.<sup>70</sup> Evidence-based policy responses to protect population mental health during periods of recession include **investment in active labour market programmes**, provision of **adequate welfare benefits**, and ensuring the workforce in contact with vulnerable individuals (not only in healthcare) receive **training in recognising and responding to risk**.<sup>71</sup>

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<sup>68</sup> Isaacs J, et al. (2022). *Alcohol use and death by suicide: A meta-analysis of 33 studies*. *Suicide Life Threat Behav.* <https://doi.org/10.1111/sltb.12846>

<sup>69</sup> Kölves K, et al. (2020). *Impact of alcohol policies on suicidal behavior: a systematic literature review*. *Int J Environ Res Public Health* **17**, 7030.

<sup>70</sup> Gunnell D, et al. (2015). *The 2008 Global Financial Crisis: effects on mental health and suicide*. Policy Bristol. [https://www.bristol.ac.uk/media-library/sites/policybristol/briefings-and-reports-pdfs/pre-2017-briefings--reports-pdfs/PolicyBristol\\_Report%203\\_2015\\_Suicide%20and%20the%20recession.pdf](https://www.bristol.ac.uk/media-library/sites/policybristol/briefings-and-reports-pdfs/pre-2017-briefings--reports-pdfs/PolicyBristol_Report%203_2015_Suicide%20and%20the%20recession.pdf)

<sup>71</sup> *Ibid.*

## Section 3: How can we all intervene earlier when people need support with their mental health?

### What more can the NHS do to help people struggling with their mental health to access support early?

- 3.1. We were informed that the considerable understaffing of the mental health workforce relative to the need is a major barrier to delivering early access to mental healthcare and treatment. Greater focus must be placed on **recruiting, retaining, training and supporting clinicians and clinical academics** across the NHS, from psychiatry and psychology to psychotherapists, mental health nurses and Improving Access to Psychological Therapies (IAPT) staff, to allow patients to access support early regardless of the severity of their condition. There is an opportunity to review and reform how we're training the next generation of mental health staff, to support a sustainable workforce of the future. See **4.3-4.6** for more on recruiting and retaining staff.
- 3.2. We heard repeatedly from people with lived experience that staff in general practice and emergency departments are generally not well equipped to respond to people with mental health issues, both in terms of immediate care and how to get patients access to long-term support. This is backed up by research identifying multiple barriers to primary care practitioners' ability to support children and young people with mental health issues, including a lack of time, knowledge, reimbursement, specialist service providers and resources.<sup>72</sup> **Regular training and addressing workforce pressures and capacity issues** is likely to enable staff to respond early and appropriately to those presenting at healthcare entry points.
- 3.3. People with lived experience also told us that there is an enduring stigma and harmful perception of what mental health issues 'look like' within the health system, leading to dismissal and failed opportunities for early intervention. A better understanding of the different experiences and symptoms that people with the same diagnosis can have can be achieved through **longitudinal research** and **training that is co-designed and co-delivered with patients**.
- 3.4. The fragmentation of services makes it increasingly difficult for patients, carers and clinicians to navigate referral pathways. A balance must be struck to ensure that people with specific needs can receive specialist care, but that services are not so siloed as to exclude people who do not fit certain criteria. This balance can only be achieved through **continuous evaluation and dialogue with service users**.
- 3.5. Identification of individuals with symptoms or those at risk of mental health problems through **population-level screening** could increase opportunities to access support early. A recent meta-analysis demonstrated that preventative interventions targeted at children identified through screening for family history of depression have a small but significant positive effect on depressive symptoms and incidence of depression.<sup>73</sup>

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<sup>72</sup> O'Brien D, et al. (2016). *Barriers to managing child and adolescent mental health problems: a systematic review of primary care practitioners' perceptions*. Br J Gen Pract **66**, e693-707.

<sup>73</sup> Loechner J, et al. (2018). *Preventing depression in the offspring of parents with depression: A systematic review and meta-analysis of randomized controlled trials*. Clin Psychol Rev **60**, 1-14.



### **Infants and their parents or primary caregivers**

- 3.6. Strategies to prevent perinatal mental health issues **through improved access to support services** (notably midwives, health visitors, family hubs and parenting programmes) **(2.8-2.13)** will provide opportunities for early intervention.

### **Children and young people**

- 3.7. The 2019/2020 Children's Commissioner report on the state of children's mental health services stated that, on average, local Clinical Commissioning Groups spent 14 times more on adult mental health services than services for children,<sup>74</sup> despite 75% of mental health illnesses beginning before the age of 24.<sup>75</sup> For the NHS to provide effective early intervention for children and young people, **Child and Adolescent Mental Health Services (CAMHS) require urgent investment and resourcing.**
- 3.8. As with prevention, researchers informed us that early intervention would benefit from **better linkage of data across different systems.** One research study is utilising **federated analytics** (where analysis is performed on multiple separated datasets without exchanging or removing data from a secure environment) **and artificial intelligence across Trusted Research Environments** to join up data across health, education and social care records to identify children who would benefit from early intervention.<sup>76</sup>
- 3.9. Parents are a key gatekeeper to treatment access for children and adolescents, and so **developing interventions that are targeted at, and accepted by, whole families,** is important.<sup>77</sup> These include improving access to free and flexible services with opportunities to develop trusting relationships with professionals, improving parents' identification of mental health problems, reducing stigma for parents, and increasing awareness of how to access services.
- 3.10. As well as contributing to prevention, **school counsellors, psychotherapists and nurses** can provide an accessible and effective form of early intervention, with the potential to have positive impacts on young people's mental health and academic attainment.<sup>78,79</sup> School nurse numbers fell by 30% between 2010 and 2019,<sup>80</sup> and we support calls made by the Secretary of State for Health and Social Care and others **to**

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<sup>74</sup> Children's Commissioner (2021). *The state of children's mental health services 2019/20.* <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/occ-the-state-of-childrens-mental-health-services-2019-20.pdf>

<sup>75</sup> Kessler RC, et al. (2005). *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication.* Arch Gen Psychiatry **62**, 593-602.

<sup>76</sup> <https://www.psychiatry.cam.ac.uk/blog/2022/01/20/analytics-and-artificial-intelligence-research-wins-prestigious-award/>

<sup>77</sup> Reardon T, et al. (2017). *What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies.* Eur Child Adolesc Psychiatry **26**, 623-647.

<sup>78</sup> British Association for Counselling and Psychotherapy (2022). *School counselling in England campaign.* <https://www.bacp.co.uk/news/campaigns/school-counselling/>

<sup>79</sup> Shuttleworth A (2019). *School nurses can support mental health and wellbeing – but only if we have enough of them.* Nursing Times, 01 March.

<sup>80</sup> Stephenson J (2019). *RCN issues warning over ongoing school nurse cuts, ahead of new term.* Nursing Times, 21 August.

**reverse the significant decline in numbers of school nurses.**<sup>81,82</sup> Furthermore, while Scotland, Wales and Northern Ireland all have government-funded school counselling services, England does not. The NHS Mental Health Support Teams, which provide access to practitioners trained in psychological therapy, aim to cover 35% of pupils by 2023. Our contributors felt that this target was not ambitious enough, leaving two thirds of young people without professional mental health support at school.

- 3.11. Treatment for children who experience trauma (**2.16-2.18**) relies on being able to identify them early, but it is estimated that only 20% of trauma-exposed children seek professional help.<sup>83</sup> Improving under-detection of childhood trauma requires a better **understanding of the barriers to care access, screening for trauma exposure** through non-specialist healthcare settings, **development of accurate prediction models** to identify the children at greatest risk of mental ill-health, and **workforce training.**<sup>84</sup>
- 3.12. A wealth of evidence supports the development of **comprehensive early diagnosis-care pathways for young children with neurodevelopmental disorders**, such as autism.<sup>85</sup> Early detection is crucial and will be dependent on wider deployment of developmental detection and monitoring tools.

### **Groups who face additional barriers to accessing support for their mental health**

- 3.13. As highlighted by the 2018 Independent Review of the Mental Health Act,<sup>86</sup> there are major concerns that ethnic minority groups, in particular Black Caribbean, Black African and South Asian people, are over-represented in involuntary routes into mental healthcare, including through criminal justice pathways and sectioning under the Mental Health Act. The demography of self-referral routes into IAPT services by ethnic group more closely match local population demographics than those reliant on general practitioner referrals,<sup>87</sup> suggesting that there may be specific barriers to accessing mental healthcare within primary care.
- 3.14. People who have recently migrated are less likely to access IAPT, indicating specific barriers for this population. This is a concern as migration is a known risk factor for more serious mental health conditions such as psychosis.<sup>88</sup>

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<sup>81</sup> Centre for Social Justice (2021). *Unsafe children: Driving up our country's response to child sexual abuse and exploitation*. <https://www.centreforsocialjustice.org.uk/wp-content/uploads/2021/03/CSJJ8804-Unsafe-Children-210325-WEB.pdf>

<sup>82</sup> Javid S (2021). *We need to bring the school nurse back to help protect children from sexual abuse*. The Mail on Sunday, 27 March

<sup>83</sup> Lewis SJ, et al. (2019). *The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales*. *Lancet Psychiat* **6**, 247-256

<sup>84</sup> Danese A, et al. (2020). *Psychopathology in children exposed to trauma: detection and intervention needed to reduce downstream burden*. *BMJ* **371**, m3073

<sup>85</sup> Green J, et al. (2022). *An integrated early care pathway for autism*. *Lancet Child Adolesc Health* **6**, 335-344.

<sup>86</sup> Department of Health and Social Care (2018). *Modernising the Mental Health Act- final report from the independent review*. <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

<sup>87</sup> Brown J, et al. (2014). *How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough*. *Soc Psychiatry Psychiatr Epidemiol* **49**, 1893-1902

<sup>88</sup> Bourque F, van der Ven E & Malla A. (2011). *A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants*. *Psychol Med* **41**, 897-910.

- 3.15. Understanding barriers to early access in ethnic minority communities has been hampered by the lack of representative data. The last representative ethnically 'boosted' survey of mental health was conducted more than two decades ago.<sup>89</sup> The Academy recommends that an **updated survey** is conducted urgently, with results published in a timely manner.
- 3.16. Prisoners were identified as another group facing barriers to early intervention. Ensuring **all prisoners receive mental health assessments within 24 hours of arrival**, and **eliminating racial disparities** in access to these assessments,<sup>90</sup> was highlighted as a particular priority.
- 3.17. We heard from one Fellow that, in line with the independent review of drugs,<sup>91</sup> there are substantial failings across addiction and substance misuse services in England. There is a need for **more robust and extensive data collection on addiction**.<sup>92</sup>

### **How can the whole of society (beyond the NHS) better identify and respond to signs of mental ill-health?**

- 3.18. Strategies to promote early help-seeking behaviours include: a) **improving societal awareness** of the early signs and symptoms of mental ill-health and specific disorders; b) **reducing stigma and discrimination** against people with mental health problems within the healthcare system and wider society; and c) **improving societal understanding of the treatment options** available.
- 3.19. Although it is recognised that mental health stigma has improved over the last decade, a number of our Fellows and people with lived experience told us that it remains a significant barrier to care access, particularly in some Black, Asian and ethnic minority communities. An evidence-based strategy to reduce stigma is the facilitation of **social contact between people with lived experience of mental ill-health and other members of the public**.<sup>93</sup>
- 3.20. The ON TRAC Project aims to challenge stigma by creating a mental health awareness training package for local Black faith-led or majority communities in South London.<sup>94</sup> The evaluation of this programme is due to be published soon.
- 3.21. The Time to Change programme ran from 2007-2021 and aimed to reduce mental health stigma. The programme was associated with a moderate but significant effect on discrimination, knowledge and positive attitudes about mental health.<sup>95</sup> There is a need for **continued anti-stigma programmes**, both nationwide and those focused

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<sup>89</sup> Blanchard M, et al. (2002). *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) - Quantitative Report*. <http://data.parliament.uk/DepositedPapers/Files/DEP2008-3141/DEP2008-3141.pdf>

<sup>90</sup> House of Commons Justice Committee (2021). *Mental health in prison*.

<sup>91</sup> Department of Health & Social Care (2021). *Review of drugs part two: prevention, treatment, and recovery*. <https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery>

<sup>92</sup> Academy of Medical Sciences (2017). *Personalised psychiatry*. <http://acmedsci.ac.uk/file-download/16107617>

<sup>93</sup> Thornicroft G, et al. (2016). *Evidence for effective interventions to reduce mental-health-related stigma and discrimination*. *Lancet* **387**, 1123-1132

<sup>94</sup> <https://ontracproject.com/>

<sup>95</sup> Evans-Lacko S, et al. (2014) *Effect of the Time to Change anti-stigma campaign on trends in mental illness-related public stigma among the English population in 2003-13: an analysis of survey data*. *Lancet Psychiat* **1**, 121-128

on specific communities or scenarios (e.g. the workplace). There should be a focus on **clear, consistent, and accessible messaging**.

### **Children and young people**

- 3.22. All members of education, childcare, health and social care workforces need to be **equipped with the skills to identify the early signs of mental health issues**, and be able to navigate referral pathways and access the correct support when required.
- 3.23. The remit of the majority of schools is to identify and support those with mild to moderate mental health problems, while the lack of capacity in mental health services means that CAMHS can only see those with the most severe problems. This has left a gap in service provision for children and young people with moderate to severe symptoms.
- 3.24. This gap could be filled by **community early support hubs** that offer self-referred drop-in support for young people. These services play a critical role in early intervention and preventing escalation of mental health issues. Ensuring that easily-accessible and evidence-based community support programmes are **available to parents and carers** is another priority.
- 3.25. Tackling mental health stigma experienced by children requires **reducing stigma experienced by parents and carers** of children with mental health problems.<sup>96</sup>

### **How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?**

- 3.26. Healthcare services are typically poorly equipped to meet the mental health needs of individuals with long-term conditions, due to the separation of secondary care services into mental and physical health. The health economic arguments for a joined-up approach are strong – it is estimated that approximately 12-18% of spending on long-term conditions is attributable to failure to manage mental ill-health.<sup>97</sup>
- 3.27. Barriers to improving mental health in people with long-term conditions include: a) failure to identify mental health problems; b) lack of resources to manage mental illnesses, including lack of training and inadequate care pathways; c) lack of financial incentives to reward good management of mental health; d) stigma and e) competing demands on clinician and service time.
- 3.28. One solution pioneered by King's Health Partners is the IMPARTS programme.<sup>98</sup> Patients attending physical health clinics complete physical and mental health outcome measures electronically, the results of which are uploaded to the health record and made available to physicians, who also receive training about care pathways.

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<sup>96</sup> Reardon T, et al. (2017). *What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies*. *Eur Child Adolesc Psychiatry* **26**, 623-647.

<sup>97</sup> Naylor C, et al. (2012). *Long-term conditions and mental health: the cost of co-morbidities*. [https://www.kingsfund.org.uk/sites/default/files/field/field\\_publication\\_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf](https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf)

<sup>98</sup> Rayner L, et al. (2014). *Embedding integrated mental health assessment and management in general hospital settings: Feasibility, acceptability and the prevalence of common mental disorder*. *Gen Hosp Psychiatry* **36**, 318-324.

- 3.29. Such programmes can be supported by new models of care delivery, including **digital therapies** designed for people with long-term conditions. Examples include COMPASS<sup>99</sup> and the “3 dimensions for diabetes” programme, which focuses on social, psychological and medical aspects of diabetes, and has shown improvements across a wide range of outcomes.<sup>100</sup>

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<sup>99</sup> Hulme K, et al. (2021). *Clinical efficacy of COMPASS, a digital cognitive-behavioural therapy programme for treating anxiety and depression in patients with long-term physical health conditions: a protocol for randomised controlled trial*. *BMJ Open* **11**, e053971.

<sup>100</sup> Ismail K, et al. (2020). *A pilot study of an integrated mental health, social and medical model for diabetes care in an inner-city setting: Three Dimensions for Diabetes (3DFD)*. *Diabet Med* **37**, 1658-1668.

## Section 4: How can we improve the quality and effectiveness of treatment for mental health?

### What needs to happen to ensure the best care and treatment is more widely available within the NHS?

- 4.1. In 2014/2015, only 39% of adults with a common mental health disorder in England were accessing treatment.<sup>101</sup> Those who do have access often experience long waits for assessment and treatment. To minimise the mental health gap (the gap between service demand and supply), there is a need to **improve the availability of care and treatment** ('supply') and/or **reduce the demand for services** through prevention.
- 4.2. Many of our contributors emphasised the need for **sustained and long-term investment in mental health services** to cultivate a robust, effective, and resilient system with increased capacity.

#### **Improving workforce capacity**

- 4.3. Healthcare providers have described workforce shortages as a long-standing reason for why services have struggled to meet demand,<sup>102</sup> and these shortages are evident across community, primary, and specialist mental health care. We were told by one researcher that this lack of workforce capacity has left a gap in service provision for people with mild to moderate symptoms of anxiety and depression, although it was recognised that the aim of IAPT is to fill this gap. People faced with long waiting lists to access psychological therapies often experience deterioration of their mental state, and as a result may require more intensive interventions.
- 4.4. Increasing access to care and treatment requires a multi-faceted approach **to increase workforce capacity**. This includes initiatives to both **recruit and train new staff** and **retain existing staff within the NHS**, particularly within psychological and psychiatric services, but also across the breadth of NHS services, including IAPT and psychotherapy.
- 4.5. We heard from multiple contributors, including researchers and clinicians, that **improving working conditions and job satisfaction**, and **supporting staff wellbeing and mental health** will be essential to retain staff.<sup>103</sup> Healthcare workers report high levels of distress and burnout, and this was likely exacerbated by the COVID-19 pandemic,<sup>104</sup> with 34% of NHS workers reporting that they felt burnt out in 2021.<sup>105</sup> Contributors described unrealistic workloads, due to high demand and staff shortages, combined with pressures to reduce waitlists, as contributing to job dissatisfaction among healthcare workers. Evidence-based approaches for supporting the mental health of the healthcare workforce are discussed in **2.31 – 2.34**.

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<sup>101</sup> McManus S, et al. (2016). *Mental Health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. [https://files.digital.nhs.uk/pdf/q/3/mental\\_health\\_and\\_wellbeing\\_in\\_england\\_full\\_report.pdf](https://files.digital.nhs.uk/pdf/q/3/mental_health_and_wellbeing_in_england_full_report.pdf)

<sup>102</sup> <https://committees.parliament.uk/writtenevidence/23250/html/>

<sup>103</sup> <https://committees.parliament.uk/writtenevidence/10944/pdf/>

<sup>104</sup> Lamb D, et al. (2021). *Psychosocial impact of the COVID-19 pandemic on 4378 UK healthcare workers and ancillary staff: initial baseline data from a cohort study collected during the first wave of the pandemic*. *Occup Environ Med* **78**, 801-808.

<sup>105</sup> NHS England (2021). *NHS Staff Survey 2021*.

[https://www.nhsstaffsurveys.com/static/b3377ce95070ce69e84460fe210a55f0/ST21\\_National-briefing.pdf](https://www.nhsstaffsurveys.com/static/b3377ce95070ce69e84460fe210a55f0/ST21_National-briefing.pdf)

- 4.6. The importance of opportunities for healthcare staff to undertake training and research to improve job satisfaction was emphasised to us. Our 2020 report, 'Transforming health through innovation: Integrating the NHS and academia',<sup>106</sup> highlighted that having **academic content in medical posts enhances recruitment and retention and can reduce burnout**. The Academy recommends that NHS staff are given the opportunity to conduct research within their posts, and that **research active staff are given dedicated time to conduct research**. As well as improving mental health, higher levels of job satisfaction are also associated with better job performance and better patient experiences.<sup>107</sup>

#### **Shifted care and alternate service models**

- 4.7. As well as supporting prevention (2.3) and early intervention (3.20, 3.24), the VCS also has a vital role to play in delivering and supporting treatment, through providing psychological therapies or building an individual's social resources.<sup>108</sup> Community services must be **available where demand is high**, especially in rural areas and areas of high deprivation, and must be **linked-up with local healthcare services** through primary care networks. Making it easier for such services to gain **long-term and sustainable funding** should be a priority.
- 4.8. Adopting interventions that use **task-shifted models of care** could help increase workforce capacity and availability of care and treatment. In task-shifted models of care non-specialist health workers deliver care under supervision. Research has shown that these models are an effective way to increase the availability of care and decrease the mental health gap,<sup>109</sup> even for chronic and severe mental health conditions.<sup>110</sup>
- 4.9. The World Health Organisation has published the Mental Health Gap Intervention Guide,<sup>111</sup> which includes evidence-based guidance for implementing and scaling up care and services for people with mental, neurological and substance use disorders and their families in non-specialist settings.<sup>112</sup>

#### **Taking a holistic view of health**

- 4.10. In the Health and Social Care Act 2012, the government made a pledge for the NHS to deliver '**parity of esteem**' between physical and mental health. Our contributors, including those with lived experience of mental health conditions, feel that more work needs to be done to ensure that parity of esteem is achieved.

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<sup>106</sup> Academy of Medical Sciences (2020). *Transforming health through innovation: Integrating the NHS and academia*. <https://acmedsci.ac.uk/file-download/23932583>

<sup>107</sup> NHS England (2018). *Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015*. <https://www.england.nhs.uk/wp-content/uploads/2018/02/links-between-nhs-staff-experience-and-patient-satisfaction-1.pdf>

<sup>108</sup> Sehmi R, et al. (2020). *No man is an island: social resources, stress and mental health at mid-life*. *BJPsych* **217**, 638-644.

<sup>109</sup> van Ginneken N, et al. (2021). *Primary-level worker interventions for the care of people living with mental disorders and distress in low- and middle-income countries*. Cochrane Database of Systematic Reviews. <https://doi.org/10.1002/14651858.CD009149.pub3>

<sup>110</sup> Hanlon C, et al. (2022) *Efficacy and cost-effectiveness of task-shared care for people with severe mental disorders in Ethiopia (TaSCS): a single-blind, randomised, controlled, phase 3 non-inferiority trial*. *Lancet Psychiat* **9**, 59-71.

<sup>111</sup> World Health Organisation (2016). *mhGAP Intervention Guide*. <https://apps.who.int/iris/rest/bitstreams/1061290/retrieve>

<sup>112</sup> Keynejad R, Spagnolo J & Thornicroft G (2021). *WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact*. *Evid Based Ment Health* **24**, 124-130

- 4.11. Mental illness can be a co-morbidity to physical illness and vice versa. At our 2017 FORUM workshop on 'Personalised psychiatry',<sup>113</sup> participants identified the need to **integrate approaches to mental and physical health**.
- 4.12. Our contributors described how **diagnostic overshadowing**, where health professionals assume that the symptoms a person with a mental health conditions experiences are due to that condition without exploring other factors, **can prevent patients from receiving appropriate care for other conditions**. This may be due in part to systemic discrimination that people with mental health conditions face in healthcare, and a misunderstanding of the lived experience of mental illness by clinicians.<sup>114</sup>
- 4.13. We were informed that there is no longer joint training to qualify nurses to work in both physical and mental health, and that mental health staff do not have adequate training to identify and support people with physical health problems. This can lead to difficulties in accessing care, particularly when inpatient mental health services are not located close to where physical healthcare is provided. New **training programmes for integrated mental and physical health practitioners** are needed.
- 4.14. We were also told that fragmentation and a lack of communication between services is resulting in poorer quality of care. People with lived experience told us that they have to explain their history, diagnoses and symptoms in the majority of their interactions with healthcare staff. A **joined-up approach**, where notes and records are shared more easily between teams and services, would improve the provision of **patient-centred, individualised care**.
- 4.15. There is a need for the social and economic determinants of health (**2.1-2.2**) to be addressed alongside treatment and care for mental and physical illness, for example through social prescribing. However, we heard from researchers and people with lived experience that navigating multiple systems (health, social, community-led care) at once can often exacerbate mental health issues. Providing **support to identify available sources of help can reduce competing stressors** and result in **better treatment outcomes**.
- 4.16. Integrated Care Systems and Primary Care Networks may allow for the joined-up multisystem approach that is necessary to support the **holistic assessment of people's needs**. It is essential that these care models involve service users in their planning and execution (**7.23-7.27**).

### **Digital interventions and apps for mental health care**

- 4.17. Digital, virtual, and application-based interventions are becoming more common in mental health care provision, particularly since the COVID-19 pandemic. Digital interventions provide an opportunity to substantially increase access to effective prevention and treatment programmes.<sup>115</sup>

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<sup>113</sup> Academy of Medical Sciences (2017). Personalised psychiatry. <http://acmedsci.ac.uk/file-download/16107617>

<sup>114</sup> Molloy RN, et al. (2021). *Seeing the complete picture: A systematic review of mental health consumer and health professional experiences of diagnostic overshadowing*. J Clin Nurs. <https://doi.org/10.1111/jocn.16151>

<sup>115</sup> Clark D, et al. (2022). *More than doubling the clinical benefit of each hour of therapist time: a randomised controlled trial of internet cognitive therapy for social anxiety disorder*. Psychol Med. In print.



- 4.18. However, there is an increased risk of exclusion for those experiencing digital poverty, or who are less able to use digital technologies, as more services shift to virtual platforms. It is important that any new platforms or technologies do not inadvertently increase inequality in access to care.
- 4.19. The Academy's 2018 'Our data-driven future in healthcare' report, sets out a framework of actionable principles for the development, evaluation and use of data-driven technologies (e.g. wearable technologies and apps), including the need to **involve patients and the public as active and meaningful partners**.<sup>116</sup> Public dialogue workshops held as part of the project highlighted concerns that the use of digital technologies might limit patient-healthcare professional face-to-face interactions that were seen to be particularly important in mental healthcare.
- 4.20. Digital interventions and apps should therefore be provided as one element of care, rather than as standalone interventions. A **"blended approach"** may provide more opportunities to build rapport and catch non-verbal distress cues (e.g., body language). It was acknowledged that some people might prefer using online services, and so treatment should be tailored to each individual's needs and preferences.
- 4.21. Although apps are often seen as a cost-saving interventions, very few apps have been evaluated for efficacy using randomised controlled trials, and there are no clear pathways to accreditation or recommendation of those that are safe and effective. We were informed that the large number of available apps makes it difficult for clinicians to know which are best to prescribe, especially as most have little evidence supporting effectiveness. There is a need for a **consensus approach to the evaluation and recommendation of apps**.<sup>117</sup> One suggestion was a Kitemark system for testing, approval and NICE-recommended implementation of apps and other digital interventions. In the few cases where there is evidence on the effectiveness of a digital intervention, investment is needed maintain applications to ensure they work across a broad variety of platforms and different iterations of operating systems.
- 4.22. At our 2020 workshop on 'Remote and digital mental health interventions and COVID-19',<sup>118</sup> participants noted that research proposals to develop effective digital interventions must bring together: 1) interventions co-designed with people with lived experience (**7.23-7.27**); 2) the mechanisms under which interventions would operate; and 3) the data to evidence their success.

### **Children and young people**

- 4.23. Access to and continuity of care is often lacking for young people as they move from CAMHS to adult mental health services, or when they move to different parts of the country for university.<sup>119</sup> The transition from adolescence to adulthood is a key period, and so **mechanisms to provide continuity of care must be improved**. As well as putting mechanisms in place to support student wellbeing (**1.10-1.11**) and prevention

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<sup>116</sup> Academy of Medical Sciences (2018). *Our data-driven future in healthcare*. <https://acmedsci.ac.uk/file-download/74634438>

<sup>117</sup> Torous J, et al. (2018) *The Emerging Imperative for a Consensus Approach Toward the Rating and Clinical Recommendation of Mental Health Apps*. *J Nerv Ment Dis* **206**, 662-666.

<sup>118</sup> Academy of Medical Sciences and MQ (2020). *Remote and digital mental health interventions and COVID-19*. <https://acmedsci.ac.uk/file-download/97689151>

<sup>119</sup> Health and Social Care Committee (2021). *Children and young people's mental health*. <https://committees.parliament.uk/publications/8153/documents/83622/default/>

of mental ill-health (2.26), universities must also be supported to identify and support those with specific mental health conditions (e.g. anxiety).

## **What is the NHS currently doing well and should continue doing, in order to support people struggling with their mental health?**

- 4.24. We heard positive feedback from people with lived experience around opportunities to access innovative initiatives, such as the First Episode Rapid Early Intervention for Eating Disorders (FREED) service model.<sup>120</sup> Integrated and innovative approaches to mental health care are becoming more common,<sup>121</sup> but contributors described a 'postcode lottery' in terms of their accessibility. There should be a focus on expanding such programs to **improve equity of access**.
- 4.25. A couple of contributors with lived experience described exchanges with individual members of staff who were kind, empathetic, and caring, and made an effort to provide personalised care. However, it was emphasised that staff shortages are a barrier to making these beneficial interactions more commonplace.
- 4.26. Although stigma and discrimination are barriers to receiving good quality healthcare (3.3), we were told that attitudes to mental health have improved, particularly among younger members of staff. Continued efforts to **provide anti-stigma training** and the **cultivation and maintenance of good working environments** will help ensure newer generations of staff are retained in mental health care services.
- 4.27. We heard that **opportunities to discuss mental health in the wider context of general health and wellbeing** (e.g., while attending services such as primary care or sexual health clinics) were appreciated by service users. Increasing such opportunities by **reducing workforce time pressures** will facilitate the provision of personalised care and promote the holistic assessment of an individual's healthcare needs.

## **What should be our priorities for future research, innovation and data improvements over the coming decade to drive better treatment outcomes?**

### ***Research and innovation priorities for new treatments and service models***

- 4.28. **Research is needed to develop and evaluate new treatments**, including pharmaceutical interventions, psychological therapies, digital interventions and apps, and new models for service delivery.
- 4.29. There can be high variability in how individuals respond to pharmaceutical treatments, in part due to genetics and individual patient physiology.<sup>122</sup> At our 2017 FORUM lecture, 'The mind-body interface',<sup>123</sup> panel members discussed opportunities for repurposing existing medicines to treat mental health conditions by identifying

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<sup>120</sup> <https://www.england.nhs.uk/mental-health/case-studies/other-mental-health-case-studies/first-episode-rapid-early-intervention-for-eating-disorders-freed/>

<sup>121</sup> <https://www.england.nhs.uk/mental-health/case-studies/>

<sup>122</sup> Preskorn SH (2014). *Prediction of individual response to antidepressants and antipsychotics: an integrated concept*. *Dialogues Clin Neurosci* **16**, 545-554.

<sup>123</sup> Academy of Medical Sciences (2017). The mind-body interface. <https://acmedsci.ac.uk/file-download/36341697>

biomarkers that were predictive of treatment response to conventional antidepressants versus anti-inflammatory drugs. Development of new, bespoke pharmaceutical treatments will require an **increased focus on personalised medicine**, and further research on the driving molecular, genetic, and biological drivers of mental illness. Contributors also called for **funding opportunities to improve collaboration** between academia, healthcare and the biotech and pharmaceutical industries.

- 4.30. People with mental health conditions will often prioritise improvements in their social circumstances over improvements in their symptoms. **Interventions to improve social circumstances**, such as addressing homelessness or unemployment, can influence positive change and prevent deterioration of mental health conditions. More research is needed to identify interventions that can support treatment outcomes by addressing the social and economic determinants of mental health.<sup>124</sup> For example, community-based and community-led psychological interventions that target social challenges have shown to be promising in a sample of women facing adversity in South Africa.<sup>125</sup> **Further research is needed to determine if similar interventions are effective and adaptable to communities in the UK.**
- 4.31. Patient peer support has been suggested as a way to provide additional support for people living with mental health conditions. However, patient peer support programs are not fully integrated or formalised across mental health services. Successful peer support programs require ongoing support, guidance, and engagement from healthcare practitioners, and **further research to evaluate the effectiveness and support the implementation of peer support is necessary.**<sup>126</sup>

#### **Implementation of effective interventions**

- 4.32. Contributors noted that there are effective, evidence-based treatments for mental health conditions, but there is often a lack of resources to deliver them at scale. **An increased focus on implementation research**, linking research and practice to accelerate the development and uptake of interventions is warranted to ensure that existing effective treatments are available and accessible to those who could benefit from them.<sup>127</sup>
- 4.33. A number of our Fellows recognised the urgent need to **understand the heterogeneity in responses to different treatments**. We do not have enough information on what treatments are effective for groups who consistently have poorer outcomes in mental health (e.g. ethnic minority groups, men, and people with severe mental illness). This is in part due to a lack of representation of some of these groups in research cohorts (**7.10**).
- 4.34. Contributors emphasised the need to ensure that adequate funding and workforce resources are made available to translate research on effective treatment and service

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<sup>124</sup> Barnett P, et al. (2022). *Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis*. BMC Psychiatry **22**, 302.

<sup>125</sup> Burgess R, et al. (2021). *Exploring the impact of a complex intervention for women with depression in contexts of adversity: A pilot feasibility study of COURAGE-plus in South Africa*. Int J Soc Psychiatry **68**, 873-880

<sup>126</sup> Hameed Shalaby RA & Agyapong VIO (2020). *Peer Support in Mental Health: Literature Review*. JMIR Ment Health **7**, e15572.

<sup>127</sup> Theobald S, et al. (2018). *Implementation research: new imperatives and opportunities in global health*. Lancet **392**, 2214 – 2228.

models into policy and practice. As one contributor with lived experience told us: **'We don't want new models for treatment if there is no one to deliver them'**.

#### ***Facilitators of research, innovation, and data improvements to drive better treatment***

- 4.35. We were told by a number of clinicians that **embedding research into healthcare settings** and **including the public**, particularly service users and carers, in the development and implementation of treatment and service models is essential for driving better treatment outcomes. Patients who attend research-active healthcare settings have better outcomes and receive better care than their counterparts.<sup>128,129</sup>
- 4.36. **Engagement with industry**, from traditional pharmaceutical companies to the biotech and digital industry, and **encouraging private investment in mental health research and development**, should be a priority. Performing clinical trials in the UK is generally perceived to be slow and bureaucratic, and so making the UK a more attractive environment for industry-led innovation in the mental health space will be dependent on **regulatory reforms and structures to make clinical trials easier**.
- 4.37. For example, the relative degree of legislative relaxation around psychedelic drugs for treatment of severe mental health issues in the UK has encouraged several companies (e.g. COMPASS, Biomind Labs and Clerkenwell Health) to do research here. However, **bringing drug scheduling laws in line with those in the United States and Germany** could bring further benefits.<sup>130</sup>
- 4.38. The Academy is supportive of efforts derived from the Life Sciences Vision to develop a **national network of trial centres** that are able to conduct nationwide trials for companies, to prevent companies from having to negotiate multiple research contracts.
- 4.39. It is important that research is not only considered in relation to treatment, but underpins the Plan from start to finish, from promoting wellbeing to supporting those in crisis. General priorities for mental health research and data (beyond treatment) are described in **section 7**.

#### **What should inpatient mental health care look like in 10 years' time, and what needs to change in order to realise that vision?**

- 4.40. Approximately 4.1% of adults who came into contact with adult mental health and learning disability services were admitted to inpatient facilities in 2017/18.<sup>131</sup> We heard that inpatient facilities are often overcrowded, and service users don't have access to an adequate range of activities. **Engagement and occupation** is an important aspect

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<sup>128</sup> Jonker L & Fisher SJ (2018). *The correlation between National Health Service trusts' clinical trial activity and both mortality rates and care quality commission ratings: a retrospective cross-sectional study*. Public Health **157**, 1-6.

<sup>129</sup> Boaz A, et al. (2015). *Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review*. BMJ Open **5**, e009415

<sup>130</sup> Neill J (2022). *Psychedelics for mental health: tripping over red tape*. Policy@Manchester, February 15. <https://blog.policy.manchester.ac.uk/posts/2022/02/psychedelics-for-mental-health-tripping-over-red-tape/>

<sup>131</sup> NHS Digital (2018). *Mental Health Act Statistics, Annual Figure 2017-18*.

<https://files.digital.nhs.uk/34/B224B3/ment-heal-act-stat-eng-2017-18-summ-rep.pdf>

of recovery-focused in-patient mental health care,<sup>132</sup> and participating in activities can impact positively on recovery, improve social connectedness, and enhance mental and physical health.<sup>133</sup>

- 4.41. Restrictive practices, such as seclusion and restraint, are often harmful and can have a detrimental impact on the wellbeing of service users and staff.<sup>134</sup> Safewards is a model designed to **reduce conflict and restrictive practices** on inpatient units.<sup>135</sup> Research illustrates that implementation of Safewards helps to reduce conflict, improve experiences of safety and increase positive perceptions of ward atmosphere.<sup>136</sup>

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<sup>132</sup> Commission for Healthcare Audit and Inspection (2008). *The Commission for Healthcare Audit and Inspection (Defence Medical Services) Regulations 2008*.

<https://www.legislation.gov.uk/ukxi/2008/1181/contents/made>

<sup>133</sup> Foye U, et al. (2020). *Activities on acute mental health inpatient wards: A narrative synthesis of the service users' perspective*. *J Psychiatr Ment Health Nurs* **27**, 482-493.

<sup>134</sup> Lawrence D, et al. (2022). *Restrictive practices in adult secure mental health services: a scoping review*. *Int J Forensic Ment Health* **21**, 68-88.

<sup>135</sup> Fletcher J, et al. (2021). *Contextual Barriers and Enablers to Safewards Implementation in Victoria, Australia: Application of the Consolidated Framework for Implementation Research*. *Front Psychiatry* **12**, 733272.

<sup>136</sup> Mullen A, et al. (2022). *Safewards: An integrative review of the literature within inpatient and forensic mental health units*. *Int J Ment Health Nurs*. <https://doi.org/10.1111/inm.13001>

## Section 6: How can we all improve support for people in crisis?

### What can we do to improve the immediate help available to people in crisis?

- 6.1. Evidence for the best approaches for assessment and management of those in crisis, and for best acute service models in general, is limited and should be a priority for future research.
- 6.2. While acute wards continue to be central to the intensive treatment phase following a mental health crisis, new approaches which **reduce coercion, address trauma, diversify treatments and make decision-making and care collaborative**, need to be developed, evaluated, and implemented. Evidence suggests that intensive **home treatment services, acute day units, and community crisis services** may prevent hospital admission.<sup>137</sup> Research should focus on **how best to implement** these services and **which interventions work best for which service users**.
- 6.3. Two of our contributors commented on the disinvestment and post-code lottery in access to acute inpatient mental health care and other forms of crisis support (e.g. home treatment services) and stated that this is a major barrier to improving support for people in crisis. Despite the growing demand for inpatient care,<sup>138</sup> there was a 25% reduction in nursing within inpatient care between 2009 and 2017.<sup>139</sup>

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<sup>137</sup> Johnson S, et al. (2022). *Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care*. *World Psychiatry* **21**, 220-236.

<sup>138</sup> <https://nhsproviders.org/mental-health-funding-and-investment/the-mental-health-sector-challenge>

<sup>139</sup> TUC (2018). *Breaking point: the crisis in mental health funding*.

[https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2\\_0.pdf](https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2_0.pdf)

## Section 7: Next steps and implementation

### **What do you think are the most important issues that a new, 10-year national mental health plan needs to address?**

#### ***Research as an integral part of the 10-year plan***

- 7.1. As we have highlighted throughout our response, research is integral to the development, evaluation and implementation of interventions across all parts of the Plan, from promoting wellbeing to supporting those in crisis. It is important that research is not only considered in relation to treatment, but **underpins the Plan from start to finish**. The Plan should integrate targets from the 2020-2030 Mental Health Research Goals (that are hosted on the Academy's website) and set out the metrics that have been developed to measure progress.<sup>140,141</sup>
- 7.2. Achieving the ambitious targets outlined in the Mental Health Research Goals will not be possible without **committed and sustained increases to research funding**. According to a report by MQ, funding for mental health research remained flat between 2008 and 2017, with just over £9 spent on research each year per person affected by mental illness between 2014-2017 (compared to £228 for cancer).<sup>142</sup> Only 2.7% of this research funding came from public donations (compared to 68% for cancer).
- 7.3. We note that funding for mental health research is likely to increase as a result of the Wellcome Trust's commitment to mental health as one of its four priority areas. The Government should work with the Wellcome Trust and other medical research charities, alongside patients and the public, researchers and healthcare workers, to ensure that **funding is focused on the areas of unmet research need**, many of which have been noted throughout our response.
- 7.4. If the UK is unable to associate with Horizon Europe, a priority for the alternative ('Plan B') funding programme should be **protecting and boosting investment** in priority areas for mental health research.
- 7.5. Beyond increased funding, priorities for strengthening mental health research include **embedding research within clinical care, building research skills and capacity in the workforce, improving data sharing, linkage and access (7.41 – 7.54)**, increasing **involvement of people with lived experience**, and strengthening **interdisciplinary** (especially bringing together physical and mental health) and **UK-wide collaboration**.<sup>143</sup>
- 7.6. To ensure all mental health patients and staff can benefit from innovative research, **research needs to be fully integrated within the healthcare system**. Our 2020 report 'Transforming health through innovation: Integrating NHS and academia'

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<sup>140</sup> National Institute for Health Research, Economic Research Council, Medical Research Council, MQ, Mental Health Research UK & The Wellcome Trust (2020). *Mental Health Research Goals 2020-2030*. <https://acmedsci.ac.uk/file-download/87520935>

<sup>141</sup> Wykes T, et al. (2021). *Shared goals for mental health research: what, why and when for the 2020s*. *J Ment Health* **9**, 1-9.

<sup>142</sup> MQ (2019). *UK Mental Health Research Funding 2014 – 2017*. <https://www.mqmentalhealth.org/wp-content/uploads/UKMentalHealthResearchFunding2014-2017digital.pdf>

<sup>143</sup> Academy of Medical Sciences (2021). *Progress and priorities for mental health science research since COVID-19*. <https://acmedsci.ac.uk/file-download/96569754>

outlines ways to achieve this.<sup>144</sup> Progress towards a research-active NHS must happen across **both physical and mental health services** in an integrated fashion.

- 7.7. Embedding research specifically into mental health care will require much **better support for and expansion of the cohort of clinical scientists training in psychiatry and other areas of mental health care**.<sup>145</sup> To meet the objectives of the Mental Health Mission sponsored by the Office for Life Sciences, we have advocated for the establishment of an **integrated national training scheme for mental health**, including: a) **more PhD training fellowships** for mental health clinical scientists at the end of their core clinical training period; b) a focus on **incentivising** medical students and recently qualified doctors to develop academic careers in mental health; and c) sustaining the research careers of academic mental health clinicians after clinical specialisation and PhD training by **increasing research opportunities and career support**. Similar support should be available to **all health care workers** and allied health professionals, such as psychologists and nurses.
- 7.8. At the Academy, we have a track record of successfully designing and administering a range of schemes for supporting clinician scientist career development.<sup>146</sup> We also have a prestigious brand representing the very best of UK medical and health science and the convening power to triangulate connections between academia, NHS and industry. We would therefore be well placed to support any initiatives focussed on supporting or building the number of clinical academics in mental health and would be open to discussions about the role we might play in the delivery of the Plan.
- 7.9. A major barrier to research and innovation-driven improvements in mental health prevention and care is the lack of clinical workforce capacity across the NHS, and so **building workforce capacity** more generally (**7.19**) must be a fundamental focus of the Plan.
- 7.10. Many research cohorts lack wider applicability due to the 'healthy cohort effect', where participants show lower rates of morbidity and mortality than the general population in the same age groups.<sup>147</sup> Barriers to participation (e.g. having to travel to research centres) can lead to exclusion of patients with mental or physical illnesses. Cohorts and trials are often under-representative of groups known to have poorer mental health outcomes, such as people with rare mental health conditions, Black people and people of ethnic minority groups. As a result, findings may not be translatable to those who already have an unmet need for prevention and treatment. Concerted **efforts are required to identify and remove the barriers that prevent these groups from participating** in research.
- 7.11. **Co-production of research methods** can help overcome recruitment challenges. There is an association between patient involvement in research and study success, and studies that involve patients to a greater extent are more likely to achieve recruitment targets.<sup>148</sup>

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<sup>144</sup> Academy of Medical Sciences (2020). *Transforming health through innovation: Integrating the NHS and academia*. <https://acmedsci.ac.uk/file-download/23932583>

<sup>145</sup> Academy of Medical Sciences (2013). *Strengthening academic psychiatry in the UK*. <https://acmedsci.ac.uk/file-download/35280-51b9e77dc4b96.pdf>

<sup>146</sup> <https://acmedsci.ac.uk/grants-and-schemes/mentoring-and-other-schemes>

<sup>147</sup> Fry A, et al. (2017). *Comparison of Sociodemographic and Health-Related Characteristics of UK Biobank Participants With Those of the General Population*. *Am J Epidemiol* **186**, 1026-1034.

<sup>148</sup> Ennis L & Wykes T (2013). *Impact of patient involvement in mental health research: longitudinal study*. *BJPsych* **203**, 381-386



- 7.12. **Larger cohorts utilising boosted or quota sampling methods and multi-centre trials** can help address under-representation of key groups and are urgently required (**3.15**). It was suggested that funding opportunities should be made available for **multisite or multi-centre studies** to promote collaboration instead of competition.
- 7.13. We were informed that there needs to be a concerted effort between funders and researchers to prevent siloing of research efforts. **Advances in research must be assessed regularly, translated into practice routinely, and evaluated in real-world settings** to inform future priorities for research and investment.<sup>149</sup>
- 7.14. Many of the biggest successes in mental health research over the past decade have relied on large consortia, such as those that led to the discovery of risk genes for schizophrenia and other serious mental illnesses and the ABCD longitudinal study of brain development and child health in the United States.<sup>150</sup> Such **open science and team science approaches** are necessary to achieve the scale and interdisciplinarity required to translate basic scientific discoveries into widespread benefits for patients. The UKRI Mental Health Research Networks<sup>151</sup> have made great progress in this area but are all soon coming to an end with no further funding.
- 7.15. Given the risk that research may feel like an additional burden placed on overstretched services and staff, it was suggested that **treatment costs could be provided as part of research grant allocations** so that research creates additional capacity.

#### ***Reducing demand through a holistic approach to prevention and tackling inequalities***

- 7.16. The Plan must focus on addressing the mental health gap between service demand and supply. Throughout our response we have highlighted strategies for prevention (**section 2**) and early intervention (**section 3**) to reduce the demand for services, and priorities for increasing access to care and treatment and the translation of research into practice (**section 4**) to increase supply.
- 7.17. The majority of our contributors, including Academy Fellows and people with lived experience, stressed the importance of social and economic inequalities as a significant driver of poor mental health and inequalities in mental health outcomes. The new plan should acknowledge that in order to prevent mental health issues, there needs to be a focus on **building resilient communities that promote mental wellbeing** (instead of placing the onus on individuals) with **adequate support systems to address the social determinants of mental health** including poverty, unemployment, and housing insecurity. Achieving this will be of central importance to delivering on the Government's ambitions for levelling up the country.
- 7.18. Research is key to understanding social, economic and mental health inequalities and evaluating strategies to tackle them. At an Academy of Medical Sciences and British Academy roundtable looking at historic and geographic patterns of health inequalities, the importance of **involving individuals and communities as equal partners in research**, and the need to **improve data linkage and access**, were stressed.<sup>152</sup>

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<sup>149</sup> Wykes T, et al. (2021). *Shared goals for mental health research: what, why and when for the 2020s*. J Ment Health **9**, 1-9.

<sup>150</sup> <https://abcdstudy.org/>

<sup>151</sup> <https://mentalhealthresearchmatters.org.uk/networks/>

<sup>152</sup> The British Academy and Academy of Medical Sciences (2022). *Historic and geographic patterns of health inequalities*. <https://acmedsci.ac.uk/file-download/86122176>

### ***Increasing supply through building workforce capacity and investment***

- 7.19. **Building workforce capacity and better supporting the workforce** is a critical determinant of being able to harness the benefits of many of the actions mentioned throughout our response. We heard that there is a particular crisis in recruiting and retaining psychiatrists, but that workforce issues need addressing across the board, both within and outside of the NHS. This includes school and university nurses and counsellors, psychologists, psychotherapists, and the IAPT and VCS workforce. As well as increasing funding for the workforce, there is also need for greater attention on training and workforce support and culture.
- 7.20. Increasing supply of services is critically dependent on **increasing funding for services**. Our contributors mentioned a number of priority areas for funding, including CAMHS (**3.7**), perinatal mental health services (**2.8**) and acute hospital care and crisis support (**6.3**). Improving access to a wide range of services, including IAPT, psychotherapy and community support, in addition to more traditional psychiatric and psychological support, is critical to be able to deal with the full range of mental health issues that people may experience.

### ***Mental health is everyone's business***

- 7.21. Numerous systems have an important role to play in mental health, from supporting wellbeing to providing early intervention and ongoing care for people with acute or chronic mental health conditions. A resilient mental health plan **requires a joined-up, cross-Government and cross-system approach** to co-ordinate efforts between **multiple systems**, including education, work, health and social care, justice, public health and the VCS. Data linkage (**7.50**) is key to achieve this.
- 7.22. The Plan must work for everyone, especially those who are at higher risk of experiencing poor mental health. Although neurodevelopmental disorders (e.g. ADHD and autism) are sometimes not considered mental health issues in themselves, their developmental needs nevertheless require specific identification and evidenced health support. The high prevalence of mental health issues in people experiencing these disorders means that they are an important group of people to focus on in the Plan.

### ***Involving people with lived experience, their families, and caregivers at all stages***

- 7.23. **Patient and public involvement** must be a vital component of the development, implementation and evaluation of the Plan and its actions.
- 7.24. **Co-production** models for the design and implementation of mental health services and interventions are essential to ensure they are effective and tailored to the needs and complexities of individuals and communities. Co-production can foster trust between service providers and communities by bringing them together through shared vision and action and empower individuals and communities to deliver and engage with programs, rather than feeling that programs are being imposed on them.<sup>153</sup>
- 7.25. Dialogue with, and involvement of, the public must be **meaningful and not tokenistic**. Meaningful involvement requires long-term engagement, is resource

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<sup>153</sup> Burgess RA & Choudary N (2021). *Time is on our side: operationalising 'phase zero' in coproduction of mental health services for marginalised and underserved populations in London*. Int J Public Adm **44**, 753-766.

intensive, and can be difficult to initiate, particularly among marginalised groups who experience poorer mental health outcomes and barriers to participation, such as Black people and people of ethnic minority backgrounds.<sup>154</sup> Exclusion of marginalised and vulnerable groups from public engagement and co-production activities means services may not account for the requirements and preferences of those who are most in need.

- 7.26. Meaningful co-production involves genuine dialogue and communication with the affected communities. Activities and outcomes **must reflect the complex realities and intersecting identities** of ethnicity, gender, disability, sexuality, and other protected characteristics of the people within local communities.
- 7.27. Strategies to overcome barriers to participation include **building capacity** (e.g. providing training opportunities), **fostering well-being** (e.g. focusing on an individual's resources and capacities rather than risk and health-related factors), and remaining **flexible** (e.g. in regards to meeting times and locations).<sup>155</sup>

### **Evaluating impact and lessons learned**

- 7.28. A number of our Fellows mentioned the need for **continuity and cohesion** between the new plan and previous policies, such as the 2011 Mental Health strategy for England.<sup>156</sup>
- 7.29. There should be a commitment to **measuring the impact of previous and future policies and programmes** that are put into place, to determine whether policy aims are achieved, and to highlight opportunities and challenges that are encountered during implementation. It was suggested that a new plan could be structured similarly to the United Nations' Sustainable Development Goals,<sup>157</sup> with **goals, targets, and indicators being defined from the outset**.
- 7.30. Global health challenges such as climate change and global recession will have worldwide impacts on mental health, the response to which will benefit from a collaborative and integrated approach. We were told that the UK could do more to **share mental health research and policy successes and learnings internationally**, and to **facilitate the movement of talented mental health researchers** between the UK and other countries.

### **What 'values' or 'principles' should underpin the Plan as a whole?**

- 7.31. The principles that underpin the government's plan for mental health and wellbeing should align with, and expand on, the principles of the Mental Health Act.<sup>158</sup> In particular, the **principles of empowerment and involvement, respect and dignity, and efficiency and equity**. We also recommend an additional principle of **individuality**.

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<sup>154</sup> Sashidharan SP & Gul M (2020). *Ethnicity and mental health: a new beginning*. *Lancet Psychiat* **7**, 380-381.

<sup>155</sup> Amann J & Sleigh J (2021). *Too Vulnerable to Involve? Challenges of Engaging Vulnerable Groups in the Co-production of Public Services through Research*. *Int J Public Adm* **44**, 715-727.

<sup>156</sup> HM Government (2011). *No health without mental health*.

<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

<sup>157</sup> <https://sdgs.un.org/goals>

<sup>158</sup> Department of Health (2015). *Mental Health Act 1983: Code of Practice*.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/435512/MHA\\_Code\\_of\\_Practice.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)

- 7.32. **Empowerment and involvement:** Empowerment and involvement should be the 'bedrock' of any policies, interventions, service models, and treatments concerning mental health (7.23 – 7.27). Empowering patients, their families, and caregivers means involving them in decisions around care, treatment, the identification of service provision and research priorities, the evaluation of interventions, and communicating information around mental health.
- 7.33. **Efficiency and equity:** The Mental Health Act states that commissioners and other organisations should work together to ensure that the commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services (4.10). These same principles should apply to the new plan and be further extended to ensure equity of access across all areas of mental health, including opportunities to participate in research, access to treatment, and high quality, personalised, patient-centred care.
- 7.34. **Respect and dignity:** Patients, their families and their carers should be treated with respect and dignity, and their individual needs and concerns should be listened to and taken into consideration by everyone involved in providing their mental healthcare. This should include a commitment to maintaining dialogues and fostering trust between patients and practitioners.
- 7.35. **Individuality:** Decisions around early interventions, treatment and care, and strategies for prevention, should be appropriate for, and tailored to, each patient, considering their individual circumstances and symptoms (3.3, 4.29). Research has a role to play in understanding the most effective strategies for prevention and treatment in different individuals and populations.

### **How can we support local systems to develop and implement effective mental health plans for their local populations?**

- 7.36. Throughout our response we have highlighted the role of the VCS in prevention, early intervention and treatment. Priorities for supporting local communities include making it easier for VCS organisations to access **long-term and sustainable funding** and ensuring they are effectively **linked up with the health and social care system (4.7)**.
- 7.37. Communities must be empowered to plan services and interventions that are acceptable, accessible, and tailored to the demands and needs of local populations. This will mean **embedding public and service user involvement and co-production** when planning, designing, delivering, and evaluating local mental health plans and programs (7.23-7.27).
- 7.38. An example of best practice is The South London Listens partnership, which was launched to identify and address mental health priorities and explore the impact of the COVID-19 pandemic.<sup>159</sup> Over 12 months, the project engaged with more than 6000 people through community meetings, group conversations, and listening campaigns. From these interactions, a two-year action plan to build community resilience and improve mental health across south London was co-produced with support from statutory, voluntary and community organisations.

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<sup>159</sup> <https://www.southlondonlistens.org/>

- 7.39. Local systems must be **equipped to make use of local health, social care, demographic, and service use data** to inform effective mental health plans, comparing local and national data wherever possible.
- 7.40. Contributors stressed the need to properly **evaluate** any new services for effectiveness, feasibility, and scalability, to ensure they will benefit as many people as possible.

## How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?

- 7.41. **Co-ordinated action** to streamline and facilitate data access while maintaining good governance is required between all stakeholders, including data custodians, institutions holding user data, and individual data users.<sup>160</sup> Researchers and data custodians must be transparent about data usage, ensure research focuses on patient- and public-centred motives and values, and maintain secure systems and processes for handling data to build and maintain public trust when patient-generated data is used.
- 7.42. Understanding risk factors for poor mental health and treatment outcomes, evaluating the effectiveness of treatments and interventions, planning and monitoring health service use, and monitoring the mental health gap all depend on effective collection of data across a range of factors: social, environmental, clinical, phenotypic and genetic.<sup>161</sup>
- 7.43. Data also needs to be collected consistently over long periods of time. It was noted by multiple contributors that **funding for longitudinal mental health research** is limited.
- 7.44. There is increasing interest in the use of electronic health records for collecting data, however there are vast variations in the quality and amount of data that is recorded. There is therefore a need to **encourage and incentivise standardised recording and support individuals to record data through training and professional development.**
- 7.45. At our 2019 meeting on 'The developing brain in health and disease',<sup>162</sup> participants highlighted that methods such as **systematic reviews, meta-analyses** and **machine learning** (e.g. natural language processing) present opportunities to make better use of existing data sources.
- 7.46. NHS data only captures patients who have engaged with the healthcare system, and therefore represents a minority of people with a mental health condition. The Adult Psychiatric Morbidity Study of Mental Health and Wellbeing<sup>163</sup> collects bespoke surveillance data on the prevalence rates of mental health conditions and service use. The next survey in the series was due to be launched in 2021 but was delayed to April 2022. **Timely collection and release of data** is critical for monitoring ongoing trends

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<sup>160</sup> Ford T, et al. (2021). *The challenges and opportunities of mental health data sharing in the UK*. *Lancet Digit Health* **3**, 333-336.

<sup>161</sup> Academy of Medical Sciences (2017). *Personalised psychiatry*. <http://acmedsci.ac.uk/file-download/16107617>

<sup>162</sup> Academy of Medical Sciences (2019). *The developing brain in health and disease*. <https://acmedsci.ac.uk/file-download/9487768>

<sup>163</sup> <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey>

(e.g. the impact of the COVID-19 pandemic) and ensuring resulting research and outcomes address the most pertinent challenges.

- 7.47. Improvements to data linkage are needed to support research. Contributors stressed the need for an **integrated data system within the NHS** that would streamline the process of linking, applying for, and accessing data. One possible solution is the use of research platforms, such as the multisite Clinical Record Interactive Search research platform at the South London and Maudsley NHS Foundation Trust.<sup>164</sup>
- 7.48. Data linkages are often expensive, with complex processes and time-consuming application processes. Interlinked medical and social registries are well established in Scandinavia,<sup>165</sup> and a similar **joined-up approach that maintains appropriate safeguarding** could be adopted in in England to facilitate research and service planning.
- 7.49. Other innovative strategies to increase the co-ordination and availability of mental health data include Health Data Research UK's DATAMIND hub for mental health informatics research development.<sup>166</sup>
- 7.50. **Improving data linkage across sectors** can support wider priorities to join up different systems (e.g. health and education). The Royal College of Paediatrics and Child Health has called for the use of the **NHS number as a common identifier** across health and social care and education, and the development and implementation of the **Child Protection Information System**.<sup>167</sup>
- 7.51. Improvements to data collection and access will need to maintain **the security and privacy** of health, social, education, and other data. The use of Trusted Research Environments (TREs),<sup>168</sup> where data remains in a secure location and is only accessible by approved researchers, should be adopted more widely, to allow for research to be carried out in a way that does not compromise public trust and right to privacy.
- 7.52. We heard from several researchers that despite high quality survey data being available in the UK, data is either not routinely made available to researchers, or there are cumbersome applications processes that can be difficult to navigate.<sup>169</sup> Additionally, there are often long lag times between the surveys being conducted and data being released for secondary data analysis, by which time the data is often several years old.
- 7.53. Early in the COVID-19 pandemic, approval process for accessing administrative data were simplified, reducing delays and giving researchers more efficient data access while maintaining and respecting data protection principles.<sup>170</sup> Data providers and the Government must work with the research community to **build data systems that replicate these successes and gives researchers streamlined and efficient access to data**.

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<sup>164</sup> Carson L, et al. (2020). *Multisite data linkage projects in mental health research*. *Lancet Psychiat* **7**, 61.

<sup>165</sup> The Lancet Psychiatry (2019). *Smorgasbord or Smaug's hoard?* *Lancet Psychiat* **6**, 631.

<sup>166</sup> <https://www.hdruk.ac.uk/helping-with-health-data/health-data-research-hubs/datamind/>

<sup>167</sup> Royal College of Paediatrics and Child Health (2018). *Child health in 2030 in England: comparisons with other wealthy countries*. [https://www.rcpch.ac.uk/sites/default/files/2018-10/child\\_health\\_in\\_2030\\_in\\_england\\_-\\_recommendations\\_report\\_-\\_2018-10.pdf](https://www.rcpch.ac.uk/sites/default/files/2018-10/child_health_in_2030_in_england_-_recommendations_report_-_2018-10.pdf)

<sup>168</sup> <https://www.hdruk.ac.uk/access-to-health-data/trusted-research-environments/>

<sup>169</sup> The Lancet Psychiatry (2019). *Smorgasbord or Smaug's hoard?* *Lancet Psychiat* **6**, 631.

<sup>170</sup> Cavallaro F, et al. (2020). *Reducing barriers to data access for research in the public interest—lessons from covid-19*. *The BMJ Opinion*, July 6.

- 7.54. Early in the COVID-19 pandemic, the Academy and MQ convened an expert group to identify priority areas for research to understand how COVID-19 directly and indirectly affects mental health.<sup>171</sup> This was followed by a workshop to explore collaborative, consortium-based approaches to consolidate and refine an existing research proposal to collect data on the neurological, cognitive and neuropsychiatric impacts of COVID-19.<sup>172</sup> The resulting proposal, the COVID-19 Clinical Neuroscience Study (COVID-CNS),<sup>173</sup> was successfully funded by UKRI and represents the benefits of using an **interdisciplinary and collaborative approach to data collection**.
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This response was prepared by Melissa Cabecinha, Policy Intern, and Dr Alice Fletcher-Etherington, Policy Officer. For further information, please contact Dr Alice Fletcher-Etherington ([Alice.Fletcher-Etherington@acmedsci.ac.uk](mailto:Alice.Fletcher-Etherington@acmedsci.ac.uk)).

The response was informed by the Academy's previous policy work across a broad range of topics with relevance to mental health, as well as evidence from Academy programme participants and grant awardees, people with lived experiences of mental health issues, and members our elected Fellowship, which includes some of the UK's foremost experts in clinical and academic psychology, psychiatry and neuroscience (Annex I).

All web references were accessed in June 2022.

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<sup>171</sup> Holmes EA, et al. (2020). *Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science*. *Lancet Psychiat* **7**, 547-60.

<sup>172</sup> Academy of Medical Sciences & MQ (2020). *Coordinating the collection of high-quality data on the mental, cognitive and neurological health impacts of COVID-19*. <https://acmedsci.ac.uk/file-download/68532659>

<sup>173</sup> <https://www.liverpool.ac.uk/covid-clinical-neuroscience-study/>

## Annex 1: Contributors

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