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Unite the union response to:

Department of Health and Social Care; Mental health and wellbeing plan: discussion paper and call for evidence

This response is submitted by Unite in Health. Unite is the UK and Ireland's largest trade union with 1.4 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport, local government, education, health and not for profit sectors.

Unite represents around 100,000 health sector workers. This includes eight professional associations - British Veterinary Union (BVU), College of Health Care Chaplains (CHCC), Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Hospital Physicists Association (HPA), Doctors in Unite (formerly MPU), Mental Health Nurses Association (MNHA), Society of Sexual Health Advisors (SSHA).

Unite also represents members in occupations such as nursing, allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

1. Introduction

1.1. Unite welcomes the opportunity to respond to the Department of Health and Social Care (DHSC); Mental health and wellbeing plan: discussion paper and call for evidence.

1.2. Unite has used its consultative provisions throughout the organisation to hear back the views of our members working in health and care settings.

1.3. Unite has a significant interest in mental health issues both because our members use mental health services or support those at work with mental health problems, and because we represent a significant number of members who work in mental health services. These include a large membership in the NHS working in mental health nursing, clinical psychology and other related professions, as well as members in local authorities, social care and the not-for-profit sector that support people in the community.

1.4. In encouraging people to respond, it is unfortunate that the only two options for submitting responses are either by online form or by posting a hard copy response. All government consultations should also offer the option of sending responses via email.

Sharon Graham
www.unitetheunion.org
General Secretary

2. Summary

2.1. The success of a long-term plan for good mental health will be dependent on an adequately resourced (including pay), well-educated, trained and dedicated workforce. Such a plan should include criteria for decent working conditions, to include the requirement not to over burden staff to the point that they themselves become traumatised.

2.2. It is vital to have the required number of staff to meet the need. This principle underpins the whole system and will require urgent investment in pay, education and training opportunities to ensure a high quality and diverse workforce reflects the general population and meets their needs.

2.3. There must be a strategic and united system wide approach across government departments, with mental health, particularly children and young people's mental health, at the heart of all planning and decision making. For example, children find themselves faced with many immediate challenges around the pressures of government-based targets related to educational achievement. This culture is placing children and young people, and in turn, teaching staff, under huge and counter-productive pressures which appears to be linked to the increase in mental health distress in children and young people.

2.4. Families also face economic pressures which will inevitably impact on the wellbeing of young people. In addition, babies, children and young people also face the challenges presented by the climate crises and looming environmental disasters.

2.5. There is already a wealth of evidence on measures that can help reduce mental ill health and societal distress and it is clear the key is to reduce health, social and financial inequalities. It is also vital to focus on the prevention of abuse, and the reduction of gender-based violence.

2.6. Targeted interventions at key points of need are vital to prevent long term mental health problems. Consequently, there is a need for specialist clinicians.

2.7. There is a need to work with children and families, and to address parental mental ill-health. There needs to be adequate funding for longer term therapies for people impacted by trauma and abuse, rather than the short-term interventions which do not provide sufficient help for the potentially profound psychological injuries and distress caused by adverse childhood and life experiences.

2.8. More investment into local communities will increase community trust, social inclusion and cohesion, all vital ingredients for population wellbeing.

2.9. The consultation document provides a comprehensive overview about the evidence around mental health in several domains – the quality and type of intervention is suggested in the analysis. Adequately funded public services, universally and freely available, will increase population health, as evidenced by previous governments, who have been bold, ambitious and compassionate enough to work for the health of all who reside in the United Kingdom and beyond. The pandemic has demonstrated the importance of global, as well as national, health.

2.10. In respect of perinatal mental health, two of Unite's health sector professional organisations are members of the Maternal Mental Health Alliance[1]. As members we wish to raise the following points:

[1] https://maternalmentalhealthalliance.org

2.10..1. Around 20% of women will experience a perinatal mental health problem at some point during the perinatal period (pre-conception, during pregnancy and the first years after birth). Too often these maternal mental health problems go unrecognised, undiagnosed, and untreated.

2.10..2. If not addressed or treated, perinatal mental health difficulties can result in poor outcomes for the mother and her transition to motherhood. Although it is not inevitable, perinatal mental illness can negatively impact the care she provides for her baby[2]. In the long term, poor perinatal mental health can lead to poorer cognitive, emotional, social, educational, behavioural and physical development of infants[3&4].

2.10..3. Stigma remains a significant barrier in parents not accessing support for fear of looking like an "incompetent" mother and, at worst, their baby being "taken away"[5,6&7]. Ensuring that women feel safe to voice their concerns is profoundly important in perinatal mental health. Many women are simply not given the space to speak about their mental health by health professionals during the perinatal period. A survey by the NCT found that, despite changes to the GP contract, the vast majority of women are not asked about their mental health during health checks.

2.10..4. Alongside the human costs of untreated perinatal mental health (PMH) problems, there are huge economic costs. A report by the London School of Economics and the Centre for Mental Health[8] showed that the costs of perinatal mental illness for every annual cohort of births were £8.1bn.

Response to the consultation questions

3. How can we all promote positive mental wellbeing?

3.1. This section invites comment on individual and population health, and agencies working together.

3.2. Unite members highlight how this must be done in a 'ground up, bottom led, top fed' approach engaging all people across our society. They were keen to highlight the importance of early intervention and often spoke of how consistent efforts should be made before and during the school-age years.

3.3. There was discussion about the importance of correct, appropriate and kind language use and encouragement that this should be 'modelled' by society's leaders including politicians. A recent

[2] The need for specialised services (2012). *Guidance for commissioners of perinatal mental health services - Volume Two: Practical mental health commissioning*. Available from: www.jcpmh.info

[3] Sutter-Dallay, A. et al. (2011) A prospective longitudinal study of the impact of early postnatal vs. chronic maternal depressive symptoms on child development. Available from: https://pubmed.ncbi.nlm.nih.gov/20621453/

[4] Khan, L. (2015) Falling through the gaps: perinatal mental health and general practice. Available from: https://www.centreformentalhealth.org.uk/sites/default/files/2018-11/falling_through_the_gaps_summary.pdf

[5] Edwards, E. et al. (2005) A qualitative study of stigma among women suffering postnatal illness. Available from: https://www.tandfonline.com/doi/abs/10.1080/09638230500271097

[6] Krumm, S. et al. (2009) Subjective views of motherhood in women with mental illness - A sociological perspective. Available from: https://www.researchgate.net/publication/232061238_Subjective_views_of_motherhood_in_women_with_mental_illness_-_A_sociological_perspective

[7] Davey, C. et al. (2007) The role of perinatal problems in risk of co-morbid psychiatric and medical disorders in adulthood Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563431/

[8] http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

example was correctly highlighted by Dr Rosena Allin-Khan MP in criticizing Lee Anderson MP use of a 'mental health trope' against a campaigner[9].

3.4. An example of a positive step that can be taken is modelled by Unite Mental Health Nurses Association (MHNA) who are members of the Mental Health Media Charter[10]. Initiatives such as this should be widely supported by government. A retrograde step was the government's decision to cease funding of Time to Change, a social movement that worked to change the way people think and act about mental health problems, leading to its closure in March 2021[11].

3.5. Concerns were raised by members about the negative impact of the Government's efforts to develop 'culture wars' and to attack people who are trying to promote positive practice as 'woke', implying it as a pejorative term.

3.6. On the issue of 'getting the language right' members also highlighted that mental health does not equal mental illness and/or distress nor should the normality of the misery of the human condition, for example, bereavement, job loss and relationship breakdown, be pathologised inappropriately.

3.7. If the Government is serious about promoting positive mental wellbeing, they must commit to investing in the workforce immediately.

3.8. All individuals require an adequate income so they can provide food and shelter, basic human rights. Reducing the gap between rich and poor is one of the most effective ways to improve the physical and mental health of the public. The provision of an income, sufficient to live on, for those currently carrying out unpaid caring would be one of the most effective ways to improve health and furthermore, reduce gender inequality in the UK.

3.9. Members report that there is a need to make access to NHS continuing professional development (CPD) easier and affordable for staff. Previous cuts to CPD budgets should be reversed and those staff who have been transferred away from NHS employers should be included in schemes in place to support staff to develop. This must be both at undergraduate and post-graduate level and include appropriate funding, and include release for time away from work.

3.10. Unite members also highlight the need for ongoing investment into specialist nursing including health visiting and school nursing and therapists including clinical psychology, counselling psychology, child and family psychotherapy, family therapy and drama therapy.

3.11. Furthermore, they highlight the need to 'frontload' primary care to ensure good universal healthcare, which is a keystone of prevention, early intervention, treatment and recognition of mental health difficulties. This must include midwives, health visitors, school nurses, general practitioners, and public health specialists.

3.12. The current workforce crisis within the health and social care sectors, with shortages in many professions, has been brought to the attention of the Government by Unite on numerous occasions. Unite members consider that government must invest in the future workforce as part of its commitment to the nation and realise that quality interventions rest upon well trained

[9] https://twitter.com/DrRosena/status/1534600551857590274?s=20&t=bMBIu00OUItSSBhvBWNSyg
[10] https://www.natashadevon.com/the-mental-health-media-charter
[11] https://www.time-to-change.org.uk/time-to-change-closure

staff. There is a need for considerably more mental health professionals including mental health nurses, learning disability nurses, doctors including psychiatrists, counselling, educational and clinical psychologists, child and family psychotherapists.

3.13. Ensuring a public health approach to mental health which also addresses health inequalities is vitally important. Many Black and Asian Ethnic Minority (BAEM) communities are concerned about the relevance and safety of mental health services. Unite members consider there is a need to co-design and co-produce services and not presume a 'one size fits all' approach in terms of what works. Collaborations with the arts and sports are vitally important, with services made available in non-stigmatised spaces such as libraries, theatres and sports clubs. In order to realise this vision, government should reverse the devastating impact that austerity has had, and continues to have, on these sectors.

3.14. It is vital that there is a multi-agency approach to this, considering all statutory agencies and public services, including the arts and sports, to ensure that mental health is truly 'everyone's business'.

3.15. Services must be co-produced with service users and their representative organisations. Many of the organisations in the voluntary and community sector are precariously funded, and it is important to bolster the long-term funding of these organisations who are often developed from grass root initiatives. However, a joint agency approach would reduce costs[12].

3.16. Finally, it is extremely concerning that the Marmot Review[13] has identified that health and social inequalities have, in fact, widened.

3.17. In respect of perinatal mental health:

3.17..1. Many different services work with new parents and families during pregnancy and after birth. Funding for these services comes from different government departments and is commissioned by different local providers. The landscape of service in maternity, mental health, early years and children's services is complex and fragmented. There are different funding streams, standards and outcome measures making integrated local working a challenge.

3.17..2. Furthermore, many services are not properly resourced. It is hard for local services to work together when they are under pressure, there are fewer resources to enable staff to attend partnership meetings and less 'headspace' to engage in joint work.

3.17..3. The crucial role of the voluntary and community sector (VCS) within the perinatal mental health sector needs to be recognised and valued, including by NHS organisations commissioning mental health services. Sustainable funding for the VCS will help provide organisations working with women and families in the perinatal period the ability to offer stable long-term support.

3.17..4. A 2022 London School of Politics and Economics (LSE)[14] report into the economic case of increasing perinatal mental health support showed that there are clear

[12] https://www.instituteofhealthequity.org/resources-reports/marmot-indicators-2015/marmot-indicators-2015-background-report.pdf

[13] https://www.health.org.uk/funding-and-partnerships/our-partnerships/health-equity-in-england-the-marmot-review-10-years-on

[14] Bauer, A. et al. (2022) Increasing access to treatment for common maternal mental health problems could have a net benefit of half a billion pounds. London: LSE. Available from: https://www.lse.ac.uk/News/Latest-news-from-LSE/2022/b-Feb-22/Increasing-access-to-treatment-for-common-maternal-mental-health-problems-could-have-a-net-benefit-of-half-a-billion-pounds

economic benefits from training midwives and health visitors so that they can confidently and skilfully ask women about their mental health, assess their needs and offer or arrange for psychological interventions. Investing in integrated service provision would achieve cost savings to the NHS over 10 years of £52 million and improvements in women's quality of life estimated at £437 million. This means it has a net benefit of £490 million over 10 years.

3.17..5. Integrated local working should be supported by a joined-up national vision and strategy for perinatal mental health and the first 1,001 days to address the needs of women, parents, babies and families which sets out clear shared outcomes for the system and describes how different Government policies will work together.

3.17..6. Government must resource health visiting services properly and hold local authorities to account for delivering services that meet Government guidelines.

3.17..7. It is a true scandal that at a time when babies, children and families have needed improved services more than ever they have, in reality, faced significant cuts. Between May 2010 and March 2022, the number of health visitors in England's NHS have fallen by 1,754 (22.3%). Looking at the decline in their number since the transfer of health visiting services commissioning to local authorities, their number have been cut by 4,184 (40.1%)[15]. The government must launch a plan similar to the 2011-15 Health Visitor Implementation Plan to address this crisis[16].

3.17..8. Looking elsewhere, the number of Sure Start Centres have been cut by over 1,000 during the last decade[17]. The promise to replace a tiny number of these with 'hubs' that provide reduced services is nowhere near sufficient.

3.17..9. Government must support local partnerships, such as Integrated Care Systems to work together to support the needs of new parents, babies and families.

4. How can we all prevent the onset of mental ill-health?

4.1. *This section invites the consideration of the following questions:*

- What is the most important thing we need to address in order to reduce the numbers of people who experience mental ill-health?
- Do you have ideas for how employers can support and protect the mental health of their employees?
- What is the most important thing we need to address in order to prevent suicide?

4.2. The causes of individual mental health problems are complex and diverse, ranging from childhood traumas, physical abuse and violence to physical health problems, bereavement, long term stress, unemployment, social disadvantage, poverty or debt. In many cases the exact causes are not known and there are currently scientific studies to investigate potential genetic causes as well. There are however significant trends that highlight that our working and social environments have a large impact on our mental health. There is a whole raft of documentation on the social determinants of mental health problems from the WHO[18] and others that highlight

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[15] https://files.digital.nhs.uk/D6/DB6B87/NHS%20Workforce%20Statistics%2C%20March%202022%20Staff%20Group%2C%20Care%20Setting%20and%20Level.xlsx

[16] https://www.gov.uk/government/publications/health-visitor-implementation-plan-2011-to-2015

[17] https://www.cypnow.co.uk/news/article/more-than-1-000-children-s-centres-closed-over-last-decade

[18] WHO (2007). Breaking the vicious cycle between mental ill-health and poverty. Geneva: WHO. doi: http://www.who.int/mental_health/policy/development/ en/index.html
WHO (2008). Improving maternal mental health. Geneva: WHO. doi: http://www.who.int/mental_health/prevention/suicide/mmh_jan08_meeting_report.pdf.

how poverty and social exclusion causes distress. There is also well documented literature on how the gap between rich and poor causes mental health problems[19]. Prolonged workplace stress has been strongly associated with mental health problems, as have discrimination, bullying and harassment at work[20].

4.3. Emotional well-being needs to be understood as the result of a complex interplay of factors. Intervention in policy terms therefore also needs to be multi-layered.

4.4. The increase in mental distress in young people needs to be addressed, particularly the pressures young people face in terms of the post-pandemic, the impact of economic hardship, the pressures on children and teachers in school and ecological crisis.

4.5. Approximately half of adult mental health problems begin in childhood, and many adults with mental health problems also had a parent with mental health problems. Early intervention is vital and contextual factors such as poverty must be addressed in order to improve health and life chances.

4.6. Reducing the gap between rich and poor would improve population health, increase inclusion and social cohesion. Members highlighted that promoting positive citizenship and destigmatising mental health conditions is key.

4.7. It is important to provide a care income for those involved in currently unpaid care work in the home. This would also reduce gender, and other intersecting inequalities.

4.8. In the most recent NHS Staff Survey (2021)[21], 46.8% of respondents stated that they have felt unwell as a result of work-related stress in the last 12 months. This figure has been increasing for four consecutive years and is now 8 percentage points higher than it was in 2017. Just as concerning is the endemic p*resenteeism,* where 54.5% of staff had gone into work in the last three months despite not feeling well enough to perform their duties.

4.9. When considering one of the reasons for this, our members describe how the chronic lack of staff is a compelling reason. This is again supported by the NHS Staff Survey which states that only 27.2% of staff reported that their organisation had enough staff to do their job properly. This figure has declined markedly since last year by 11% and by over 16% amongst staff in ambulance trusts.

4.10. Members, including in our ambulance service, have highlighted the dramatic negative impacts and increasing likelihood of 'moral injury'[22].

4.11. Employees need strengthened, not weakened rights at work, with trade unions that are able to protect employees from unfair treatment and discrimination at work. Unionised

WHO (2008). Mental health gap action programme (mhGAP): Scaling up Care for Mental, Neurological and Substance Abuse Disorders. Geneva: WHO.
WHO (2010). mhGAP intervention guide. Geneva: WHO.
WHO. (2011) Mental health atlas. Geneva: WHO.
WHO (2013). Comprehensive mental health action plan 2013-2020. Geneva: WHO.
WHO & Calouste Gulbenkian Foundation (2014). Social determinants of mental health. Geneva: WHO.
[19] Wilkinson, R.G. & Pickett, K. (2009). *The spirit level: why more equal societies almost always do better*. London: Penguin.
[20] http://www.hse.gov.uk/stress/furtheradvice/bullyingindividuals.htm
[21] https://www.nhsstaffsurveys.com/static/b3377ce95070ce69e84460fe210a55f0/ST21_National-briefing.pdf
[22] https://twitter.com/Unite_MHNA/status/1281510022036557824?s=20&t=P3xVxZxMVG9PmfroNCV2Lw

workforces with good industrial relations are more productive. Workers need to be afforded adequate health adjustments at work, so the work culture is compassionate and inclusive. This will then be reflected in the care they provide.

4.12. Considering employers outside of the health sector, it is of great concern that the Government appear to make repeated attempts to demonise trade unions and the defence of workers. Our members across all sectors support each other and try to ensure safer and more supportive workplaces for all. Our member's view is that rather than welcome and develop this, the Government has repeatedly undermined this work.

4.13. There are well known factors associated with suicide, and some of these are strongly associated with economic pressures, as well as stigma and gender. There is much to be done to reduce unhelpful gender-based pressures for men and boys in particular. Early and adequate help for the impacts of complex trauma are needed.

4.14. Local authorities and private companies that own, for example, high buildings and car parks, must be obligated to make their buildings suicide safe and to train staff in the recognition and support of people who may be at risk of taking their own lives.

4.15. An issue that requires continued focus in relation to suicide relates to professions in the health service that have higher levels of suicide. Unite has supported the work done by NHS England and NHS Improvement to address the facts uncovered by the National Confidential Inquiry into Suicide and Safety in Mental Health, 'Suicide by female nurses: a brief report'[23]. This report highlighted that female nurses had a risk of suicide 23% above the risk in women in other occupations.

4.16. Unite/Mental Health Nurses Association has previously partnered with the Zero Suicide Alliance to produce a special edition of their Menta Health Nursing journal on the subject. This was made freely available to anyone that wanted to access a copy[24]. We commend their work to this call for evidence.

4.17. In respect of perinatal mental health:

4.17..1. Mental ill health remains one of the leading causes of maternal death in pregnancy and the first postnatal year. Assessment, identification and support for new and expectant mothers' mental health is critically important.

4.17..2. Access to specialist perinatal mental health services has increased significantly in recent years. However, ongoing commitment is required at both the national and local level to ensure funding and staffing continue.

4.17..3. The 2021 MBRRACE[25] report looks at 62 women who died by suicide and a further 58 women who died in relation to substance misuse between 2017-19 in the UK&I during pregnancy or up to one year after the end of pregnancy.

4.17..4. The report shows that there are significant health inequalities, and the rate of maternal mortality is four times higher among women from Black ethnic backgrounds and twice as high for women from Asian ethnic backgrounds compared to white women.

4.17..5. MBRRACE 2022 also highlights that many of the women who die from suicide or substance misuse face multiple adversity. The needs of other traditionally seldom

[23] https://sites.manchester.ac.uk/ncish/%20suicide-by-female-nurses/
[24] https://twitter.com/Zer0Suicide/status/1230782860908515328?s=20&t=od84hXNCboCPi6L5WTLNoA
[25] https://www.sciencedirect.com/science/article/pii/S2589537021005186

heard voices including women in the criminal justice system, asylum seeking women and those who have had or are at risk of having children removed must be addressed.

4.17..6. The report makes nine specific new recommendations for the NHS, such as greater consideration of previous history in assessment of women with perinatal mental health symptoms, ensuring clarity of roles between midwifery and mental health services, lowering mental health assessment thresholds for women in the perinatal period and ensuring women with previous mental health conditions are regularly reassessed during pregnancy and after birth. The report also lists nine existing recommendations from previous cases that still require improved implementation.

4.17..7. The findings from MBRRACE highlight the need for an understanding of how complex social problems impact maternal mental health care and support.

4.17..8. The plan should ensure all recommendations from the MBRRACE report are adopted and fully delivered across the country.

4.17..9. Sustainable funding for specialist perinatal mental health services in all areas of the country is essential.

5. How can we all intervene earlier when people need support with their mental health?

5.1. This section also invites the consideration of the following questions:

- Where would you prefer to get early support for your mental health if you were struggling?
- What more can the NHS do to help people struggling with their mental health to access support early?
- Do you have any suggestions for how the rest of society can better identify and respond to signs of mental ill-health?
- How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?
- How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?

5.2. It is vital to provide mental health support in naturalistic settings, with a pluralism of approach and a variety of methods for accessing information, support and help. Helplines should be staffed by well-trained people.

5.3. There should be national frameworks that explicitly tackle childhood trauma, violence against women and children and reduces economic inequality. 'Trauma informed care' must be adequately funded and realised. There is a large body of literature that demonstrates the negative impacts of 'adverse childhood experiences' (ACEs). Services and the workforce employed in them need to be 'trauma informed'. This could mirror the approach already undertaken in Scotland[26].

5.4. Members highlighted that a person with a 'serious mental illness' (SMI) needs the full panoply of services whilst someone with a mild to moderate 'self-limiting' condition need a service which includes an assessment and an intervention. This needs to be easily and quickly available with the intervention brief in timescale. Staff working in early intervention services need suitable caseload numbers to be able to do this work appropriately. This requires a workforce that is responsive to those needs and is appropriately equipped.

[26] http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx

5.5. Members highlighted that crisis resolution and home treatment teams can get pushied beyond their capacity by work that should be most appropriately dealt with in community mental health trusts. Trying to support these people 'inappropriately' because there's no one else to help support people in need is not appropriate but is the only solution. As these teams can be seriously under-resourced they cannot then take on new patients. Members highlighted that people were then left on waiting lists with infrequent calls to check the person had not entered a crisis rather than being able to provide care early on.

5.6. Members who are 'duty workers' highlighted how they don't have capacity and so 'it's unsafe'. The only resolution is to call paramedics so the person can be taken to accident and emergency. As part of this call for evidence, we heard of examples of members taking 17 calls per shift with on average each caller requiring at least 30 mins. This was highlighted to be 'an impossible situation' which then 'dominos' onwards to future days. The only solution that members can see to resolve this is more staff.

5.7. Members highlighted that good early intervention services are key. Examples were given of the importance of taking a good 'history' at initial appointments but that this was difficult when, for example general practitioners have so little time. If more time was available, problems could be picked up much earlier and subsequent treatment may be of a shorter duration with better outcomes.

5.8. Further suggestions were made by members:

5.8..1. Protect the NHS and social care, which will directly benefit people accessing services, through ensuring that it is adequately funded and in full public ownership
5.8..2. Activate the socioeconomic duty under the Equality Act 2010
5.8..3. Ensure that mental health, particularly that of children and young people, is centralised across Govt departments, and across all strategy, from housing, health and education to the environment
5.8..4. Ensure mental health is appropriately included in the strategic agenda at local authority and Integrated Care Service (ICS) level. Bolster the powers of scrutiny and regulatory bodies to ensure that quality services are in place, for example via Health and Wellbeing Boards (HWBs).

Early years and school age

5.8..5. Adopt the first 1,001 days[27] approach to child wellbeing.
5.8..6. Fund nursery places at their true cost.
5.8..7. Additional help for the most vulnerable children.
5.8..8. Implement a whole school approach to mental health – from promotion to prevention to early intervention to accessing specialist help. Improve help for those with special educational needs who often face huge challenges in getting access to the care they need.
5.8..9. Adequately trained and funded in-house staff at schools, who can offer psychological help.
5.8..10. Ensure fair funding for all schools.
5.8..11. Immediately reduce testing and pressures on teachers and children to perform academically and value other forms of learning and life skills.

[27] https://parentinfantfoundation.org.uk/1001-days/

5.8..12. Local Education Authorities (LEAs) to have reinstated responsibility for planning and oversight of all schools in their area.

Higher education and training

5.8..13. Better transition from child to adult mental health services – finally operationalise 0-25 years pathways which have been spoken about for years but not realised.

5.8..14. Children in care are one of the most vulnerable groups of young people. There needs to be a continuity of social worker and other professionals. Better fostering and adoption support, particularly those who have been through adoption trauma.

5.8..15. Students in further and higher education are vulnerable and there have been reports of increased suicide rates in students. Better university support, pastoral care and access to rapid help are needed and the financial burden on student's needs to be removed – end student loans and return to a grant system.

Specialist help

5.8..16. Child and Adolescent Mental Health Service (CAMHS) assessments should be rapid but to achieve this a skilled, well-resourced and safe workforce is required.

5.8..17. Specialist treatment options should be within a reasonable distance of home.

5.8..18. There should be crisis supports such like the May Tree in London, which have ready and multiple access.

5.8..19. Good quality drug and alcohol services with a focus on mental health

5.8..20. Tackle the gambling industry to reduce those young people falling into addiction and debt. Ensure that all industries associated with addictive behaviour that is linked to ill health (alcohol, smoking and gambling) are properly taxed, regulated and meet their corporate social responsibilities.

5.8..21. Make the internet and social media a safer place for children, working with big tech and information technology companies.

5.9. In respect of perinatal mental health:

5.9..1. Most mothers and pregnant women encounter a range of practitioners during the perinatal period. It is important for all services working with pregnant women and new mothers to provide a non-judgemental and welcoming space for women to voice mental health concerns. Maternal mental health training for GPs, other primary care staff, midwives, health visitors and maternity service can improve early intervention and reduction in inpatient admission for perinatal mental health problems[28]. However, cuts to statutory services, for example health visiting and family services, have limited the extent to which services have the capacity and resources to address mental health as part of the maternity pathway[29]. It is easy for mental health concerns to be missed.

5.9..2. We know, for example, despite being part of GP contracts, only 15% of mothers surveyed by NCT reported having an appointment that was focused on their own health and wellbeing.

5.9..3. Recent research reported that health visitors feel they do not have the time to assess parent-child interaction and lack confidence in the area of parent-infant relationships and mental health due to poor or insufficient training[30].

[28] Hogg, S (2013) Prevention in mind - All Babies Count: Spotlight on Perinatal Mental Health. London NSPCC. Available from: https://maternalmentalhealthalliance.org/wp-content/uploads/NSPCC-Spotlight-report-on-Perinatal-Mental-Health.pdf

[29] Papworth, R. et al. (2021) Maternal mental health during a pandemic. Available from: https://maternalmentalhealthalliance.org/wp-content/uploads/CentreforMH_MaternalMHPandemic_FullReport.pdf

[30] Barlow, J. (2022). Specialist Health Visitors in Perinatal and Infant Mental Health.

5.9..4. Ensuring that women feel safe to voice their concerns is profoundly important in perinatal mental health. Many women are simply not given the space to speak about their mental health by health professionals during the perinatal period. The MATRIx study[31] noted that inadequate workforce in perinatal services often led to rushed or dismissive staff and care being delivered in a 'tick box' way that discouraged women from disclosing mental health concerns. This evidence and the resulting recommendations should be taken into consideration in the 10 Year Plan.

5.9..5. The 10 Year Mental Health Plan should aim specifically to tackle stigma in maternal mental health, making it easier for women find the help they need and ensure that women get the time, space and sense of safety to disclose distress.

5.9..6. The Plan should make it clear that maternal mental health is the business of all health professionals involved in the perinatal period and, as per NICE guidelines, professionals should make a safe space for women to share and ask specifically about a woman's emotional wellbeing at every contact.

5.9..7. A system that supports the mental health of all women in the perinatal period must embed mental health competency and support across services: maternity services, health visiting, primary care, child and family social services, and public health approaches. These services are as vital to many women's mental wellbeing as specifically targeted mental health provision, and are critical to early detection, intervention and ongoing wellbeing monitoring. Whilst there has been some investment in perinatal mental health care, especially in specialist services, this will not be appropriate for all women. Furthermore, there is evidence of cuts in recent years to some services for women and families during the perinatal period, meaning comprehensive perinatal mental health support is not always available.

5.9..8. A 2022 LSE report into 'The economic case for increasing access to treatment for women with common mental health problems during the perinatal period'[32] noted that 'developing a model of service delivery in which mental and physical health care are integrated into the work of maternity and health visiting services generates nearly half a billion pounds of net benefit over a ten-year period.'

6. How can we improve the quality and effectiveness of treatment for mental health conditions?

6.1. This section also invites the consideration of the following questions:

- What needs to happen to ensure the best care and treatment is more widely available within the NHS?
- What should be our priorities for future research, innovation and data improvements over the coming decade to drive better treatment outcomes?
- What should inpatient mental health care look like in 10 years' time, and what needs to change in order to realise that vision?

6.2. Members highlighted how much more work is needed to significantly decrease the number of out-of-area placements, where people are forced to move significant distances from their family and friends to receive treatment. This has a deleterious impact on people's recovery with considerably more costly. This could be in part achieved by increasing NHS provided bed numbers and reduced reliance on more costly private provision

[31] The MATRIx Study (2022). Available from: https://www.matrixstudy.org/_files/ugd/7f09ad_5e78709dd0e24deda9af3f505235924c.pdf

[32] Bauer, A. et al. (2022) Increasing access to treatment for common maternal mental health problems could have a net benefit of half a billion pounds. London: LSE. Available from: https://www.lse.ac.uk/News/Latest-news-from-LSE/2022/b-Feb-22/Increasing-access-to-treatment-for-common-maternal-mental-health-problems-could-have-a-net-benefit-of-half-a-billion-pounds

6.3. In the week that included the deadline for submissions of responses to this call for evidence, The Guardian highlighted how desperate the situation is for some people in England by reporting on what is believed to be the longest wait in A&E ever endured by someone experiencing a mental health crisis, over eight days. The charity Mind correctly identified this as 'unacceptable, disgraceful and dangerous'[33]. Whilst this is an 'extreme case', many suffer unacceptable waits below this.

6.4. Allow for adequate training and research in NHS settings in order to improve mental health treatments and interventions. Ensure that co-produced research with survivors and people with lived experience becomes the norm. Move towards a national strategy around proper and meaningful trauma informed care within mental health services.

6.5. Ensure that there is adequate research into therapeutic offers for people impacted by childhood trauma and adult adversity. Ensure that research culture is built into every NHS organisation and is properly funded and valued.

6.6. Too many people have died following restraint in mental health units, and people from black and minority ethnic groups are disproportionately affected. It was welcome that after years of campaigning, the Mental Health Units (Use of Force) Act 2018[34] came into force earlier this year however it is important to assess its impact over the short and medium term ensuring that it addresses the issues it was created to address.

6.7. Our mental health nurses members highlighted how important the maintenance and development of pre-registration mental health nurse education is. They also described their concerns of how they feel this may be at risk including highlighting concerns around the list of proficiencies in the current Nursing & Midwifery Council (NMC) standards[35].

6.8. In respect of perinatal mental health:

6.8..1. There is clear, compelling evidence that the first 1001 days, beginning in pregnancy, are a significant and influential phase in development. What happens during this period lays the foundation for every child's future mental health and wellbeing.

6.8..2. Everyone who comes into contact with women before, during or after pregnancy has the opportunity to provide mental health support. The plan needs to ensure that women, new parents, babies and families can access a system of maternal mental health care[36].

6.8..3. We know that there are significant inequalities in how women from different backgrounds experience services. For example, research by the MMHA and Centre for Mental Health[37] identified that PMH needs increased across the board during the pandemic. However, the impact has not been equal, women and families of colour and poorer families have been amongst the most adversely affected. We also know that incidence and severity of domestic abuse increased during the pandemic and is particularly prevalent during pregnancy.

6.8..4. A statement by the Royal College of Obstetricians & Gynaecologists describes how racial bias plays a part in poorer outcomes: "it can negatively influence diagnosis and

[33] https://www.theguardian.com/society/2022/jul/04/woman-suffering-mental-health-crisis-left-waiting-eight-days-in-ae
[34] https://www.legislation.gov.uk/ukpga/2018/27/contents/enacted
[35] https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/
[36] https://maternalmentalhealthalliance.org/campaign/make-all-care-count/
[37] Papworth, R. et al. (2021) Maternal mental health during a pandemic. Available from: https://maternalmentalhealthalliance.org/wp-content/uploads/CentreforMH_MaternalMHPandemic_FullReport.pdf

treatment options made by clinicians, including pain management, and indirectly affects medical interactions through loss of patient-centeredness in treatment plans and removal of patient autonomy"[38]. This can lead to a 'feedback cycle' where people from Black, Asian and Minority Ethnic backgrounds might be less likely to interact with healthcare professionals through fear of potential prejudice and discrimination following poor experiences, or a perception of poorer care.

6.8..5. Some women face additional barriers to accessing information and support. Language barriers affect large numbers of women whose communication with health professionals is impaired by a lack of mutual understanding, leading to poor care experiences and worse outcomes[39]. Women from migrant groups face barriers including a lack of personal resources and a lack of information about how the NHS works. Research has also found that women seeking asylum experience prejudice and discrimination, for example by being refused by reception staff[40].

6.8..6. All services should understand and address how trauma, domestic abuse, addiction, deprivation and discrimination impact on fear of child removal and therefore women's engagement with professionals.

6.8..7. A confident, well-equipped workforce is a key element of ensuring all women and families across the UK have equitable access to comprehensive high-quality PMH care.

6.8..8. The plan should detail a clear workforce strategy, supported by sufficient resource which includes details on how current staffing shortages will be addressed. This strategy should also include a commitment for all professionals involved in the care of women during pregnancy and the first years after birth to receive ongoing training in PMH care, including trauma-informed care.

6.8..9. In addition to NHS mental health services, Government must also attend to the workforce capacity and service sufficiency in other universal and targeted services, such as health visiting.

6.8..10. Data on the mental and physical health of women during the perinatal period should be collected and published. This should include data on the uptake of PMH services, types of interventions received, the number of women assessed, referred and supported by midwifes and health visitors and other professionals, such as general practice staff, with regard to women's mental health, deaths from all causes, and hospital admissions.

6.8..11. Data must include robust monitoring across equality groups to identify inequalities in prevalence, experience and outcomes.

6.8..12. The NHS should also facilitate sharing and common data collection across services working with new and expectant mothers and families, including maternity, health visiting, mental health and children's services.

6.8..13. Covid-19 has brought about significant changes in the way mental health support is delivered and we do not yet know the long-term consequences of the pandemic. The use of remote support and digital technologies became more prominent in a several health and care contexts. Going forward, the impact of 'remote' mental health care on mothers must be better understood[41].

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[38] Royal College of Gynaecologists (2020) Position Statement: Racial disparities in women's healthcare. Available from: https://www.rcog.org.uk/media/qbtblxrx/racial-disparities-womens-healthcare-march-2020.pdf

[39] Van Rosse, F. et al. (2015) Language barriers and patient safety risks in hospital care. A mixed methods study. Available from: https://pubmed.ncbi.nlm.nih.gov/25840899/

[40] Maternity Action (2012) Guidance for commissioning health services for vulnerable migrant women. Available from: https://www.maternityaction.org.uk/wp-content/uploads/2013/09/guidancecommissioninghealthservvulnmigrantwomen2012.pdf

[41] Papworth, R. et al. (2021) Maternal mental health during a pandemic. Available from: https://maternalmentalhealthalliance.org/wp-content/uploads/CentreforMH_MaternalMHPandemic_FullReport.pdf

7. **How can we all support people living with mental health conditions to live well?**

7.1. This section also invites the consideration of the following questions:

- What do we (as a society) need to do or change in order to improve the lives of people living with mental health conditions?
- What things have the biggest influence on your mental health and influence your quality of life?
- What more can we do to improve the physical health of people living with mental health conditions?
- How can we support sectors to work together to improve the quality of life of people living with mental health conditions? What can we change at a system level to ensure that individuals with co-occurring mental health and drug and alcohol issues encounter 'no wrong door' in their access to all relevant treatment and support?

7.2. Once again, ensuring that people have enough money to live on, somewhere safe and secure to live, are socially connected and included in their local community, that their community feels safe, they are engaged in meaningful activity and that they have a sense of hope, are all key ingredients for any of us to live well.

7.3. The Money and Mental Health Policy Institute has done excellent work in both identifying issues though their research; for example, 58% of people were not offered any support with their finances while under the care of secondary mental health services and 81% said their crisis or relapse prevention plan did not mention finances[42], and their campaigning, for example in relation to 'debt threats'[43]. We commend their work to this call for evidence.

7.4. Whilst the current 'cost of living' crisis has impacts across our society, it also has a dramatic negative effect on people who work in the health service. We are being contacted by increasing numbers of members who are reporting that they are finding it much more difficult to cope month on month. The government could quickly make a difference in this by matching trade union demands for a restorative pay award for all NHS staff as part of an urgent retention package. NHS workers in England have suffered real terms pay cuts and pay freezes for the past 12 years and have seen, in many cases, pay drop by around a fifth in real terms since 2010[44].

7.5. Whilst it is commendable that charities and some employers, including at least six NHS trusts, have stepped in to support health staff with food banks or food voucher schemes to survive, Gordon Brown was correct in calling this a 'humanitarian issue'[45].

7.6. More adequate help for those impacted by trauma is vital as this is also recognised to be associated with health harming behaviours and earlier mortality. Adequately research what helps people who are impacted by addiction, and take a 'health lens' to this area, to reduce criminalisation of addiction.

[42] https://www.moneyandmentalhealth.org/how-mental-health-act-reform-could-prevent-financial-difficulty-for-people-with-severe-mental-illness/
[43] https://www.moneyandmentalhealth.org/press-release/debt-threats-campaign-victory/
[44] Unite evidence to the National Health Service Pay Review Body (NHSPRB) 2022-23
[45] https://www.mirror.co.uk/news/politics/low-income-nurses-forced-queue-27171976

7.7. Social inclusion is key to reducing the harms of being minoritized, stigmatised and this is a civil rights issue.

Smoking and mental health

7.8. Unite's health sector is a member of the Mental Health and Smoking Partnership[46] which highlights in its ambition that most smokers who have a mental health condition want to quit and it's vital that they receive the services and support they need to quit.

7.9. Smoking is a leading cause of the 7–25 year reduced life expectancy among people with mental health conditions. It makes people poorer and less likely to be employed, which increases the likelihood of poor mental health[47]. In a recent report, 'Public mental health and smoking: A framework for action', makes several recommendations which we commend to this call for evidence:

7.9..1. A new Tobacco Control Plan focused on tackling smoking in all people with a mental health condition, through targeted investment and effective data monitoring systems, underpinned by targets for reduced smoking prevalence in this population

7.9..2. Nationally, Improving Access to Psychological Therapies (IAPT) services should include support for smokers to quit, to improve both mental and physical health outcomes.

7.9..3. National communications activity on promoting positive mental health should include messages about the benefits of stopping smoking and avoiding starting. Similarly, national 'stop smoking' communications should include information on the benefits to mental health.

7.9..4. Coproduction with service users locally should be supported to resource peer support workers using QI (quality improvement) methodology, to maximise signposting to help and quit rates.

7.9..5. Major gaps in the data must be addressed. Data is needed to monitor smoking rates across all populations with a mental health condition, to measure the provision of evidence-based support and the outcome of treatment.

7.10. Smoking contributes directly and indirectly to the burden of poor mental health in society through increasing risk of some mental health conditions and contributing to circumstances which lead to poor mental health such as ill health and poverty.

7.11. Action to address smoking for individuals and the population will reduce the burden of mental ill health in society and improve the wellbeing of people living with mental health conditions. Targeted action within mental health services and wider action across the population can secure change

7.12. The Government ambition is for smoking to be at less than 5% by 2030. As current rates of smoking are much higher among people with mental health conditions there is a risk that those still smoking by 2030 will be concentrated in the mental health population exacerbating the health inequalities and the stigma already experienced by this population.

7.13. The 10 Year Mental Health Strategy can contribute to the change needed but setting aspiration for lower smoking among people with mental health conditions and noting the action needed to achieve this.

[46] https://smokefreeaction.org.uk/smokefree-nhs/smoking-and-mental-health/
[47] https://ash.org.uk/wp-content/uploads/2022/06/Public-mental-health-and-smoking.pdf

7.14. The 10 Year Mental Health Strategy should heed the recommendation of the Independent Review of tobacco, the Khan Review[48] to "*Tackle the issue of smoking and mental health. Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training. And make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care.*"

8. How can we all improve support for people in crisis?

8.1. This section also invites the consideration of the following questions:

- What can we do to improve the immediate help available to people in crisis?
- What would enable local services to work together better to improve support for people during and after an experience of mental health crisis?
- What 'values' or 'principles' should underpin the plan as a whole?
- How can we support local systems to develop and implement effective mental health plans for their local populations? How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?
- What do you think are the most important issues that a new, 10-year national mental health plan needs to address?

8.2. There is much which can be done to prevent crisis such as tackling the social determinants of health. As previously described, debt is a significant driver of mental ill health. More services are needed to help people deal with debt.

8.3. Further suggestions were made by members:

8.3..1. It is important to take up the Marmot recommendations, which includes community development.

8.3..2. There should be tighter regulation of activities, like alcohol consumption and gambling, that are known to have a damaging relationship with poor mental health

8.3..3. Commit to properly tackling Violence Against Women and Girls, including intimate partner violence.

8.3..4. Ensure equity of access to mental health care but in culturally acceptable ways, which reduce the need for crisis care.

8.3..5. Reduce restrictive practices which are used disproportionately against black and ethnic minority people and have led to many deaths. This includes the use of tasers and prone restraints.

8.3..6. Commit to properly tacking the drivers of suicidal behaviour, which includes pressures upon men and stereotyping, financial pressures, minoritized status and social exclusion, abuse and violence.

8.3..7. Trauma informed care is needed – the prevention of abuse, and adequate help for those who have been harmed is key in reducing mental distress.

8.3..8. Trauma informed principles must be built into all services and into the fabric of public life. The provision of universal health, education and social care, free at the point of access and not dependent on financial means, would mean not only equity of access – we should pay attention to equity of outcomes.

8.3..9. Community development - mental health is moderated through strong and supportive social networks. It is vital to commit to community development, which enhances

[48] https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete/making-smoking-obsolete-summary

relational wellbeing, participation in the community and reduces loneliness. Invest into the arts, culture and sport to increase public health.

In terms of priorities, there must be a multi-layered approach to mental healthcare, rather than attempts to reduce what is complex to something which has a simple and single answer. However, ensuring that the income gap between the wealthiest and poorest in society is one of the most compelling ways in which to improve population mental health. There Govt needs to close the gap between its stated intentions to level up and improve the circumstances of the most vulnerable in society, and the actions which follow. Promises made, need to be kept.

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