Mind: The Lived Experience of Mental Health

On behalf of Mind from YouGov

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Introduction

This report summarises findings from research conducted by YouGov on behalf of Mind, with the purpose of gathering lived experience insights to inform the upcoming government 10-Year Mental Health Plan. The research aimed to ensure the voices and perspectives of people with lived experience of mental health problems are featured prominently in decision making. The research explored areas including: experiences of mental health support and service provision; the needs, preferences and priorities of people with lived experience of a mental health problem; and how experiences differ among different groups within the population.

The research consisted of four elements:

- A quantitative survey of adults with a diagnosed mental health problem;
- A quantitative survey of young people (aged 14-15);
- An online qualitative community with adults with lived experience of a mental health problem and;
- Depth interviews with young adults with learning disabilities as well as lived experience of a mental health problem.

Throughout the research, there was a focus on the experiences of groups who are at higher risk of experiencing mental health problems. Mind identified six priority groups who were of particular interest and relevance to the research. These were:

1. Black (African or Caribbean) people
2. LGBTQI+ people
3. People with severe mental illness
4. Young people with a learning disability
5. Young women who have experienced trauma
6. People living in poverty

Promoting positive wellbeing and preventing the onset of mental health problems

Many factors can affect mental health, both positively and negatively, and promoting good wellbeing in general is likely to have a positive impact on mental health.

Most commonly, people cite relationships, traumatic experiences, and loneliness and isolation as factors which have had a *negative* impact on their mental health, while many also mention physical health, body image and employment issues. Fewer respondents cite stigma and discrimination (e.g. racism, homophobia, sexism), as a factor, but the proportion doing so rises among relevant groups such as Black adults and LGBTQI+ respondents.

Highlighting the role relationships can also play in maintaining positive mental health, three in five say that having supportive relationships has had a *positive* impact on their mental health. This is followed by hobbies and interests, having a good understanding of someone's own mental health, and feeling comfortable talking about mental health. This strongly highlights the importance of open and destigmatised discussions around mental health.

Many of those we spoke to in the qualitative community comment that their poor quality of life when it comes to relationships, housing and employment has a significant impact on their mental health. Most are facing multiple issues and marginalisation simultaneously, which exacerbate existing mental health problems. Whilst understanding of individual triggers and how they can help themselves is high, often their conditions impede them from putting steps in place to improve their own wellbeing.

Earlier intervention

Over half of adults with lived experience selected 'providing early support for mental health problems' as a top priority area for the Government to address within the field of mental health, demonstrating the importance of early intervention.

Across the priority groups in the qualitative research, preventative measures (i.e. early support and quick diagnostic processes) were preferred over reactive solutions and treatment that tended to come once that their mental health had worsened. Many had only been able to access support once they had reached crisis point, which often meant their needs were complex and acute. Participants felt that care should be preventative, holistic, compassionate and consistent.

Quality and effectiveness of treatment

When considering issues to address within the sphere of mental health, adults with lived experience are most likely to suggest 'improving access to services' as a focus area, with two-thirds of respondents selecting this.

Among adults with lived experience of a mental health problem, most sources of treatment, advice and support are seen as helpful by those who have accessed them. Private healthcare providers or counsellors are considered more helpful than NHS mental health services or counsellors. Whilst the majority say that NHS mental health services or counsellors are helpful, a fifth found these unhelpful, which could act as a barrier to people seeking treatment again. Notably, young women with experience of trauma were less likely than other respondents to feel that many sources of support were helpful, including GPs and NHS mental health services/counsellors.

When accessing mental health treatment, advice and support, the most common issues are: long waiting times; being embarrassed or ashamed to reach out for treatment and support; a lack of treatment and support options available, and support available not being relevant or suitable.

A key issue emerging from the research for this group is not feeling supported during the process of accessing treatment – an issue which is more common among: those with severe and enduring conditions; young people with a learning disability; young women with experiences of trauma; LGBTQI+ people, and those living in poverty.

Participants in the qualitative research also mentioned dismissive health care professionals, inconsistent care and incorrect diagnoses. Those with additional needs or vulnerabilities (e.g. learning disabilities or severe and enduring mental health problems) are more likely to have a negative experience due to a lack of tailored options and strained services which mean that healthcare professionals do not have the extra time needed to dedicate to understanding their situation and helping them to feel heard.

Among adults with lived experience of a mental health problem, a quarter say they have personally experienced substance misuse issues. This is almost twice as likely among those with experience of trauma than those without such experience, and also more common among those living in poverty.

Among those with lived experience of substance misuse issues, over half say that they experienced barriers as a result of this when accessing treatment, support or advice for their mental health. The issues most commonly experienced are: being blamed for health issues due to substance misuse; healthcare professionals attributing wider mental health issues to substance misuse; and stigma related to substance misuse.

Support beyond mental health

There is a complex interaction between mental and physical health, with both of these able to negatively or positively affect the other.

Half of those with lived experience of a mental health problem state that greater continuity of care for people with mental health problems (for example being able to see the same GP regularly) would have a positive impact on physical health, and over two-fifths say that improving the ability to discuss physical health alongside mental health would have a positive impact. Continuity of care is a particular priority for those living in poverty. Taken together, the results suggest that the distinction between mental and physical health can be experienced as restrictive or unhelpful by patients.

Crisis support

Over half of adults with lived experience selected ‘supporting people in need of immediate care or experiencing a mental health crisis’ as a top priority area for the Government to address within the field of mental health, demonstrating the importance of this area.

A mental health crisis is defined as when someone feels at breaking point and needs urgent help. This could include feeling extremely anxious and having panic attacks or flashbacks, feeling suicidal or self-harming, having an episode of hypomania or mania, and psychosis. When asked, around two-fifths of adults with lived experience of a mental health problem say they have experienced a mental health crisis. This is more common among those in lower income groups and those with a background of trauma.

In the view of those with lived experience, the three most helpful ways to support those in need of crisis care are shorter waiting times; better treatment and support before reaching a crisis point, and increased treatment or support options available, including follow-up support.

Key conclusions and recommendations

Mental health can be affected by many factors, which interact in complex ways, and these should be viewed holistically rather than considering mental health as an issue in isolation. Actions to improve other aspects of people's lives, such as promoting healthy relationships, promoting good physical health, and combating stigma and discrimination, are also likely to have a beneficial impact on mental health.

When accessing mental health treatment, common issues include long waiting times, being embarrassed or ashamed, a lack of treatment and support options available, and support available not perceived as relevant or suitable. There could be value in producing communications that inform people about mental health treatment and support, who it is suitable for, and how it could be relevant to them.

Given the varied experiences of those with lived experience of a mental health problem, there is a necessity for a tailored approach for individuals, as opposed to 'one-size-fits-all'. This is particularly key for people with co-occurring conditions, those who have experienced trauma, and marginalised groups. Additionally, for those in marginalised groups, support needs to be culturally sensitive with an understanding of how they may have been impacted in other facets of their lives due to their identities.

Those with additional needs or vulnerabilities, such as learning disabilities or severe and enduring mental health problems, are more likely to have a negative experience of mental health treatment due to lack of tailored options, and time-pressured services. This highlights a need to ensure sufficient time is allocated to those living with disabilities, in order to better explain medication and ensure understanding.

Support for those in poverty with mental health problems needs to take account of the multiple stressors that may exacerbate their mental health problems, such as housing and employment pressures. A multi-disciplinary approach, with signposting to other support organisations, will help to ensure that such individuals can fully benefit from treatment.

The findings suggest that the distinction between mental and physical health can be experienced as restrictive or unhelpful, with many saying that the ability to discuss physical health alongside mental health would have a positive impact on their physical wellbeing. As highlighted earlier, improving physical wellbeing is also likely to improve mental health, and it would be beneficial to consider different aspects of health more holistically.

The recommendations outlined above can also be expected to contribute to the improvement of crisis care: a more tailored, personal and holistic approach in primary care, and delivering care with a more long-term focus and with more follow-up, may act preventatively, making it less likely that a crisis point will be reached.

2 Introduction

The upcoming government 10-Year Mental Health Plan will aim to improve the nation's mental health and wellbeing and address disparities across the population. The Department for Health and Social Care (DHSC) ran a 12-week consultation seeking evidence on areas including the causes of mental ill-health, the experiences of mental health service users, effectiveness of different approaches, and how experiences differ among different groups within the population. The responses to this consultation, along with this research, will inform and support the development of commitments within the new Mental Health Plan.

This report presents the findings of a study conducted in May - June 2022 which explored mental health among both adults and young people (aged 14-15), covering a range of topics from experiences of mental health treatment and support and factors influencing mental health, to mental health in the workplace and substance misuse. The research was conducted by YouGov on behalf of Mind.

Content warning: this report covers discussion of mental health issues including: suicide; self-harm; eating disorders, and substance misuse, and on experiences of discrimination including: racism, homophobia, and transphobia.

Method

The research consisted of four elements:

1. A quantitative survey of adults with lived experienced of a mental health condition, including coverage of certain priority groups who were of particular interest to Mind and DHSC (outlined below)
2. A quantitative survey of young people (aged 14-15)
3. An online community with adults with lived experienced of a mental health condition who fell into the priority groups
4. Depth interviews with a specific priority group: young adults with learning disabilities and lived experienced of a mental health condition

Priority groups

A key objective of the research was to explore disparities between groups within the population and the experiences of groups who are at higher risk of experiencing mental health problems. To support this objective, Mind identified the following six priority groups who were of particular interest and relevance to the research. These were:

1. Black (African or Caribbean) people
2. LGBTQI+ people
3. People with severe mental illness
4. Young people with a learning disability
5. Young women who have experienced trauma
6. People living in poverty

These groups were included in both the quantitative and qualitative strands of the research, with some minor differences to the definitions used for certain groups. Details of each phase of the research, including the definitions used for the priority groups, are included below.

Quantitative survey of adults (aged 16+)

YouGov conducted a survey of adults (aged 16+) with lived experience of a mental health condition. The sample was sourced from the YouGov panel. The sample group comprised people who had been diagnosed with a mental health condition (i.e. excluding those who had only self-diagnosed). This sampling strategy was chosen based on practicality and efficacy: YouGov had access to a pool of respondents who were already known to have been diagnosed with a mental health condition, while the same was not true for self-diagnosis. Additionally, published data from the Adult Psychiatric Morbidity Survey (APMS) could be used to ensure a sample of diagnosed individuals was broadly representative of the overall group in question, whereas this data does not cover those who have self-diagnosed.

Fieldwork was carried out online between 31st May and 20th June 2022. The total sample size was 4,139 UK adults with lived experience of a diagnosed mental health condition.

The data has been weighted to be representative of this group by gender and age. Weighting adjusts the contribution of individual respondents to aggregated figures and is used to make surveyed populations more representative of a project-relevant, and typically larger, population by forcing it to mimic the distribution of that larger population's significant characteristics. The weighting tasks happen at the tail end of the data processing phase, on cleaned data.

In this case, information on the age and gender profile of people diagnosed with a mental health condition was taken from the APMS, and used to ensure that the final data reflects the overall population of those with lived experience of a mental health condition, according to these factors.

Details of the unweighted and weighted sample are shown in the table below.

Table 1: Adult survey sample breakdown

	Unweighted n	Weighted n
Age		
16-34	1,239	1,407
35-44	808	745
45-54	868	786
55-64	704	662
65+	520	538
Gender		
Male	1,454	1,614
Female	2,685	2,525
Social grade[1]		
ABC1	2,262	2,276
C2DE	1,877	1,863
Total sample	**4,139**	**4,139**

Table 2 below shows how each of the six priority groups was defined in the quantitative survey, and the number of interviews achieved with each of these groups.

[1] Social grade is a classification system based on the occupation of a household's chief income earner. Developed by the National Readership Survey (NRS), it has been the research industry's source of social-economic classification for over 50 years. The categories are: A (Higher managerial, administrative and professional); B (Intermediate managerial, administrative and professional); C1 (Supervisory, clerical and junior managerial, administrative and professional); C2 (Skilled manual); D (Semi-skilled and unskilled manual); E (State pensioners, casual and lowest grade workers, unemployed with state benefits only). For analysis purposes, the report groups the categories together into ABC1 and C2DE, allowing key comparisons to be made.

For these groups, we estimated at the project design stage the approximate numbers that were expected to fall naturally out of a sample of 4,000 adults with lived experience. In most cases, the expected numbers were robust and adequate for analysis purposes. In the case of Black adults, as well as young people with a learning disability, it was anticipated that sample numbers were likely to be low. For these groups, we attempted to maximise the achievable numbers from our panel. In the case of young people with a learning disability, we aimed to achieve at least 50 responses, and that target was met successfully. However, for Black adults, we aimed to achieve at least 100 interviews, but ultimately were only able to achieve 67.

Table 2: Priority groups – definitions and achieved numbers

Priority group	Definition used	Achieved n (unweighted)
1. Black adults	Age 16+ and ethnicity is Black African, Black Caribbean or Black Other	67
2. LGBTQI+	Age 16+ and identify as LGBTQI+	1,073
3. People with severe mental illness	Age 16+ and diagnosed with bipolar, personality disorder, psychosis, schizoaffective disorder or schizophrenia	639
4. Young people with a learning disability	Age 16-30 and diagnosed with a developmental disability (e.g. Down's syndrome)	53
5. Young women who have experienced trauma	Women aged 16-30 who said yes to this question: *Examples of traumatic events include having a serious accident, serious health problems, racism, abuse or experiences of violence, or witnessing a violent death (amongst others). Based on this information, have you ever experienced trauma?*	474
6. People living in poverty	Age 16+ and with a household income of less than £20,000 p.a.	1,228

Total sample	**4,139**	**4,139**

Quantitative survey of young people (aged 14-15)

YouGov conducted a survey of young people (aged 14-15). In contrast to the adults' survey, this sample was not selected based on lived experience of a mental health condition, but instead included those in this age group more generally. The sample was sourced from one of YouGov's panel.

Fieldwork was carried out online between 9th and 16th June 2022.

The total sample size of the young people survey was 1,072 14-15 year olds, and the data was weighted to be representative of this group by gender, age and region. Details of the unweighted and weighted sample are shown in the table below.

Table 3: 14-15s survey sample breakdown

	Unweighted n	Weighted n
Age		
14	432	536
15	640	536
Gender		
Male	556	536
Female	516	536
Region		
North	243	247
Midlands	176	171
East of England	101	96
London	124	139
South	243	246
Wales	56	54
Scotland	101	96
Northern Ireland	28	21
Total sample	**1,072**	**1,072**

Qualitative community and in-depth interviews

YouGov's qualitative research team ran a one-week online community with around 70 people with lived experience of mental health problems. We spoke with approximately 12 people from each of Mind's priority groups below, and an additional number of Black African-Caribbean people – up to 17.

This was followed by conducting five additional one-to-one interviews with young adults with learning disabilities, to ensure that the research was accessible and inclusive, irrespective of digital confidence.

The definitions of the priority groups, as applied in the qualitative research, are as follows:

Table 4: Qualitative community sample breakdown

Priority group	Definition used
1. Black adults	Age 18+ and ethnicity is Black African, Black Caribbean or Black Other
2. LGBTQI+	Age 18+ and identify as LGBTQI+ (with a mix of sexualities and gender identities)
3. People with severe mental illness	Age 18+ and diagnosed with bipolar, personality disorder, psychosis, schizoaffective disorder or schizophrenia
4. Young people with a learning disability	People aged 18-25 and diagnosed with a developmental disability, learning difficulty, or speech and language disability.
5. Young women who have experienced trauma	Women aged 18-25 who said yes to this question: *Examples of traumatic events include having a serious accident, serious health problems, racism, abuse or experiences of violence, or witnessing a violent death (amongst others). Based on this information, have you ever experienced trauma?*
6. People living in poverty	Age 18+ and with a household income of less than £20,000 p.a., *and* said yes to the following statements: *I am falling short of a decent standard of living* *I can't afford to eat, keep clean, and stay warm and dry*

Quotations are attributed to one of the priority groups throughout this report, however many participants fit into multiple categories e.g. Black African-Caribbean, LGBTQI+ with a severe mental illness.

We spoke with people from a mix of ages, social grades and locations. In contrast to the quantitative survey of adults, those who had self-diagnosed mental health problems were included in the qualitative sample as well as those with a medical diagnosis, to provide a well-rounded insight into the varying nature of lived experiences of mental health problems, which often involve complex diagnostic processes.

3 NHS and government policy, strategy and prioritisation

Chapter summary

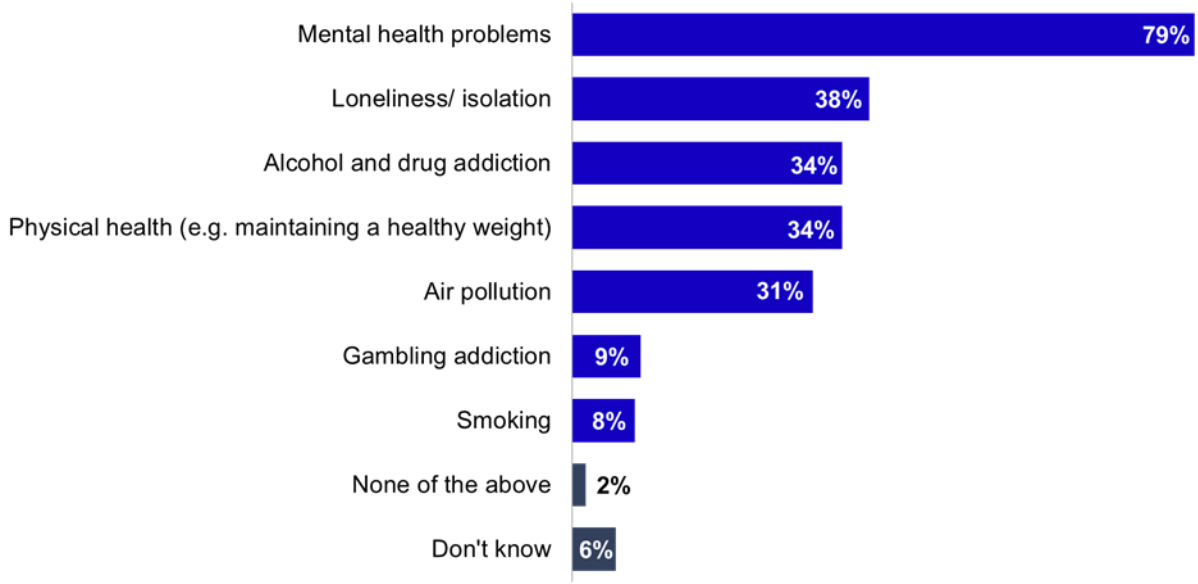
Adults with lived experience of a mental health problem are most likely to prioritise mental health among public health issues which the Government should tackle. Within the sphere of mental health, 'improving access to services' is most cited as a key focus area. The importance of crisis care and early intervention is also recognised, with a majority choosing 'supporting people in need of immediate care or experiencing a mental health crisis', and over half selecting 'providing early support for mental health problems'.

Once support is accessed, it is important that treatment is conducted with care, respect, compassion and skill, with recognition that individuals' experiences are unique and intersectional.

Overall public health priorities

When asked what health issues the Government in England needs to tackle most urgently, the vast majority (79%) of adults with lived experience of a mental health problem state mental health problems, demonstrating the importance of this issue to patients and service users. This is followed by those who say loneliness or isolation (38%), alcohol and drug addiction and physical health (both 34%).

Figure 1: Health issues UK Government needs to tackle



Base: All adults with lived experience of a mental health problem (n=4,139)

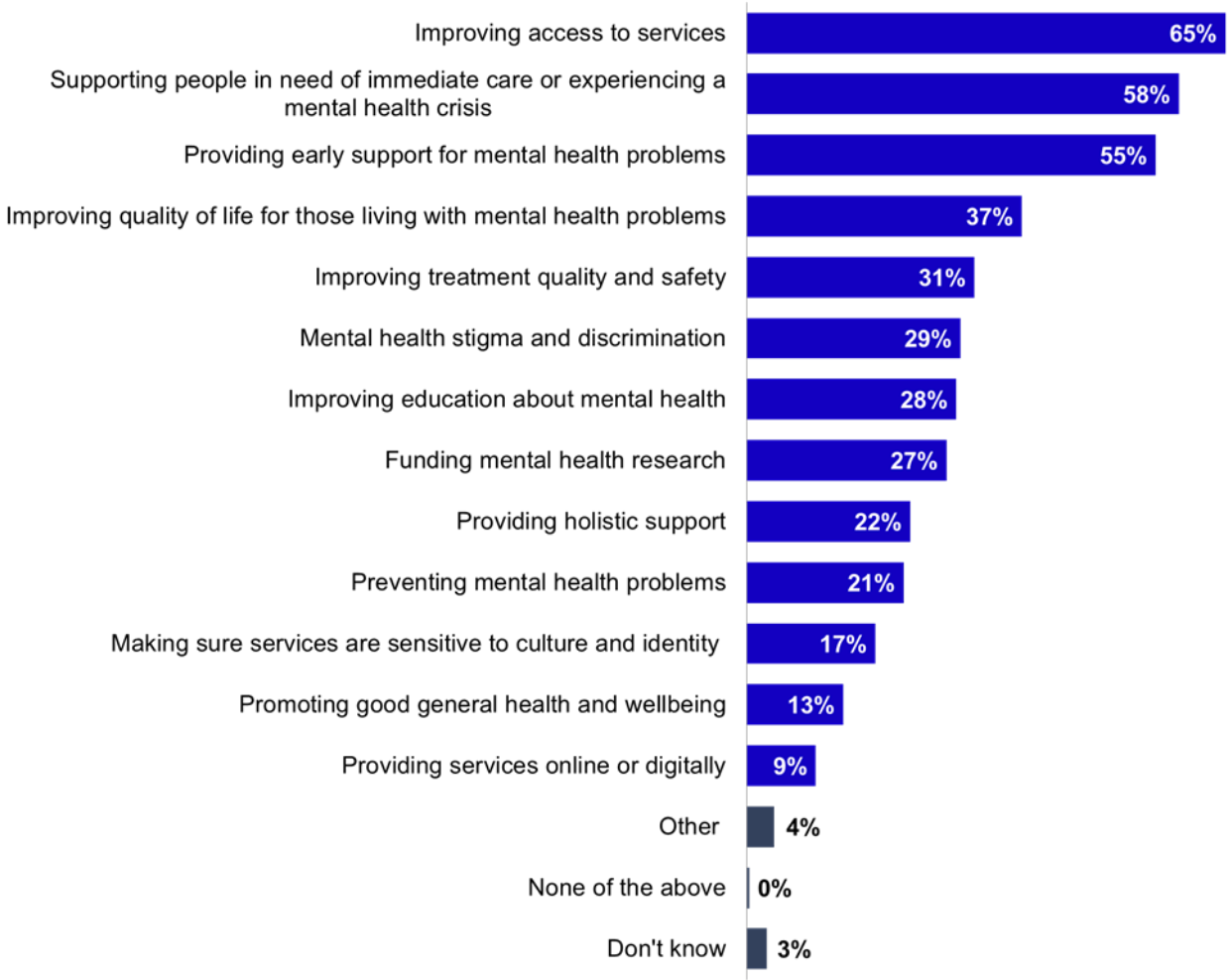
There is no significant difference between men and women and their likelihood to cite mental health problems. Younger and middle aged adults are slightly more likely to mention mental health problems than older adults (82% of 16-34 year olds and 80% of 35-44 year olds compared with 74% of those aged 55+). By contrast, older people are more likely to say alcohol and drug addiction than younger people, with 41% of 55+ year olds selecting this, compared with 32% of 16-34 year olds. Furthermore, young women (16-30) who have experienced trauma are more likely than those who have not experienced trauma to select loneliness or isolation as a top issue which needs tackling (44% vs. 35%).

Similarly, in the qualitative research, addressing mental health problems is believed to be a top issue that the government should address, along with the economy. The two issues are seen to go hand in hand – there is an understanding that a focus on the economy will trickle down into greater allocation of funding for mental health services.

Priorities in mental health strategy

In addition to asking which health issues the Government need to tackle urgently, people were also asked about important issues the Government ought to address in relation to mental health specifically. Approximately two-thirds (65%) of adults with lived experience of mental health problems cite ‘improving access to services’, making this the most common response. A majority (58%) also say ‘supporting people in need of immediate care or experiencing a mental health crisis’, with 55% selecting ‘providing early support for mental health problems’. Similarly, the qualitative findings highlight a need for greater immediacy, with early support and quick diagnosis.

Figure 2: Mental health issues Government need to address



Base: All adults with lived experience of a mental health problem (n=4,139)

Women are more likely to choose ‘improving access to services’ than men (69% vs. 58%), as well as issues relating to provision of support, including ‘supporting people in need of immediate care or experiencing a mental health crisis’ (62% vs. 52%) and ‘providing early support’ (58% vs. 51%). By contrast, men are slightly more likely to mention ‘improving quality of life for those living with mental health problems’ (40% vs. 36%) and ‘preventing mental health problems’ (23% vs. 20%).

There are also interesting differences between age groups: younger adults are more likely than older people to choose ‘preventing mental health problems’ (25% of 16-34 year olds vs. 19% of 55+ year olds) and ‘making sure services are sensitive to culture and identity’ (24% of 16-34 year olds vs. 15% of 55+ year olds). Older adults place more value on ‘holistic support’ (25% of those aged 55+ vs. 19% of 16-34 year olds) and ‘supporting people in need of immediate care or experiencing a mental health crisis’ (65% vs. 52%).

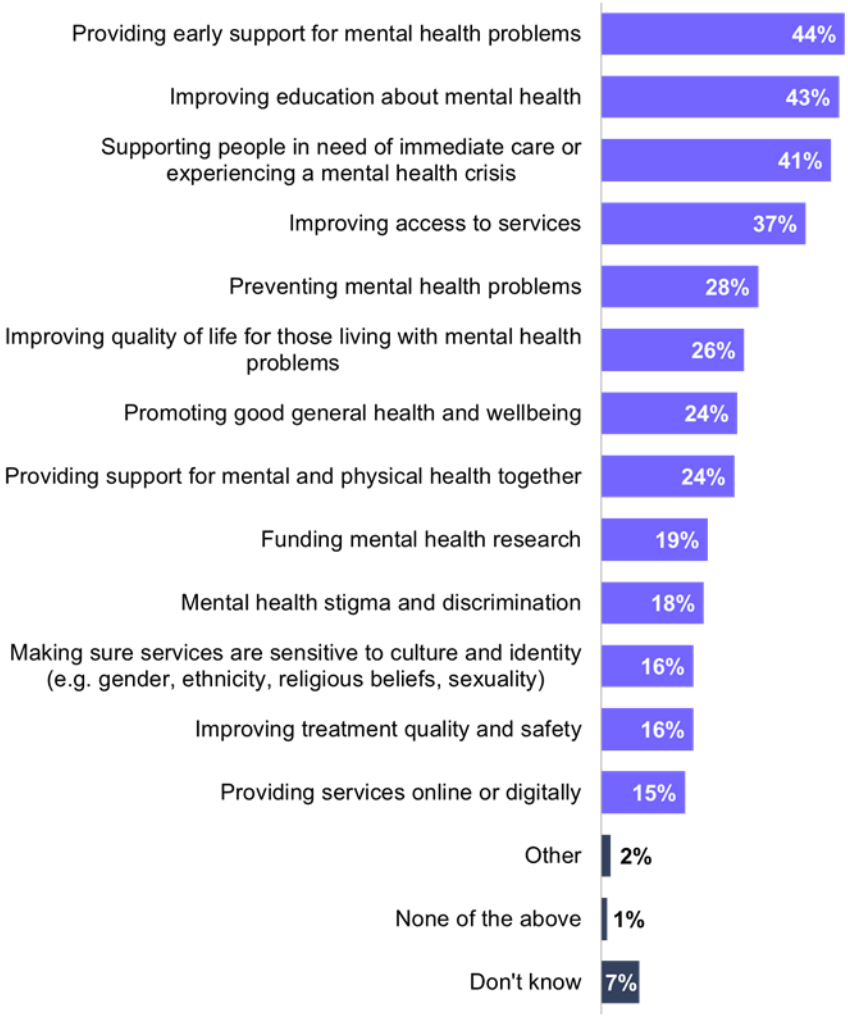
Further groups who are more likely to cite ‘making sure services are sensitive to culture and identity’ include young women who have experienced trauma, who are significantly more likely than those who have not experienced trauma to select this (28% vs. 16%), while Black adults are also twice as likely as White adults to say this is an important mental health issue the Government ought to address (44% vs. 17%).

Black people with lived experience of mental health problems are also significantly more likely to select ‘mental health stigma and discrimination’ than White people (45% vs. 29%). White people are more likely to select ‘improving access to services’ than Black people (65% vs. 43%).

Those living with a disability or long-term health condition are more likely than those who are not disabled to cite ‘improving quality of life for those living with mental health problems’ (42% vs. 27%).

Alongside the adults’ survey, 14-15 year olds were also surveyed on which issues related to mental health are most important for the UK Government to address. More than four in ten (44%) cite ‘providing early support for mental health problems’, with a similar number also believing that ‘improving education about mental health’ and ‘supporting people in need of immediate care or experiencing a mental health crisis’ are most important for the UK Government to address (43% and 41% respectively).

Figure 3: Health issues UK Government need to tackle



Base: All young people aged 14-15 (n=1,072)

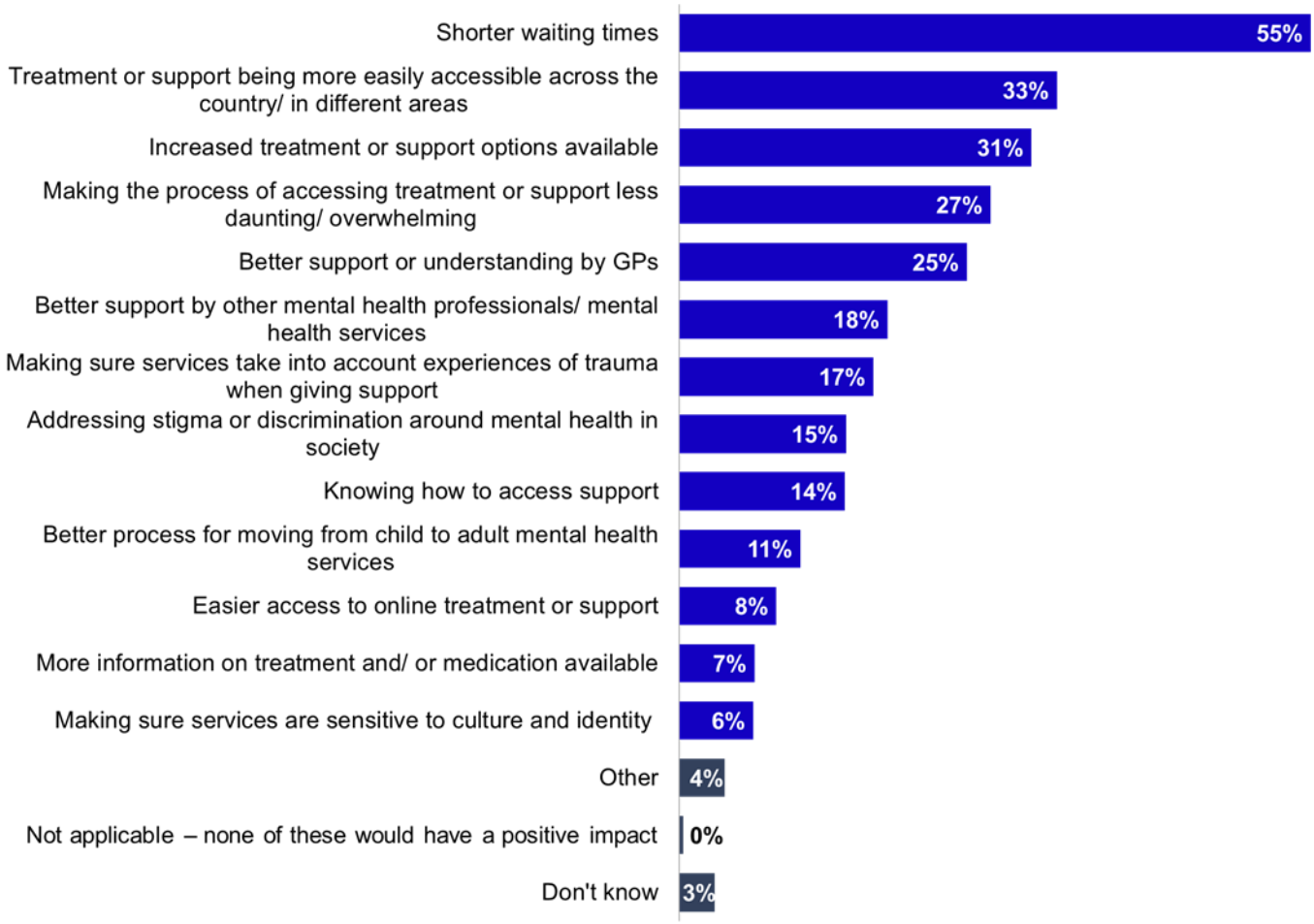
Among 14-15 year olds, girls were significantly more likely than boys to cite various issues relating to the improvement of services and provision of support. This includes 'improving access to services' (43% vs. 31%), 'improving education about mental health' (47% vs. 38%) and 'supporting people in need of immediate care or experiencing a mental health crisis' (45% vs. 37%).

Those 14-15 year olds who have personally experienced a mental health issue are more likely than those who have not to say that 'providing early support for mental health problems' (52% vs. 39%), 'supporting people in need of immediate care or experiencing a mental health crisis' (50% vs. 36%) and 'improving access to services' (45% vs. 37%) should be priorities, which could well reflect their lived experience.

Positive factors for mental health treatment and support

When asked “what would have the most positive impact on mental health treatment and support”, approaches related to increasing the provision of services are most popular. Indeed, a majority (55%) of adults with lived experience of a mental health problem say shorter waiting times would have the most positive impact, followed by a third (33%) who say treatment being more easily accessible across the country, and 31% citing increased treatment or support options being available. This follows on from the barriers people experience when accessing mental health treatment and support, with long waiting times coming out on top. Additionally, efforts to make support less intimidating are chosen by a sizable proportion of people with lived experience of a mental health problem. For example, 27% cite making the process of accessing support less daunting or overwhelming, with a similar proportion (25%) saying better support or understanding from GPs.

Figure 4: Initiatives which would have the most positive impact on mental health treatment



Base: All adults with lived experience of a mental health problem (n=4,139)

Younger people with lived experience of a mental health problem are more likely than older people to cite shorter waiting times as something that would have the most positive impact on mental health treatment and support. For example, 61% of 16-34 year olds state this, compared with 49% of 55+ year olds.

Unsurprisingly, Black people with lived experience of a mental health problem are more likely than White people to say that making sure services are sensitive to culture and identity would have the most positive impact on mental health treatment. Indeed, they were around four times more likely than White people to say this (24% vs. 6%). This is in conjunction with the earlier finding that Black people with lived experience of a mental health problem were more than twice as likely as White participants to state that making sure services are sensitive to culture and identity is an important mental health issue the UK Government needs to address.

Black people (28%) are also twice as likely as White people (14%) to mention 'Addressing stigma or discrimination around mental health in society' as having the most positive impact, while ensuring that services are sensitive to culture and identity is also more of a priority for LGBTQI+ people (12%) than those who are not in this category (4%).

Prioritisation

Participants in the qualitative community found it difficult to rank different options for improving mental health in the nation, as most were felt to be important, although some were felt to be more urgent than others.

Across the participants, preventative measures (i.e. early support and quick diagnosis) were preferred over reactive solutions. Many had only accessed support once they had reached crisis point, which often meant their needs were complex and acute. Participants also highlighted that preventative care would ultimately lead to less pressure on services, as there is currently an over reliance on crisis care. Once support is accessed it is important that treatment is conducted with care, respect, compassion and skill.

Younger people we spoke to felt that if they had been educated about mental health problems during school, they would have spoken about and addressed problems earlier, rather than waiting until adulthood.

Participants concluded by indicating the importance of holistic care, which recognises how these different issues interact and exacerbate each other. They commented that addressing current wait times and providing holistic care would not only improve the nation's mental health but have an impact on quality of life, particularly in education, substance abuse and employment.

"Not addressing the issues also has a disproportionate impact on minority groups - e.g. disabled, LGBTQI+, racial minorities, as culturally appropriate services and holistic treatment are much more important for these groups." (Young woman with a learning disability, 18-25)

"Mental health crisis in the country getting worse. People turning to drugs, self-harm and alcohol to feel better which can lead to further issues in society like rising crime." (Young woman with a learning disability, 18-25)

Participants in the community were asked what they would prioritise if they were in the government. Their suggestions included early intervention; increased funding to reduce wait time; ensuring medical staff are trained to offer targeted and compassionate care; education in schools and workplaces, and addressing structural issues which impact on quality of life (e.g. the cost of living; housing, and unemployment). Early intervention and reduced waiting times are considered to be key in ensuring that mental health problems do not escalate and warrant more extensive treatment later down the line. As well as this, support currently offered is often felt to be unsympathetic towards the individual, and untailored to their needs, with a lack of understanding of how other facets of their life may be driving mental health problems.

"I would prioritise holistic treatment, culturally appropriate services, and prevention of mental illness." (Young woman with a learning disability, 18-25)

Intervention

Most participants we spoke to in the qualitative research feel that mental health should be the top priority of the government, followed by the economy. Health, and the NHS more specifically, is felt to be overstretched and chronically underfunded; this lack of healthcare has serious knock-on effects in other areas, such as education, housing, and crime.

"I picked health, housing, and benefits as I believe these are the basic rights for every person to have access to. Good free health care, affordable housing and enough money given in benefits to cover the basics without life being a constant struggle and a cause of stress" (Woman with severe mental illness, 51-60)

"I picked health because I believe, after over a decade of systematic and purposeful underfunding, the NHS is in crisis and that was highlighted by the pandemic. I have acquaintances who died as a direct result of lack of capacity" (Young man with a learning disability, 18-25)

Participants feel that addressing mental health problems is a joint responsibility, however the government's action and inaction permeates into individual's day to day lives, e.g. housing, employment, and health.

The government allocates funding and resources for mental health, this has a significant impact on waiting times, a key concern for those we spoke to. As well as this, assigning funding for local government which then trickles down to participants and the support which they are able to access.

"Governments [are the most responsible] because they dictate the funding and resources that are available to help with mental health professionals because if someone reaches out for help, they have a duty to help or if they cannot help, to at least refer on to someone else who they think might be better placed to help." (Black African-Caribbean woman, 31-40)

"Government needs to take a role in investing in mental health services and educating parents/teachers/doctors about how to recognise mental health issues and promote ways to reduce stigma. I think all action starts with the government and then eventually it will trickle down." (Young woman with experience of trauma, 18-25)

Some friends and family who are closely connected to those with lived experience of mental health problems also hold a responsibility. Spending extensive time with those experiencing problems means that they can have a more direct impact on participants. As well as this, many felt that families have a moral responsibility to take care of their dependents.

Along with family, particularly parents, teachers are felt to have a duty of care.

"Parents are not therapists and do not have the power to offer the full range of mental health interventions, though they should always be respectful, caring, open-minded and attentive which all go a long way to safeguarding the mental well-being of the humans they care for." (LGBTQI+, 31-40)

"Friends and family: while they can be amazingly helpful, we shouldn't have to rely on untrained, non-professional acquaintances to provide support." (Man, living in poverty, 31-40)

Teachers and schools are an appropriate 'substitute' if family is not an option for participants, as they spend prolonged periods with them and can spot early signs of distress. As well as this, teachers play a critical role in educating students and working to destigmatise conversations around mental health. Participants felt that parents and teachers play a pivotal role to play in having a preventative rather than curative attitude towards mental health.

"I feel have a duty of care for staff and children. I feel MH counsellors or services should be accessible in schools and younger people should be taught and informed about MH problems, so they are educated and informed about it and it is not stigmatised or a taboo subject." (Woman, living in poverty, 18-30)

However, many are concerned about putting pressure on friends, families, or teachers; instead, they believe professionals with formal training and expertise hold responsibility. Health professionals, including GPs and counsellors, are the first line of care and must effectively signpost those who have waited to access treatment. They are felt to have a duty of care, ensuring that the treatment and care offered is both effective and compassionate.

Although offering support is health professionals' key role, they are dependent on the funding which they receive from the government.

"GP is responsible to provide additional support needed if you express MH concerns and health concerns whether this be medication, referrals/signposting as they have a duty of care to ensure everyone has access to appropriate support." (Woman, living in poverty, 18-30)

Support from charities and crisis lines are welcomed, however they are not felt to have a clear and explicit responsibility compared to parents and the government, many also felt that the lack of funding meant that they could not offer the holistic care needed.

"Funding and resourcing from the national government is most responsible for the country's mental health. Charities can only plug the gaps so much, and family friends can only act as support networks and encourage someone to seek professional help." (Man with severe mental illness, 18-30)

"The government needs to allocate funding to the issue and the local government needs to make sure any supplementary funding also goes to that area. But in reality the burden falls on charities who do not have the resources to help." (LGBTQI+, 18-30)

Finally, there was caution around approaching religious organisations, many have faced abuse and stigmatisation in the past when trying to access support for mental health problems, this was particularly true for LGBTQI+ participants.

"Faith organisations often view mental health through a moral lens, or in more fundamentalist circles, outright don't believe in mental illness, so they aren't trustworthy in every case." (LGBTQI+, 31-40)

Participants had mixed views around who they find most trustworthy when discussing mental health problems, they often oscillate between friends, parents, GP, counsellors, and crisis helplines. A key factor which influenced perceptions of trust was whether they felt a person or organisation 'knew them' or 'had their interests at heart' – ultimately being 'bound by ethics or by love'.

"The people close to someone are usually the ones who care the most and therefore the ones who are more trustworthy." (Young woman with experience of trauma, 18-25)

"I trust my GP and counsellors on the NHS and privately because I've had experience with both and have found they were really helpful to me most of the time (although there were occasions when they weren't). I also trust my friends the most as I've made a lot of friendships on the basis of my mental health and it's easy to confide in them." (Young woman with experience of trauma, 18-25)

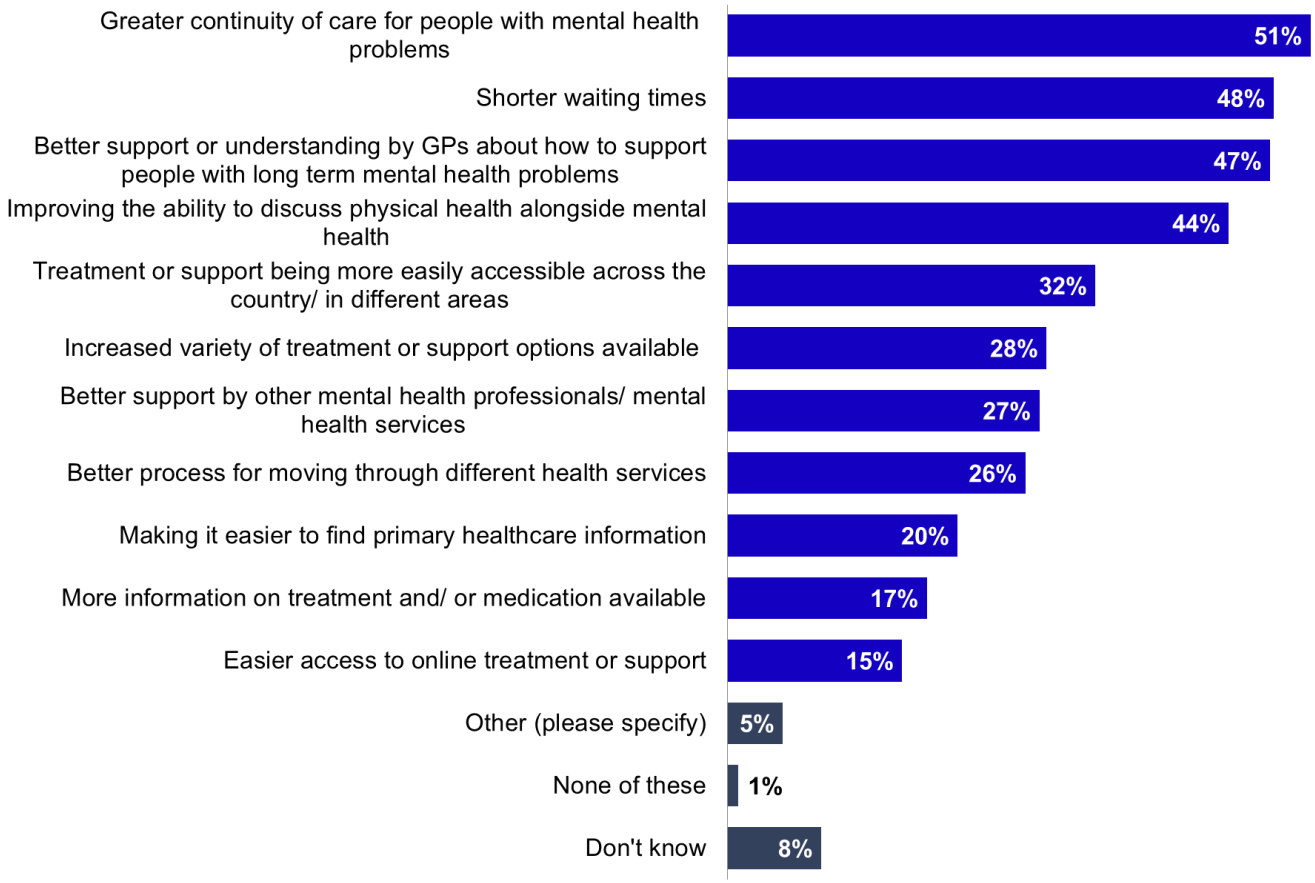
Past experiences and interactions also have a significant impact on perceptions of trust. Most reflect on how they have or have not been supported previously; lack of sensitivity, consistency and competency means that those who urgently need support are delayed in accessing appropriate care or are reluctant to reach out for support until they reach crisis point.

"Trust for me is based on the level of expertise the organisation or individual has in mental health. If they have been trained to provide mental health service, I would trust them better." (Black African-Caribbean man, 31-40)

Improvement of physical health for people with mental health problems

Alongside asking about provision of support, adults with lived experience of a mental health problem were surveyed about the improvement of physical health for those with mental health problems. Half (51%) state that greater continuity of care for people with mental health problems (for example being able to see the same GP regularly) would have a positive impact on physical health. Following this, 48% believe shorter wait times would help improve their physical health, and 47% say better support or understanding by GPs about how to support people with long-term mental health problems. In addition to better support, 44% say that improving the ability to discuss physical health alongside their mental health would have a positive impact on physical wellbeing.

Figure 5: Initiatives which would have a positive impact on physical health, for those with mental health problems



Base: All adults with lived experience of a mental health problem (n=4,139)

Greater continuity of care is more important to women than men (54% vs. 45%), as well as older people (62% of 55+ year olds vs. 45% of 16-34 year olds). Those living with a disability or long-term health condition are also more likely than those without to cite continuity of care as important for improving physical wellbeing (54% vs. 44%). They are also more likely to desire better understanding from GPs (51% vs. 41%) and an improvement in the ability to discuss their physical health alongside mental health (46% vs. 40%).

There was also a significant difference between ethnic groups on the importance of better provision of primary healthcare information. Black people with lived experience of a mental health problem are more likely than White people to state that making it easier to find primary healthcare information would best improve the physical health of people living with mental health problems (31% vs. 20%).

Greater continuity of care is also a higher priority for those living in poverty (earning less than £20,000 p.a.) than all other income brackets: 56% of this group mention this, compared with 50% of those earning more than £20,000 p.a.

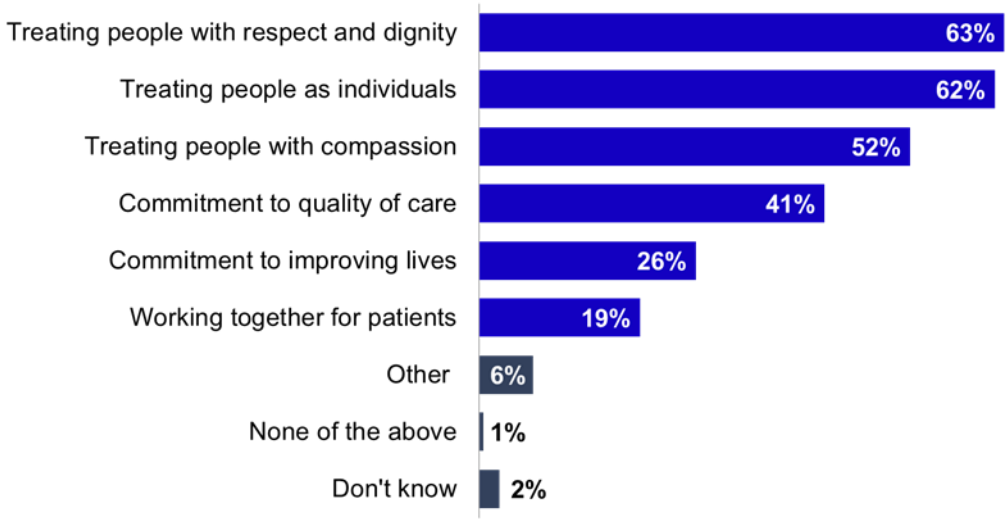
Young people (aged 16-30) diagnosed with a developmental disability express significantly greater levels of support for a range of actions compared with those not in this category. For example, a majority (65%) of this group desire better support or understanding from GPs, compared with 47% overall.

Desire for better support or understanding from GPs is also a higher priority for young women with experiences of trauma (54%) than it is for respondents who have not experienced trauma (40%).

Important values when delivering mental health care

Adults with lived experience of a mental health problem were also surveyed on values which they consider most important in the delivery of mental health care. A majority (63%) believe treating people with respect and dignity is important, with a comparable proportion (62%) stating that treating people as individuals is key. Half (52%) also think that treating people with compassion is important.

Figure 6: Important values in the provision of mental health care



Base: All adults with lived experience of a mental health problem (n=4,139)

When looking at age groups, there is a statistically significant difference in the likelihood to choose values which focus on treating people with respect. Indeed, older people are more likely to cite treating people with respect and dignity than younger people (71% of 55+ year olds vs. 60% of 16-34 year olds) and treating people as individuals (66% of 55+ vs. 57% of 16-34 year olds) as important values in the delivery of mental health care.

Additionally, Black people with lived experience of a mental health problem are more likely than White people to believe treating people with respect and dignity is important in the delivery of mental health care (78% vs. 63%). Similarly, Black people are more likely to value a commitment to improving lives (37% vs. 26%).

4 Experiences of mental health

Chapter summary

Most participants indicate that their mental health is part of a long journey, with some citing key moments from their formative years as crucial (for example incidences of trauma or marginalisation), whilst others cite cumulative events (such as unemployment or the breakdown of a relationship). It is noted that narratives surrounding mental health significantly impact how people experience and access support, and whilst improvements are being made in speaking about mental health in the media and beyond, a generational gap remains around attitudes to mental health problems. Equally, whilst progress is felt to have been made around talking about common mental health problems such as depression and anxiety, severe and enduring mental health problems such as bipolar and schizophrenia are less accepted and are often used to stigmatise people with lived experience of mental health problems.

Mental health journey: the past

Participants in the qualitative research said they have had a variety of formative experiences that negatively affected their mental health and wellbeing in the past. Abuse, family or personal illnesses, joblessness or substance abuse afflicted several participants from a young age. Many see their experience of mental health problems as beginning early in their lives, often as the result of a traumatic event. For many participants, they have experienced symptoms of anxiety or depression for most of their lives.

For some participants, misdiagnoses and/or apathetic support have exacerbated their mental health problems. Many participants say they were shuffled from GP to GP or other specialists, never receiving the right support or experiencing adequate care for their specific mental health concerns. Finding care or finding GPs who would listen to their concerns proved to be a challenge. Some feel they cannot openly and honestly articulate what they are feeling with friends and family, leaving them feeling isolated and fearful for the future.

Many participants feel their past has shaped their perspectives on how they understand their own mental health. For many, they take it as a given that they feel anxious or sad, and some assume they may continue to for the rest of their lives, due to factors they deem to be unchangeable, such as their health, or experiences of trauma.

Mental health journey: the present

Anxiety and depression occupy the day-to-day interactions and experiences of participants. In the worst instances, participants say they are experiencing near-constant suicidal thoughts and a great deal of fear and isolation. Others said they are actively seeking therapy and managing the intense symptoms and changes in mood relatively well. For some, they are finally being treated with a medication that suits them best.

Some participants say they are regularly interacting with peer support groups - either close friends also experiencing mental health problems - or people they have met through accessing mental health support or treatment.

Mental health journey: the future

Despite the difficulties faced day-to-day by participants in regard to their mental health, most can look ahead to a better long-term outlook. When thinking about their future, participant say they are optimistic that they have taken the steps required to improve their overall mental wellbeing and address the anxiety and depression they have experienced. Either through counselling or better peer support, participants are optimistic about feeling better in the future.

Some of this optimistic thinking comes from a belief in the efficacy of therapy and personal connection. Participants state that in the future, they hope to have regular counselling sessions and to have forged deeper social connections with friends and family than they had previously. Some feel they need to make shifts in how they manage their own personal relationships or behaviours, including ending relationships with negative personalities. This perspective is not shared by all participants, as many are still concerned about how their mental health problems are affecting their lives and the lives of their loved ones. As a result, some say they are not particularly optimistic about the future and are concerned they might not have the strength to continue.

“I really hope I can get to a stage where my mental health is not an issue! I want to get better - and this to me, is something that I use to get through the bad days.” (Young woman with experience of trauma, 18-25)

How mental health is discussed in England

Participants with lived experience of mental health problems have varying attitudes around speaking about mental health. This is often dependent on their age and social network.

Those we spoke to have noticed and experienced a generational gap around attitudes to mental health problems. There is a perception that older people have a more 'traditional' attitude, where mental health is considered to be a private matter. This was felt to be connected to the British attitude around needing a 'stiff upper lip' and a 'keep calm and carry on' attitude.

"Mental health is discussed privately and slightly judgmentally. We're British, we don't share feelings, and it's odd to do so." (Man, LGBTQI+, 18-30)

Whereas young people are felt to have an empathetic, and non-judgemental attitude towards speaking about mental health. Both younger and older participants commented that young people are encouraging those around them to have more open conversations about mental health.

"I do think things are improving and are much better than even a decade ago, but I think with the older generation there still seems to be a lot of judgment that mental health issues are actually just someone being lazy or selfish." (LGBTQI+, 31-40)

YouGov

Case study: Emily*, Young Person with a Learning Disability

Their mental health

Emily has suffered with anxiety and depression for most of her life and was diagnosed with it when she was 14. However, she has learnt to manage her mental health over the years with some of her coping mechanisms which includes meditating, relaxing, writing down what makes her feel overwhelmed, and finding distractions.

Over the years I've learned to kind of separate my mind and my body. So in my mind, I do not need to be anxious, but my body's like, no, you are..., I've kind of learned to manage mental health over the years - mostly through my own methods.

Mental health services

She finds family and friends to be the most trustworthy as they offer 'genuine' support and advice on mental health and wellbeing. She feels that mental health support in England needs a lot of improvement in areas like offline/online resources, accessibility, long wait time and limited staffing.

Narratives around mental health

Emily believes that older people do not see mental health as a genuine issue but that wider narratives around mental health are generally improving. She also feels that media has always spoken about mental health negatively which has had severe impacts on her wellbeing, but being around supportive friends, positive community and workplace has helped her.

I feel like in the media it is always spoken about quite negatively...there is always a lot of comments from people being like, oh, well, back in my day, we didn't have any of this or young people just need to grow up and stop being such snowflakes and stop being so sensitive

Intervention

She thinks GPs and health professionals have the most responsibility to address mental health problems and should be provided with proper funding to achieve that. She believes that early access to support is critical, alongside improving quality of life. The ideal mental health support should be tailored as per the needs of different individuals.

How mental health is discussed amongst family members and friends

Participants with an extensive social network, including friends and family, feel that the support they are given is critical, as friends and family tend to have a deeper understanding of individual needs as well as their history and how this might impact on them. A close and non-judgmental social circle means that those with lived experiences of mental health problems have a less formal structure to rely upon, where they feel understood and listened to.

"My support network, mainly my close friends, and seeing more open conversations about mental health in social media really encouraged me to take that first step and seek help." (Young woman with experience of trauma 18-25)

How mental health is discussed in the workplace

There was a mix of experiences in how workplaces support employee mental health. This often depends on the size of the organisation and how much support they can offer. Some workplaces are part of formal schemes, such as offering counselling or mindfulness through Employee Assistance Programmes, whereas others have fewer formal interactions with employees. Alongside this, the makeup of their colleagues has an impact, particularly the mix of ages and whether they have any shared experiences. Many also felt that the line managers and culture at work had a critical part to play.

Many of those we spoke to were not currently working due to their mental health problem, others hide their diagnoses from colleagues due to shame or stigma. This a barrier for accessing support, as many feel that they will be seen as a 'burden' or 'incapable' at work.

"Although I think the stigma towards mental health is not as bad as it used to be I feel great shame and embarrassment for having my issues and for not being in work." (Woman with severe mental illness, 51-60)

"I work as a freelance musician, and that means that there are effectively no formal work-place wellbeing resources." (HR departments or sick/compassionate leave) (LGBTQI+, 18-30)

How mental health is discussed in education

Older participants (aged 30+) commented that mental health did not tend to be openly discussed when they were at school but that this has changed to some extent in more recent years. Similarly to the workplace, narratives around mental health at university have improved and broadened, but limited support services meant that there was a lack of practical long-term support for students.

"When I was in university, mental health was theoretically discussed in a supportive way. In practice, there was little support available, and staff had no understanding of students who were struggling with their mental health." (Young woman with experience of trauma, 18-25)

How mental health is discussed in the media

The media's representation of mental health has improved in recent years, with different campaigns focusing on depression, anxiety, and tools like mindfulness. Alongside this there is more coverage from celebrities, however participants feel that this can be performative and a form of 'lip service', with the media being more concerned about 'profitability' rather than 'genuine' concern for wellbeing.

Participants commented that common mental health problems such as depression and anxiety are less stigmatised and viewed as acceptable by the media. However, severe and enduring mental health problems such as bipolar and schizophrenia are less accepted and are often used to stigmatise people with lived experience of mental health problems. For severe and enduring mental health problems, there is less understanding or acceptance of how these manifest in behaviour. Simplistic, misinformed, or unauthentic representation can contribute to the stigma which still exists around mental health problems.

"Lack of representation in the media of disorders like bipolar leads to misunderstandings in the wider community, I feel nervous about opening up and often have times where I do feel 'crazy' and like an outsider." (Young woman with experience of trauma, 18-25)

"Conditions such as depression and anxiety are somewhat less stigmatised than in the past, but mental illness in general, and many specific diagnoses are completely demonised." (Young woman who have experienced trauma, 18-25)

Finally, social media has a mixed impact on mental health. Some participants felt that there was more openness on online platforms from Reddit to TikTok, connecting to people in your community; whereas others felt that there was widespread bullying and abuse online, which contributed to mental health problems. Along with this many compare themselves with others when looking online, this has a negative impact on them.

"Social media always makes me anxious and feeling vulnerable." (Man, LGBTQI+, 18-30)

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5 Experiences of mental health treatment and support

Chapter summary

Most adults with lived experience of mental health problems had accessed some form of either formal or less formal mental health treatment or support. Additionally, the vast majority of 14-15 year olds surveyed with lived experience have received some form of treatment, advice or support for their mental health.

For those who have accessed mental health treatment, advice or support, the most common issues are long waiting times, feeling embarrassed to reach out for support, finding there are a lack of support options and similarly finding that the support available is not relevant or suitable. When accessing treatment, the qualitative research highlighted that there are often prevailing issues, such as feeling patronised by healthcare professionals, or receiving treatment that is not informative or helpful for their specific situations. There are also issues communicating with healthcare professionals, and in particular, people with learning disabilities struggle to speak the 'correct' jargon or adequately articulate their problems.

Awareness of treatment, support and advice

Awareness and knowledge surrounding sources and types of mental health support and treatment are particularly high, and most participants were aware of mental health services such as The Improving Access to Psychological Therapies programme (IAPT), and Community Mental Health Teams (CMHT), as well as other charities or support services such as YoungMinds, Mind, Samaritans, and Childline.

Awareness and understanding of various treatment and support techniques is also high, with many referring to Cognitive Behavioural Therapy (CBT), counselling, art therapy, group work/therapy, occupational therapy, and Eye Movement Desensitisation and Reprocessing Therapy (EDMR).

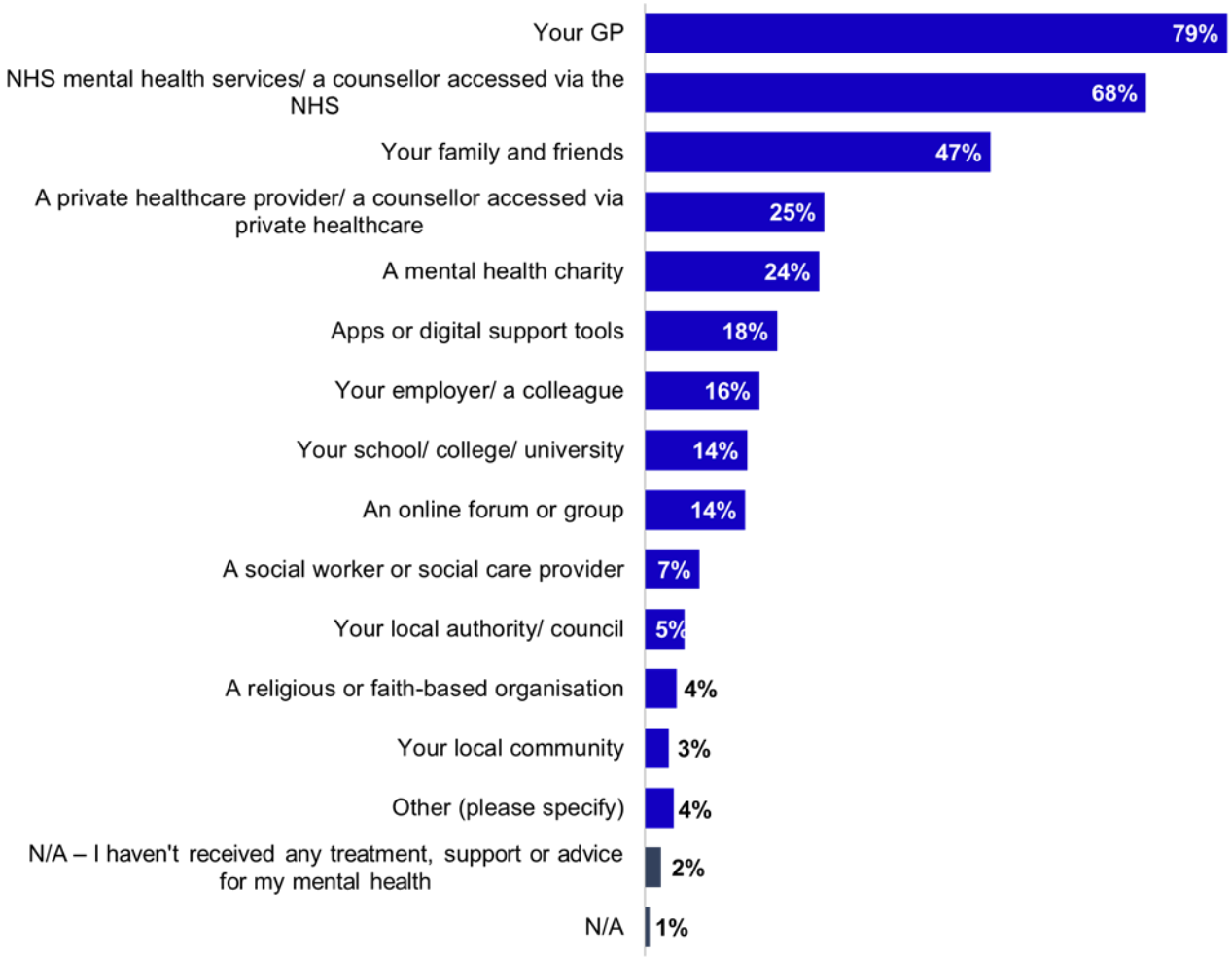
Figure 7: Word cloud from the qualitative community outlining the most frequently mentioned words when asked about awareness of mental health support:

Usage of treatment, support and advice

Among the adults surveyed with lived experience of a mental health problem, almost all have received some form of treatment, advice or support. The vast majority have accessed some form of treatment (93%), most commonly though their GP (79%) or NHS mental health services (68%). It is worth noting that the sample consisted of people who had been diagnosed with a mental health problem (i.e. excluding self-diagnosis), therefore it is unsurprising that most report having accessed formal treatment. However, many (71%) have also sought less formal forms of support, including speaking to family or friends (47%), a mental health charity (24%) or using apps or digital support tools (18%).

The qualitative research has shown that most participants with lived experience of a mental health problem have received or are in the process of waiting for some form of treatment, advice, or support from a formal source (i.e. their GP, NHS mental health service, employer, college/university etc).

Figure 8: Forms of treatment, advice and support people have received



Base: All adults with lived experience of a mental health problem (n=4,139)

Given that there is such a broad range of mental health problems and diversity of individual experiences, treatment and support accessed naturally varies by type of mental health problem. Those with severe and enduring conditions such as psychosis (85%), a personality disorder (83%) or schizoaffective disorder or schizophrenia (82%) are most likely to have used NHS mental health services or a counsellor accessed via the NHS. These groups are also more likely to have received support or advice from a mental health charity, with four in ten (40%) of those with a diagnosis of a personality disorder reporting this. People who have been diagnosed with an eating disorder are also more likely to have sought support or advice from a mental health charity (38%), whilst those with anxiety or depression are less likely (24%).

The qualitative community also identified that those with severe and enduring mental health problems are slightly more likely to have reached out to their GP or mental health service, as they are more likely to have co-occurring mental and physical illnesses which

healthcare professionals will be aware of and administering treatment and/or support for. This group are also more likely to access crisis care and make themselves known to their local health service for this reason.

There are also notable differences by age group in service access. Younger adults with lived experience of a mental health problem are more likely to have used online services, including apps or digital support tools (26% of 16-34 year olds vs. 8% of 55+) or online forums or groups (19% of 16-34 year olds vs. 6% of 55+).

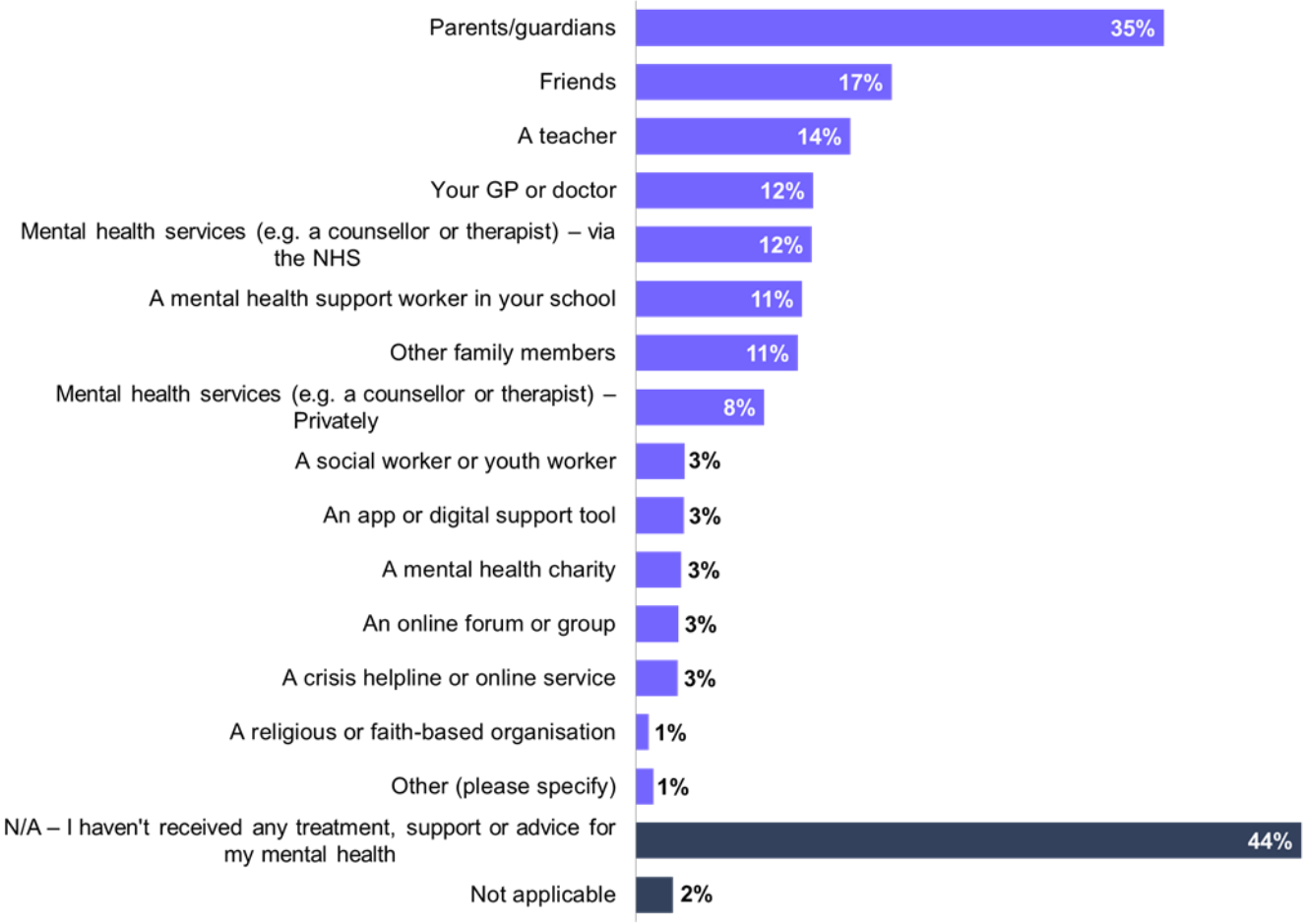
The qualitative research supports the finding that younger people are much more likely to access apps and digital support (including social media) for their mental health than older adults, and use them regularly in order to maintain a level of positive wellbeing. This can partially be attributed to digital confidence, but many young people also find that the online space provides a forum where they can receive information without being judged.

For those in the youngest age group (16-24), school, college and university also play a key role in support for mental health, with over half (55%) saying they have received support or advice from these. This is also the case for young women (16-30) who have experienced trauma, with 44% reporting this.[2]

Among all young people (aged 14-15) surveyed, over half (54%) say they have received some form of treatment, advice or support for their mental health. This includes young people with and without mental health problems. This tends to be from less formal forms of support, such as parents/guardians (35%), friends (17%) or teachers (14%). One in eight (12%) say they have received treatment or support from their GP or doctor or mental health services (e.g. a counsellor or therapist) via the NHS. Only 3% say they have received treatment or support for their mental health from a mental health charity or an app or digital support tool.

[2] In the survey, a definition of traumatic events was given: *Examples of traumatic events could be having a serious accident, serious health problems, racism, abuse or experiences of violence, or witnessing a violent death (amongst others).*

Figure 9: Forms of treatment, advice and support young people have received



Base: All young people aged 14-15 (n=1,072)

Among young people (aged 14-15) with lived experience of a mental health problem, the vast majority (86%) had received some form of treatment, support or advice. This was more likely to be from less formal sources, with parents/guardians (59%) the most common source, followed by friends (27%).

The data shows girls (aged 14-15) are more likely than boys to have received some form of treatment, support or advice for their mental health. For example, they are more likely to have spoken to parents/guardian (41% vs. 28%), friends (21% vs. 13%) or a teacher (19% vs. 9%). Given mental health problems can affect anyone, regardless of gender, this suggests there could be value in continuing the conversation around male mental health and the importance of reaching out for support.

The qualitative research identifies that, to an extent, this gender divide continues well into adulthood. For adult men, a fear of judgement prevents them from reaching out to access support, either formally or from their loved ones.

"My health setbacks have impacted my mental health severely. However it is difficult as I was brought up to be stoic with a stiff upper lip so have found it difficult to admit that I suffer from time to time" (Man, living in poverty, 51-60)

Some worry about being a burden to their loved ones and feel that there is little that could be done to help their situations.

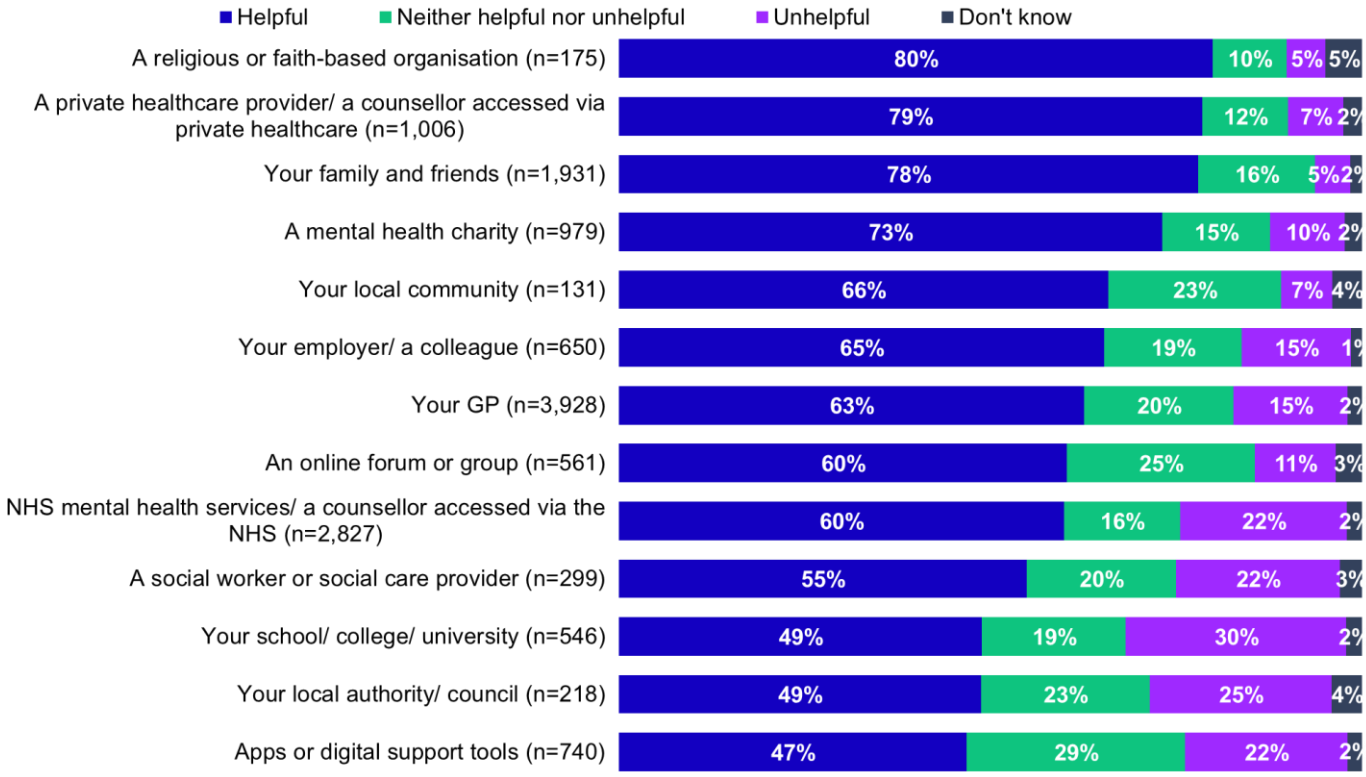
"I think my wife sees that I am struggling but I feel uncomfortable talking to anyone. She has given up so much to be with me…she has had cancer, back operations, and several other illnesses but she never moans. I feel I would be letting her down more again. She deserves someone better than me. She tries to talk to me but I just can't – I have no idea what she could do to change." (Man, living in poverty, 41-50)

Effectiveness of treatment, support and advice

Most sources of treatment, advice and support for those with lived experience of a mental health problem are seen as helpful (either very or quite) among adults with lived experience of a mental health problem. Private healthcare providers or counsellors are considered more helpful than NHS mental health services or counsellors (79% vs. 60%). Whilst the majority say that NHS mental health services or counsellors are helpful, a sizable proportion (22%) found these unhelpful, which could act as a barrier to people seeking treatment or support again. This is also the case for support from schools, colleges and universities, with three in ten (30%) saying support or advice from these was unhelpful. Among the less formal sources of support and advice, most found family and friends (78%) and a mental health charity (73%) helpful, whilst a lower proportion reported this for apps or digital support tools (47%).

The qualitative research highlights that those who need CBT or counselling for anxiety disorders or depression are more likely to have satisfactory experiences. If an individual's mental health is more complex, for example with conditions such as Post Traumatic Stress Disorder alongside anxiety and depression, treatment is not tailored enough, or sufficient.

Figure 10: Helpfulness of each form of treatment, advice and support



Bases shown in brackets

Generally, older age groups (aged 55+) with lived experience of a mental health problem are more likely to find each form of treatment, advice and support helpful than their younger counterparts (aged 16-34). This was the case for mental health charities (81% vs. 67%), GPs (72% vs. 53%), NHS mental health services or counsellors (68% vs. 52%) and local authorities or councils (68% vs. 28%), amongst others. Among the youngest age group (16-24), around one in three found NHS mental health services or counsellors (37%) and apps or digital support tools (33%) unhelpful. This suggests there is a need to ensure not only that mental health treatment and support is available, but also that it is relevant and ultimately helps people of all different ages.

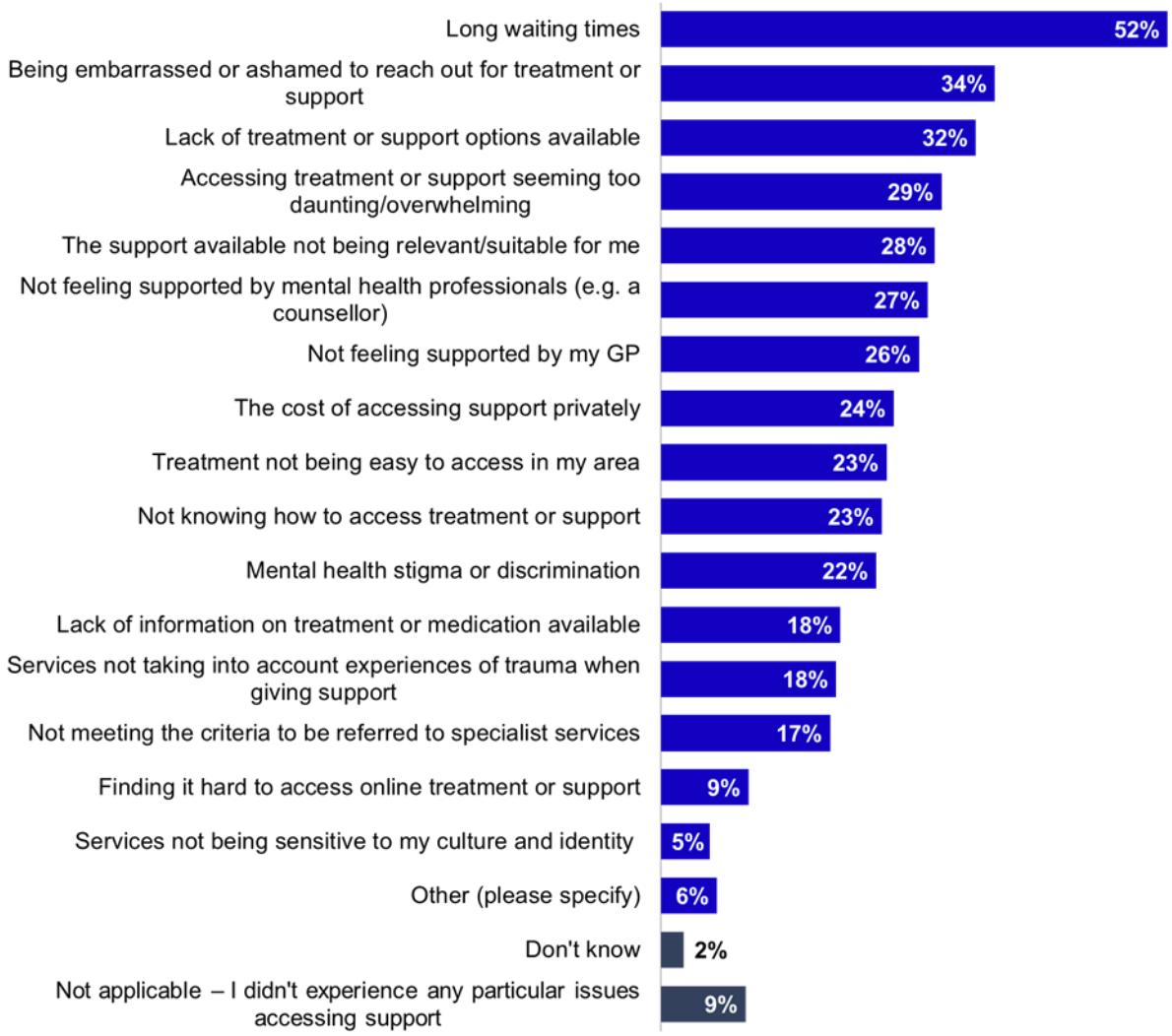
Considering the priority groups of particular focus for this research, young women (aged 16-30) who have experienced trauma are significantly less likely to report that they found these forms of support helpful, when compared with those who have not experienced trauma. This deficit is particularly apparent for GPs (48% vs. 68%), NHS mental health services or counsellors (45% vs. 64%) and apps or digital support tools (35% vs. 53%).

Similarly to adults, young people (aged 14-15) who used treatment, support and advice generally found this useful. Less formal forms of support are more likely to be perceived as useful than formal ones (e.g. GPs and mental health services). Four-in-five say that parents/guardians (84%) and friends (81%) were helpful. In comparison, half say that a GP or doctor (56%) or mental health services (e.g. a counsellor or therapist) via the NHS (52%) was helpful. Mirroring the pattern among adults, young people are more likely to find private healthcare providers or counsellors helpful than those accessed through the NHS (82% vs. 52%).

Ease of accessing treatment, support and advice, among adults

The most common issue that adults with lived experience of a mental health problem encounter when first accessing treatment, advice or support is long waiting times (52%). Stigma is also a key issue, with one in three (34%) saying they were embarrassed or ashamed to reach out for treatment and support. Similar proportions mention lack of treatment and support options available (32%), accessing treatment or support seeming daunting or overwhelming (29%) and support available not being relevant or suitable (28%). This highlights the potential value in producing communications that inform people about mental health treatment and support and how it could be relevant to them, as well as increasing awareness of treatment services and their suitability for different types of people.

Figure 11: Issues experienced when first accessing treatment, advice or support



Base: All adults with lived experience of a mental health problem who have accessed treatment, advice or support (n=4,005)

Those with severe and enduring mental health problems are more likely to say they experienced issues when they first tried to access treatment, support or advice for their mental health.[3] A key issue emerging from the research for this group is a lack of support, with half (54%) saying they didn't feel supported (vs. 41% with common mental health problems). The lack of support is felt when accessing support from both healthcare professionals (39%) and GPs (36%), and is particularly experienced by those with a personality disorder (45% and 38% respectively). People with severe and enduring mental

[3] Severe and enduring conditions include bipolar disorder, personality disorder, psychosis, schizoaffective disorder and schizophrenia.

health problems are also more likely than average to cite mental health stigma or discrimination as an issue when accessing support (31% vs. 22% of participants overall).

Those living with a disability or long-term health condition are more likely than those without to report experiencing many of these issues.[4] This includes not feeling supported by healthcare professionals (32% vs. 18%), mental health stigma or discrimination (25% vs. 16%) and services not taking into account experiences of trauma when providing support (23% vs. 9%). Among those aged 16-30 with a developmental disability (e.g. Down's Syndrome), the proportion not feeling supported rises to 63% (vs. 42% overall). They are also more likely to mention the support available not being relevant/suitable for them (53% vs. 28% total) and a lack of treatment or support options available (48% vs. 32% overall).

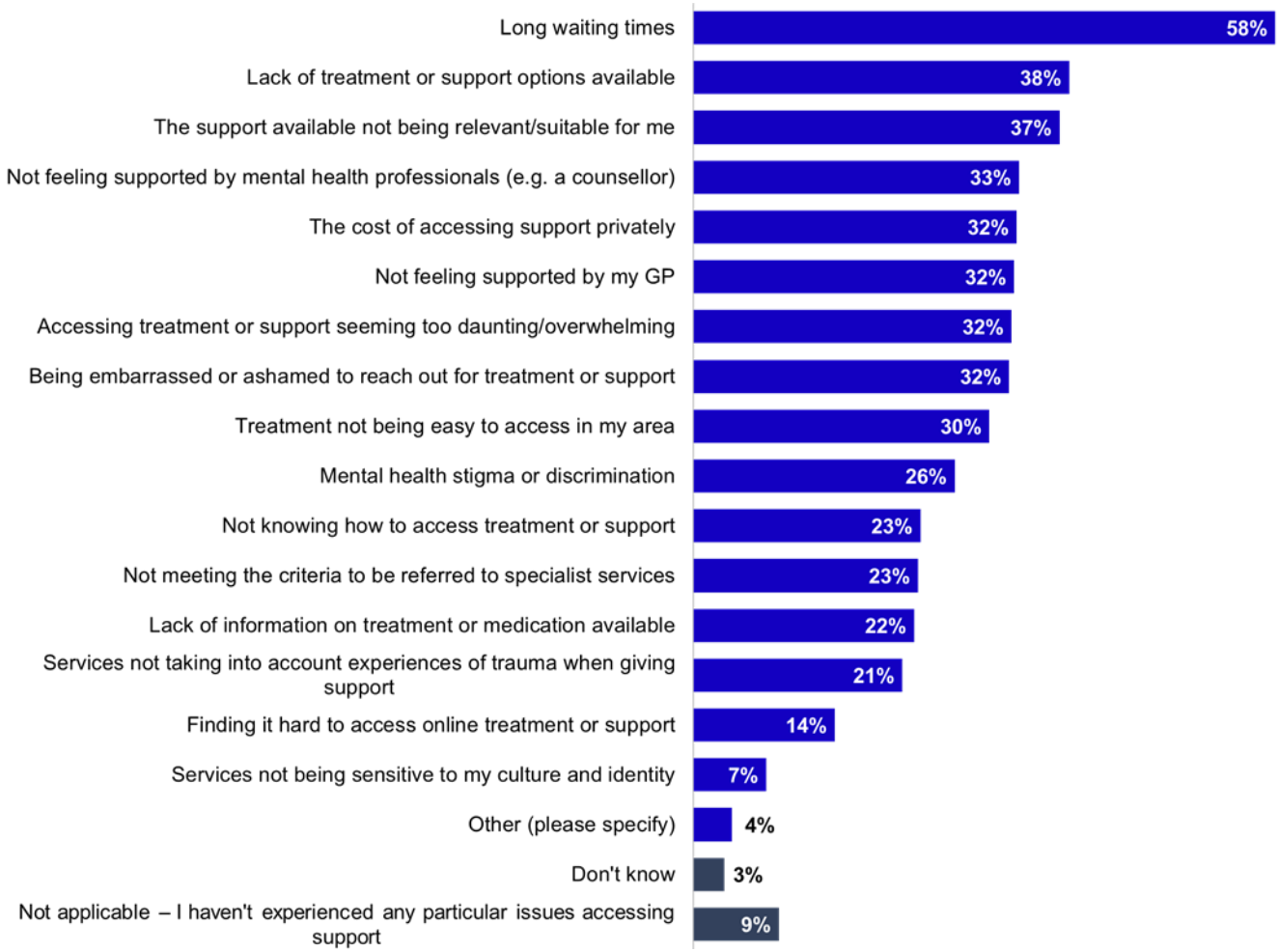
A feeling of not being supported is also prominent across several of the key priority groups for this research. Groups particularly likely to report not feeling supported include young women with experiences of trauma (59% vs. 32% of those without experience of trauma), LGBTQI+ (49% vs. 38% of those not in this category) and those living in poverty (45% with a household income of up to £20,000 p.a. vs. 38% of those with an income of over £20,000 p.a.).

[4] This is those saying their day-to-day activities are limited a lot due to a health problem or disability which has lasted, or is expected to last, at least 12 months.

Younger people (aged 16-34) with lived experience of a mental health problem are more likely to report many of the issues than older people (aged 55+). Half (50%) say they didn't feel supported, higher than for those aged 55+ (35%). The lack of support is felt across support provided by both healthcare professionals (33% vs. 23%) and GPs (32% vs. 21%). Not meeting the criteria to be referred to specialist services is also an issue for younger people, with one in four (24%) mentioning this (higher than 11% for those aged 55+).

When thinking about issues people have experienced at any time when accessing treatment, support or advice, the findings mirror issues people experienced when first reaching out. Those with lived experience of a mental health problem are most likely to say they experienced long waiting times (58%), that there was a lack of treatment or support options available (38%) or that support was not relevant or suitable to them (37%).

Figure 12: Issues experienced at any time when accessing treatment, advice or support



Base: All adults with lived experience of a mental health problem who have accessed treatment, advice or support (n=3,957)

Overall, mental health services are rated poorly by qualitative participants, including both NHS support, and that of mental health charities. In their pursuit of sources of support and treatment, many feel judged and patronised by health professionals, and do not always find the support helpful, informative, or empowering.

"I have always felt like people from the doctors and NHS psychologists made my issues seem small and not real. I have had a difficult time with this so I moved to private psychology due to being discharged from missing one appointment with my previous NHS psychologist." (Woman, LGBTQI+, 18-30)

The qualitative research highlights that, to an extent, awareness of current issues with accessing support via word of mouth and in the media can be off-putting for some. There is the widespread perception, even for those who have not accessed support, that waiting times to access mental health support are lengthy.

"I was reluctant to seek out therapy for a long time, particularly through the NHS, as I was told how long the wait lists were." (LGBTQI+, 18-30)

Long waiting time is the most frequently mentioned issue facing those with lived experience of mental problems. Some have been waiting for over a year to access treatment; Covid-19 had a significant impact for those we spoke to as there is a considerable backlog of patients waiting for treatment.

Access to care feels like a 'postcode lottery' for some, those in more rural areas do not have access to face-to-face treatment and those in large cities often faced extended wait times due to the demand for support.

"The biggest barriers to accessing support are the regional inequalities in access to mental health care and the long waiting lists for cognitive behavioural therapy, counselling, etc." (Man with severe mental illness, 18-30)

"The counselling services have very large waiting lists so by the time you finally get through, your situation has completely changed and it may not be quite as much of an emergency." (LGBTQI+, 18-30)

Of those that have received treatment, there are regional variations in the effectiveness of mental health treatment and support. Some feel stark differences in their experiences of support in England, versus the other nations in the UK, having experienced both.

"99% of my interactions with mental health services in England made me feel guilty and confused about my mental illness, I think I would quite possibly have been safer without their involvement. I desperately needed professional support but was mocked and invalidated instead. If my current support in Scotland were to be taken away, I would be devastated." (Young woman with experience of trauma, 18-25)

"My impression of services in Wales would be around an 8. I have found the support to be really good when needed, including from crisis services and the charities (such as Barnardo's) which help with socialising and gaining confidence. I have found that the quality of services do greatly depend on the region however. Meanwhile, in England I have found the waiting lists to be quite long and that not all GPs were very understanding, sometimes presenting limited treatment options" (Man with severe mental illness, 18-30)

Many are under the impression that private mental health support would be accessed more quickly, and be of better quality, longer, and more tailored to the individual than that of NHS. As a result, some participants are unwilling to access NHS support, instead waiting for a time where they can afford private support, as a 'gold standard.' However, due to the financial vulnerability of many participants in the online community, this moment is unlikely to arise - particularly as many feel they need long-term counsellors:

"My hope is to find an affordable long-term counsellor who I can check in with every week to keep my mental health in perspective and begin to work through some of my previous trauma." (Woman, living in poverty, 18-30)

Once they access treatment many face communication issues with health professionals. Those with lived experience of mental health issues do not feel listened to or taken seriously. In particular, many feel that their GPs were dismissive of their experiences – often commenting that they were 'too young' or 'too dramatic', with symptoms being ignored or dismissed.

"Before I moved to a new area my GP was very dismissive and seemed like I was more a pain and wasting his time. I then felt ashamed and embarrassed to return. I was actually pushed to by a sister. I did look into counselling privately, but I wouldn't have been able to afford the sessions." (Woman, LGBTQI+, 31-40)

Overall, many feel that they must reach crisis point before they are offered sufficient or formal support and that HCPs consider them to be either 'not ill enough', 'too ill' or 'too

complex' to receive support. Some shared that they had to reach a point of being suicidal to be referred or offered crisis care.

"I have had issues with professionals saying my case is too complicated and so they can't help me or aren't equipped to help me, which leaves me feeling stuck. Many services do not understand intersectionality and are not well informed about trauma" (Young woman with a learning disability, 18-25)

If support or treatment was offered, it was often felt to be inconsistent and disconnected across professionals and organisations. Furthermore, treatment does not feel tailored to the individual and their specific needs, instead many are offered generic, standardised solutions to complex problems. For example, young women experiencing trauma are often recommended CBT, this tends to trigger them through recalling traumatic experiences, and cause more distress due to the treatment being unsuitable for their complex needs. These experiences discourage people from reaching out for support in future and leave problems to worsen over time.

"I saw a counsellor for 4 sessions (meant to be 6) and we did CBT that I found quite unhelpful as I was in a suicidal crisis and mainly filled in forms and did colouring (no exaggeration!)" (Young woman with experience of trauma, 18-25)

The likelihood of trusting health professionals or having a positive experience with mental health treatment and support tends to be lower amongst participants with multiple co-occurring illnesses (mental and physical) and/or severe and enduring mental health problems, and other marginalisation. Some who had been formally diagnosed with a mental health problem were incorrectly diagnosed or were given incorrect medication or were not monitored after they were medicated, which reduces trust and faith in services.

"Basically when I was referred to mental health services nobody could really diagnose what I was going through or pinpoint what it actually was." (Young woman with experience of trauma, 18-25)

“Sometimes I've felt that my doctors don't understand what is going on with me and that makes me worried the treatment I will be receiving would be incorrect... I also don't think some therapists have understood how racism and sexism have affected my mental health.” (Black African-Caribbean woman, 18-30)

“My first experience was with social workers and CAHMS and both were very bad experiences as the social workers didn’t understand me and they changed every few months, so it was never consistent. It also gave me a bad expectation of therapy and made me reluctant to try again” (Young man with a learning disability,18-25)

The majority of those we spoke to the qualitative community faced issues around communicating with health care professionals when accessing support, making them less likely to return or to give up on treatment entirely. Navigating the mental health system can be particularly challenging for those with neurodevelopmental conditions such as autism, as extra time is required to process their emotions, articulate themselves and advocate for themselves and treatment.

“There are basically no mental health services with sensitivity training for autistic adults specifically, let alone LGBTQ+ autistic adults. When I am suffering from mental health issues or even in crisis I consistently find that I must take the role of educator to tell people what is happening to me because they are unfamiliar with what mental health looks like in people like me, and I often don't have the capacity to teach them anything in the moment.” (Woman, living in poverty, 18-30)

Many also say they have faced transphobia, sexism or racism when trying to access treatment; experiences and identities are often denied.

“I tried to access mental health support with some trepidation as I was worried how I would be treated as a trans person within the NHS. I'm sure my experience was unusual, but the counsellor I saw was nonetheless dismissive of my identity, which made it hard to go back to those services” (Young person with a learning disability, 18-25)

“I believe some professionals use the stigma as an excuse to dismiss younger women or AFAB people (assigned female at birth) who they assume are 'overreacting' or 'attention seeking'” (Young woman with experience of trauma, 18-25)

Nevertheless, some do have a helpful and positive experience with treatment, once they have navigated long waiting lists and secured treatment via the NHS or a charity. This is more likely for those with common mental health problems who are likely to feel satisfied with counselling or CBT. Some were also able to access private treatment, although this is not an option for most.

"My GP strongly encouraged me to see a counsellor when first prescribing me antidepressants. She helped get the process started by referring me and her certainty that it would help me was encouraging" (Young woman with a learning disability, 18-25)

For some this support, despite being accessed later than preferred, proved to be crucial. Only a minority feel that they would be unaffected if their support were to be taken away.

"I am no longer in therapy but if it was taken away while I was in the course, especially at the beginning, I would probably have committed suicide eventually…it was a life changer for me." (Young woman with a learning disability, 18-25)

Many have been or are going through a long journey with their mental health, have gone through multiple routes and are now reliant on their treatment (either in the form of contact with a medical professional, or through regular medication).

"My mum wants me to stop seeing my therapist because she thinks I'm fine but honestly I really need someone who will listen to me and actually let me feel my feelings." (Young woman with a learning disability, 18-25)

Despite most with lived experience of a mental health problem having reached out to a GP or other mental health professional, this is not viewed as the only source of support. Help from friends and family is rated almost as highly as support from a GP, and for some, trust is higher and there is reduced likelihood of feeling judged for sharing their feelings. For some, talking to friends/family/partners would be their first port of call, as opposed to contacting their GP. As part of their mental health journey, many draw support and advice from a variety of different services and participants. Older participants appear more open to talking to their family, whilst younger demographics rely on their friends for support, perhaps due to potential increased openness across the younger demographics.

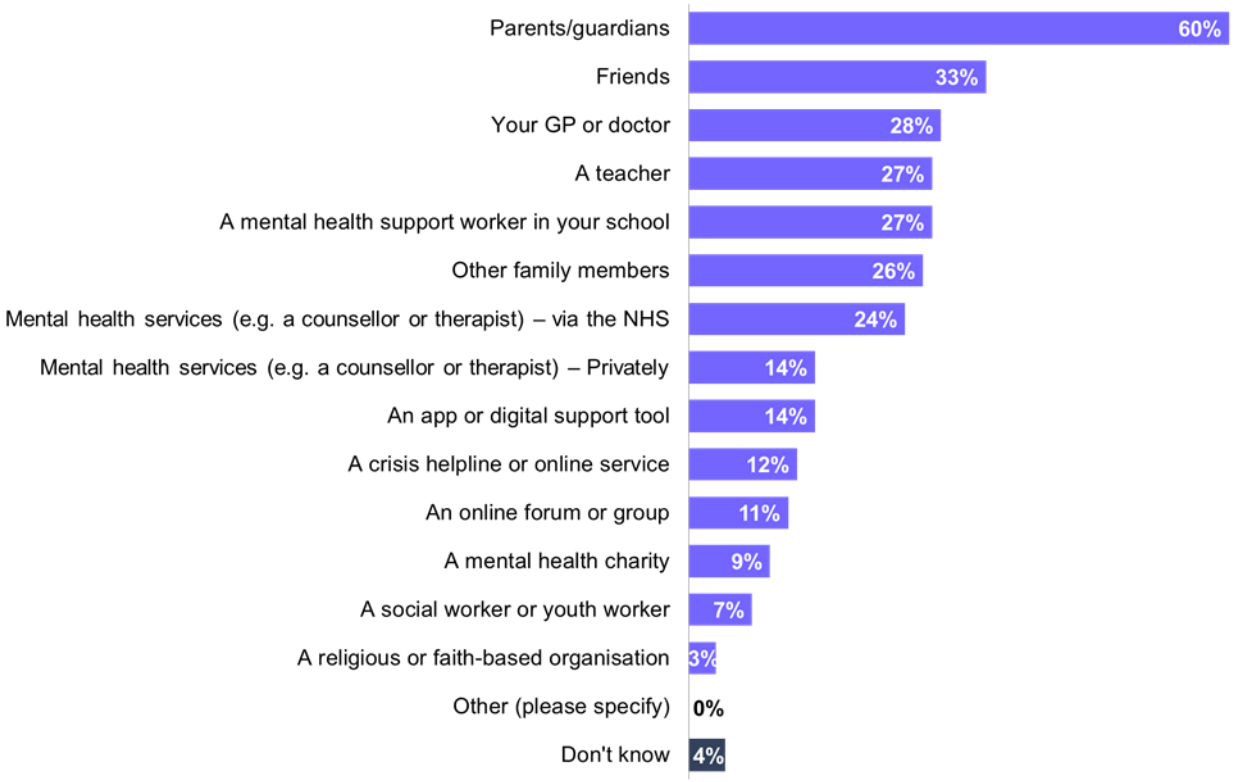
“I think for my generation I see people talking about mental health very openly and supporting mental health charities and doing what feels to me like the right thing, but I don't necessarily think that's the same for like older generations. I feel like each generation probably has a different perception and talks about it differently or not at all.” (Young woman with a learning disability, 18-25)

Ease of accessing treatment, support and advice, among young people

Among young people (aged 14-15), the majority (81%) say that if they wanted support or advice for their mental health and wellbeing, they would know where to go or who to ask. This is made up of 24% who say they definitely would, and 57% who say they would have some idea. The proportion saying they definitely would know is higher among those with a diagnosis of a mental health problem than without (32% vs. 18%). This suggests that there would be value in increased communications for young people in general about where to get mental health and wellbeing support.

If young people (aged 14-15) wanted support or advice for their mental health and wellbeing, they would most commonly reach out to parents/guardians (60%) or friends (33%), in keeping with the forms of support or advice young people are more likely to have received for their mental health. Whilst only 3% say they have used an app or digital support tool, 14% cite this as a preferred source of support, suggesting that raising awareness of these could be beneficial.

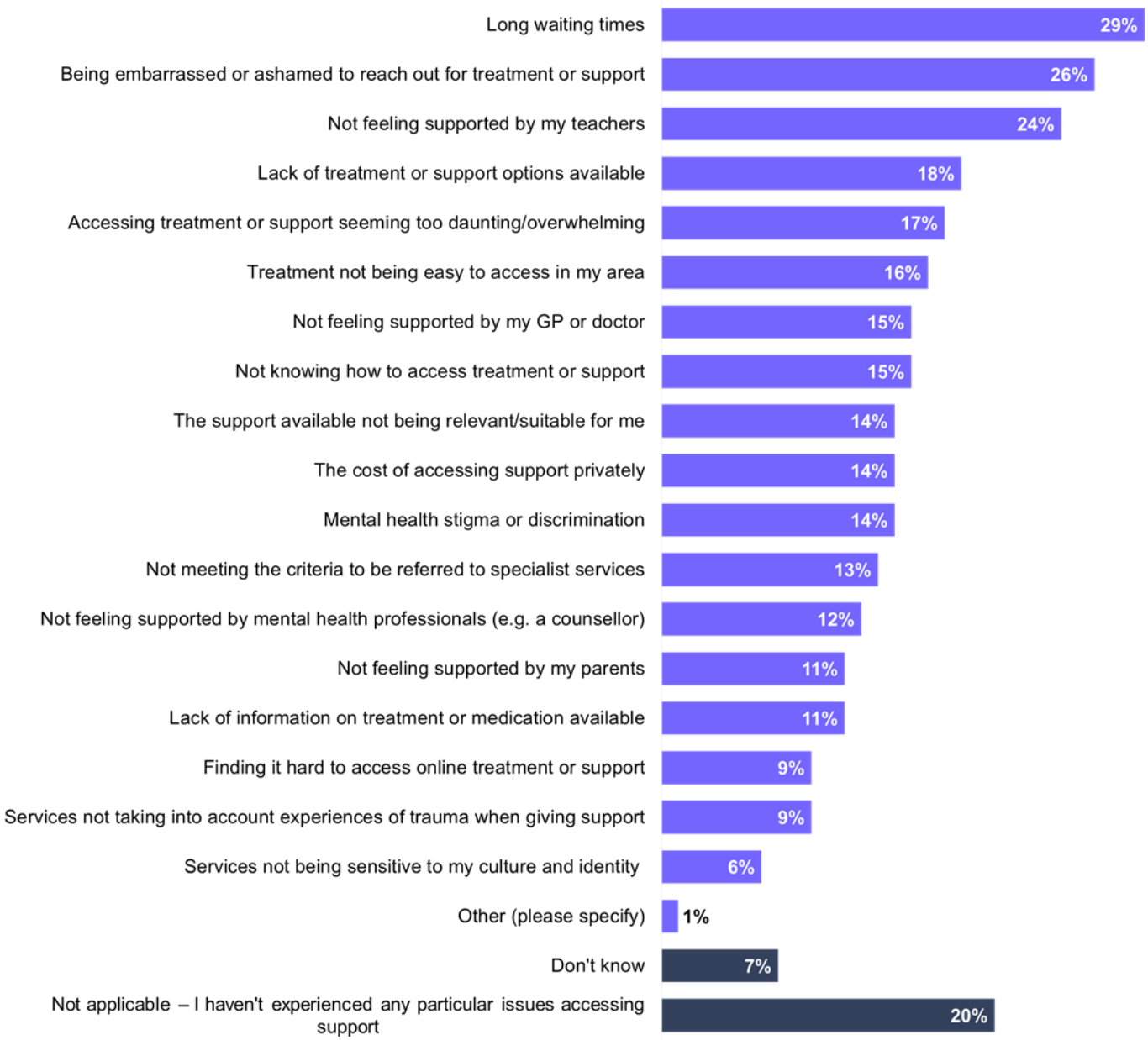
Figure 13: Who young people would go to for advice or support



Base: All young people aged 14-15 (n=1,072)

Among young people (aged 14-15) who have accessed treatment, support or advice for their mental health, many reported experiencing issues, such as long waiting times (29%), being embarrassed or ashamed to reach out for treatment or support (26%) or not feeling supported by teachers (24%). Slightly lower proportions mention a lack of treatment or support options available (18%) or accessing treatment or support seeming too daunting.

Figure 14: Issues experienced at any time when accessing treatment, advice or support



Base: All young people aged 14-15 who have accessed treatment, advice or support for their mental health (n=562)

Girls are more likely than boys to report experiencing many of the issues, including long waiting times (33% vs. 23%), being embarrassed or ashamed to reach out for treatment and support (29% vs. 21%) and not feeling supported by teachers (28% vs. 18%).

Among those with a diagnosis of a mental health issue, the top issues are more commonly mentioned: long waiting times (61%), being embarrassed or ashamed to reach out for treatment or support (34%) and not feeling supported by teachers (37%).

6 Factors influencing mental health

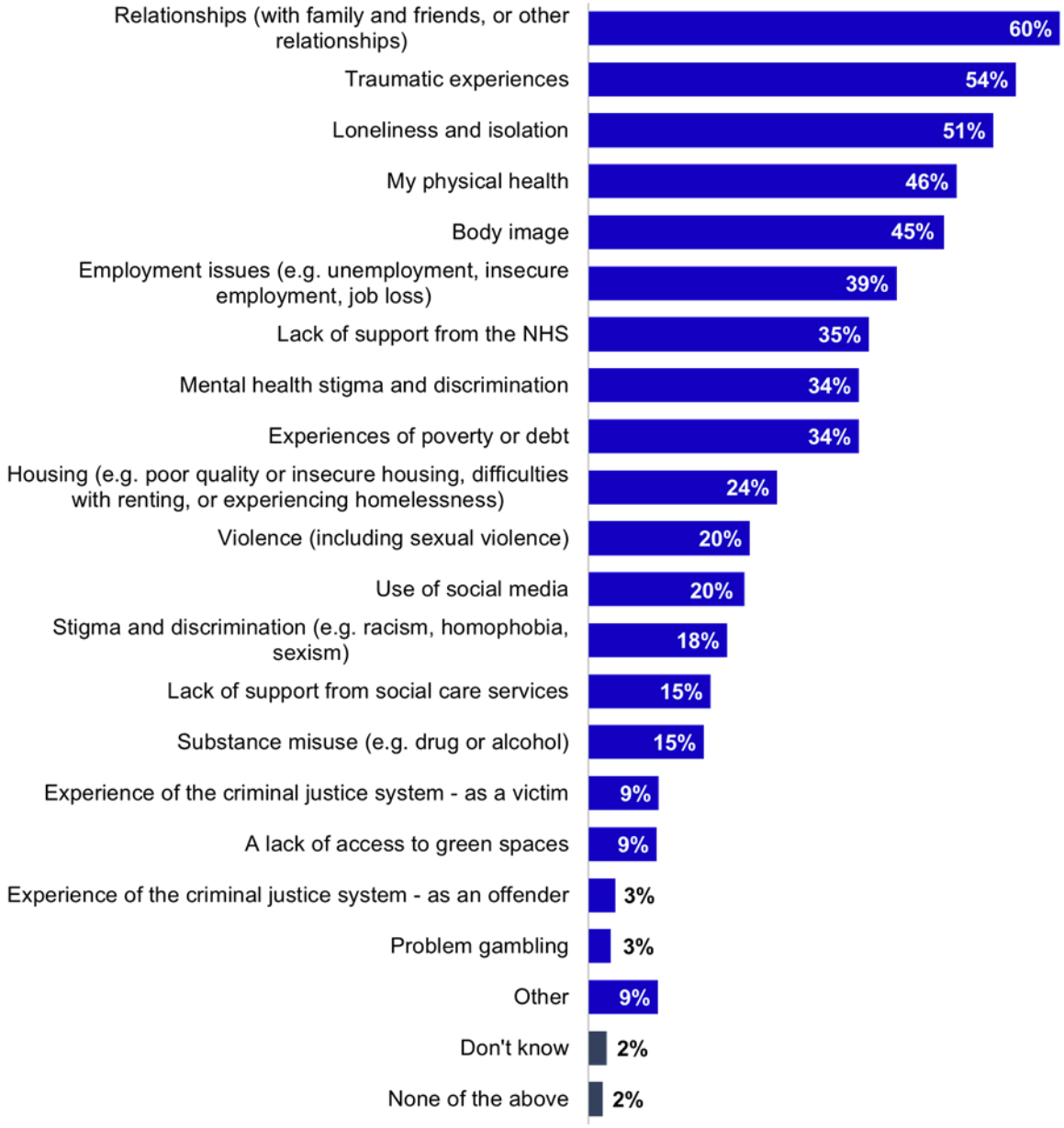
Chapter summary

It is most common for people to cite relationships, traumatic experiences and loneliness and isolation as factors which have negatively impacted their mental health. Whilst fewer cite stigma and discrimination, it is important to note that the proportion doing so rises among relevant groups such as Black and LGBTQI+ adults. Similarly, among qualitative participants, many explain that their poor quality of life in relation to relationships, housing and employment has a significant impact on their mental health. Furthermore, whilst understanding of individual triggers and how they can help themselves is high, often their conditions can prevent them from putting steps in place that are in their best interest.

Factors influencing mental health negatively

Most commonly, people cite relationships (60%), traumatic experiences (54%) and loneliness and isolation (51%) as factors which have had a negative impact on their mental health. Additionally, physical health (46%), body image (45%) and employment issues (e.g. unemployment, insecure employment, job loss) (39%) are key factors. One in five (20%) say that violence (including sexual violence) has had a negative impact on their mental health, and a similar proportion (18%) cite stigma and discrimination (e.g. racism, homophobia, sexism).

Figure 15: Factors which have had a negative impact on mental health



Base: All adults with lived experience of a mental health problem (n=4,139)

The factors that have had a negative impact on mental health differ depending on the mental health problem that people have been diagnosed with. For example, those with an eating disorder are most likely to say that body image has negatively affected their mental health (78%). Those with a diagnosis of psychosis or a personality disorder are more likely than average to say that many of the factors listed have had a negative impact on their mental health. This includes mental health stigma and discrimination (psychosis - 53% and personality disorder - 50%), poverty and debt (psychosis - 53% and personality disorder - 52%) and substance misuse (psychosis - 30% and personality disorder - 29%).

Additionally, the qualitative research shows that, whilst many are adversely impacted by specific factors as demonstrated above, those with a severe and enduring mental health problem are more likely to experience a higher level of negative impacts on their mental health spontaneously, potentially due to the complexity of these diagnosed conditions.

"Due to the nature of bipolar, depression and mania are not always reactive so can come along without a trigger. This means I do not feel in control as I always seem to be waiting to spiral again. I take medication (morning and night) to help my mental wellbeing as well as seeing a psychologist and psychiatrist." (Young woman with experience of trauma, 18-25)

Those living with a disability or long-term health condition are more likely than those without to cite many of the factors as having a negative impact on their mental health. This includes traumatic experiences (60% vs. 43%), their physical health (56% vs. 28%), mental health stigma and discrimination (39% vs. 25%), a lack of support from the NHS (42% vs. 23%) and a lack of support from social care services (20% vs. 6%), amongst other impacts. Among young adults with a learning disability, loneliness and isolation stands out, with three in four (74%) saying this has negatively impacted their mental health (vs. 51% overall).

Similarly, findings from the qualitative community also demonstrate the interplay of disabilities and long-term health conditions on poor mental health. Many are faced with competing illnesses alongside their mental health problems, which can impact on their ability to care for themselves in ways they would like:

"I feel like the main factor is the folate deficiency anaemia. This causes extreme fatigue as well as poor mental health, which is what prompted me to get a blood test. It also stops antidepressants working as effectively as they should which probably doesn't help." (Young woman with experience of trauma, 18-25)

"The fibromyalgia flare ups have been very bad this past year and that greatly influenced my ability to do things like university work and leaving the flat." (Young man with a learning disability, 18-25)

The quantitative findings also highlight the link between social media and mental health. A third (33%) of those aged 16-34 with lived experience of a mental health problem say that social media has had a negative impact on their mental health, much higher than for those in the middle and older age groups (18% of 35-54 and 6% of 55+).

Participants from racialised communities are more likely than white people to say that stigma and discrimination (e.g. racism, homophobia, sexism) has had a negative impact on their mental health (30% vs. 16%). The same pattern exists for LGBTQI+ adults, with 43% mentioning stigma and discrimination, compared with 8% of those not in this category.

Almost half (47%) of those with a household income of less than £20,000 say poverty and debt has been detrimental to their mental health (compared with 29% among those with a household income over £20,000). Meanwhile, lack of support from the NHS is a key issue cited by young women with experience of trauma, who are more than twice as likely to mention this than people without experience of trauma (54% vs. 22%).

The qualitative research also highlights that experiences are intersectional, as are the factors that have a negative impact on mental health. For example, many are currently in poverty because they cannot work - often due to a physical impairment, disability or due to their mental health problems - which in turn worsens their health, causing added stress. For some, the inability to work is also disempowering and can make them feel trapped.

Many with lived experience were affected by several interconnected factors which aggregated each other, creating what feels like a continuous feedback loop. For example, some had experienced trauma, abuse or a chronic medical condition which had a sustained impact over an extended period. There can also be acute fluctuations in mental health, for example if they experience relationship problems, physical health or body image problems, or employment issues.

“My issues with body image have affected my mental health for some time - it's frustrating because I find it hard to exercise and it becomes a vicious cycle” (Young man with a learning disability, 18-25)

“A mix of all of them have had a massive impact on my mental health. Starting with body image when I was teenager and going through traumatic events, I don’t think there was

ever just one single element at one time affecting my mental health - it was always more than one" (Young women who have experienced trauma, 18-25)

Financial problems have a significant impact on some participants, as they feel that they cannot have a good quality of life day-to-day due to the constant stress of managing their finances or ensuring that their basic needs are met. These stresses can then lead to issues with sleep and isolation from friends and family, which in turn impacts on their mental health.

"I think lack of money has had a huge impact on my mental health especially since I have not been working. Claiming benefits makes me feel like a third-class citizen and very ashamed, I know my family are embarrassed that I'm not working and of course they don't know the reason why as I have never shared this with them." (Woman with severe mental illness, 51-60)

Along with this, having financial savings or consistent access to welfare benefits is critical, as this allows for participants' basic needs to be met so that they can focus on their health.

"The times when our finances have been less strained have been generally less stressful. Turns out, people who can reliably meet their basic needs tend to have better mental health than those who can't." (LGBTQI+, 31-40)

The COVID-19 pandemic had a detrimental impact on many, particularly those who already had a limited social network, groups marginalised by society, or those with a pre-existing health condition which meant that they needed to shield. Services also moved treatment and support services online, which was not felt to be effective or conducive to open and deep conversation about their needs.

"My condition requires my wounds to remain open, so they bleed and leak between surgeries which makes being out of my house difficult. My emergency surgeries and hospital stays have been traumatic, especially during COVID where the experience is especially isolating." (Young woman with a learning disability, 18-25)

For some, the pandemic is where their mental health problems first began. Some feel continued isolation from being unable to see vulnerable family members, are suffering with the impacts of having family members pass away, or have suffered from health anxiety prompted by lockdowns that now continues to impede their ability to socialise or be in large groups or with non-mask wearers.

"I suffer with OCD…and I think OCD has morphed during the pandemic - less on checking and now has become a protection barrier against Covid - which is where my anxieties come from." (Man, LGBTQI+, 41-50)

"I used to go to the cinema every week and theatre - but that's all stopped now - and I cannot think of anything scarier than being inside with strangers." (Man, LGBTQI+, 41-50)

The qualitative research also identified that thoughts about the future, employment, progression and success are a significant stressor for young people (18-25). Due to being in a formative time in their lives, and perhaps beginning to complete full-time education, thoughts of next steps can be daunting and difficult to overcome:

"The biggest pressure for me is learning how to navigate the adult world - it's terrifying. I'm used to being in an academic environment and treated as a child and now it's completely changed so I'm trying to cope with that." (Young woman with experience of trauma, 18-25)

Negative thoughts or worries about the future can also be exacerbated in young people with a learning disability, who are striving for independence but currently constrained through living with parents, who often act as their carers:

"My biggest hope is for independence, to live independently and then to live with my partner one day." (Young woman with a learning disability, 18-25)

Young people (aged 14-15) were also asked about things that might affect young people's mental health in a negative way, with school, bullying and exam stress being most often mentioned in this context.

"Being forced into uncomfortable situations in school. Being bullied. Not doing well in school. People having extremely high expectations of them." (Boy, 14-15)

"I think not being praised or always being put down. Being bullied or not doing good at school and not getting on with your parents."

"Exams and lessons that are hard, friends being nasty, worrying about the future.

Bullying. Dishonest social media influencers. Too much pressure and anxiety about schoolwork and exams."

Given that a third (33%) of 16-34 year olds cite social media as a factor which can negatively impact mental health, it follows that many 14-15 year olds also think that social media negatively impacts mental health. Much of this comes down to unrealistic expectations and body image, as highlighted in the quotes below. Others mention that time is spent on social media instead of on group activities and socialising, which has knock-on negative impacts.

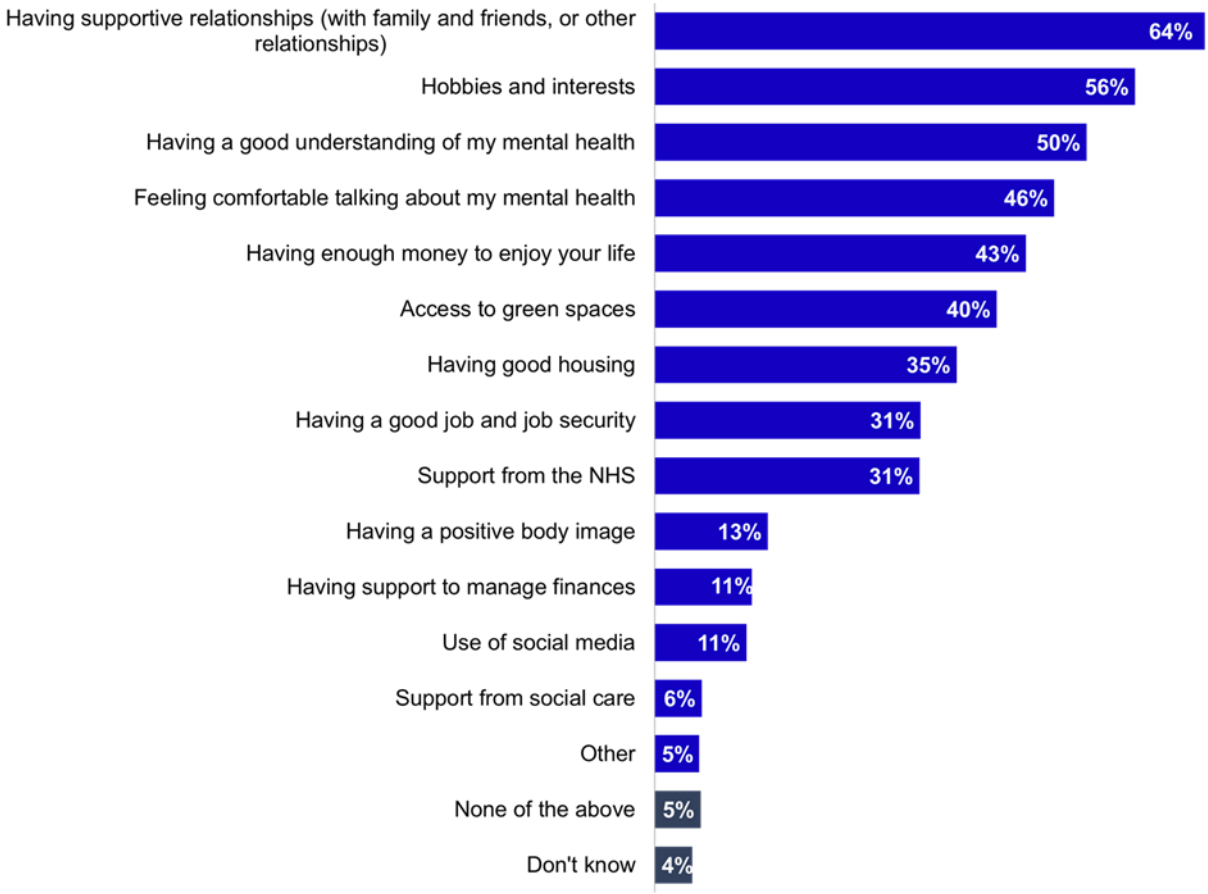
"Comparing yourself with others (especially on social media). Pressure to look good, do well in exams, etc." (Girl, 15)

"Not enough exercise with too much social media time and expectations. Too much time in a dark room and on phone, TV and play station." (Boy, 15)

Factors influencing mental health positively

Highlighting the role relationships can also play in maintaining positive mental health, three in five (64%) say that having supportive relationships has had a positive impact on their mental health. This is followed by hobbies and interests (56%), having a good understanding of their own mental health (50%) and feeling comfortable talking about mental health (46%). This strongly highlights the importance of open and destigmatised discussions around mental health. There is also a clear link between money and employment and mental health; 43% say having enough money to enjoy their life has had a positive impact on mental health, and 31% say having a good job and job security.

Figure 16: Factors which have had a positive impact on mental health



Base: All adults with lived experience of a mental health problem (n=4,139)

There are some key differences by age among those with lived experience of a mental health problem. For example, younger people (aged 16-34), who are more likely to be starting out in their careers, are more likely to say that having a good job and job security has had a positive impact on their mental health (38% vs. 33% of 35-54 year olds and 19% of 55+). They are also more likely to mention having a positive body image (19% vs. 12% of 35-54 year olds and 8% of 55+), in keeping with this age group saying that body image has negatively impacted their mental health.

The qualitive community also highlighted the importance of having a supportive social network which they can rely upon.

"Being listened to in a safe and non-judgmental space and experiencing validation and unconditional support is the key to recovering and managing symptoms." (Woman, LGBTQI+, 18-30)

For some, family – and particularly children – are the reason to 'keep going' and resolve to seek help for their mental health before it worsens.

"A year ago I experienced my depression in its strongest form and did not want to continue living at all. Every day was a battle to keep myself safe so that I could continue to be here for my children. If it had not have been for my children, I would not be here today." (Black African-Caribbean woman, 18-30)

Despite a high level of awareness shown for how best to look after themselves, many find that it is not always easy in practice to implement these measures in their day-to-day lives:

"I know that eating well, staying hydrated, getting appropriate sleep, moving my body enough-but-not-too-much and spending time outdoors will all help my well-being but if I am already struggling, the energy and focus required to stay on top of self-care is often not available and sometimes trying to force the issue can make things worse, leading to a chain reaction of negative effects." (LGBTQI+, 31-40)

Young people (aged 14-15) were asked to think of things that might affect young people's mental health in a positive way. Friends and family were the most common answers, highlighting the importance of having a supportive network. These are also the people young people are most likely to have received mental health support or advice from.

"Meeting their friends and doing things like football, gaming and just being together. Having friends who support you and don't do anything bad like bullying. Having caring parents. Having a family that is not poor and can't afford things." (Boy, 15)

School also plays a key role, with many associating doing well at school with positive mental health.

"Being praised. Doing well in exams." (Boy, 14)

"Time talking to good friends, getting outside having fun, not too much schoolwork, no bullies in school, cuddles with mum and dad and my pets." (Girl, 14)

Young people (aged 14-15) also refer to the positive impact that exercise and sports can have on mental health. Many refer to the group aspect of sport, suggesting the importance of young people getting involved in group activities in order to feel a sense of community.

"Playing sports and being in group activities at school and outside of school." (Boy, 15)

"More physical activity and more days for expressing yourself without judgement." (Boy, 14)

7 Young people's mental health

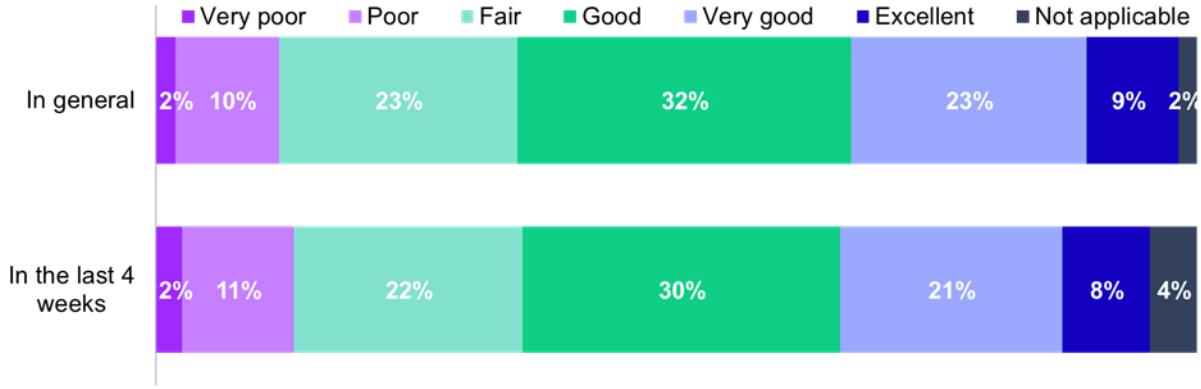
Chapter summary

Most young people (aged 14-15) say that they know people in their age group who have experienced depression and anxiety. Furthermore, two-in-five young people say they have personally experienced a mental health problem, with girls more likely to report this. The qualitative community indicated that younger groups (18-25) prefer to discuss mental health problems with their friends – often due to their friends going through similar situations – which differs to older age groups (40+), who are more likely to consult partners or family members.

General mental wellbeing

Overall, young people (aged 14-15) are more likely to say that their mental health is 'good', 'very good' or 'excellent'. A lower proportion say that it is 'fair', whilst around one in ten say it is 'poor' or 'very poor'.

Figure 17: Young people's self-reported mental health



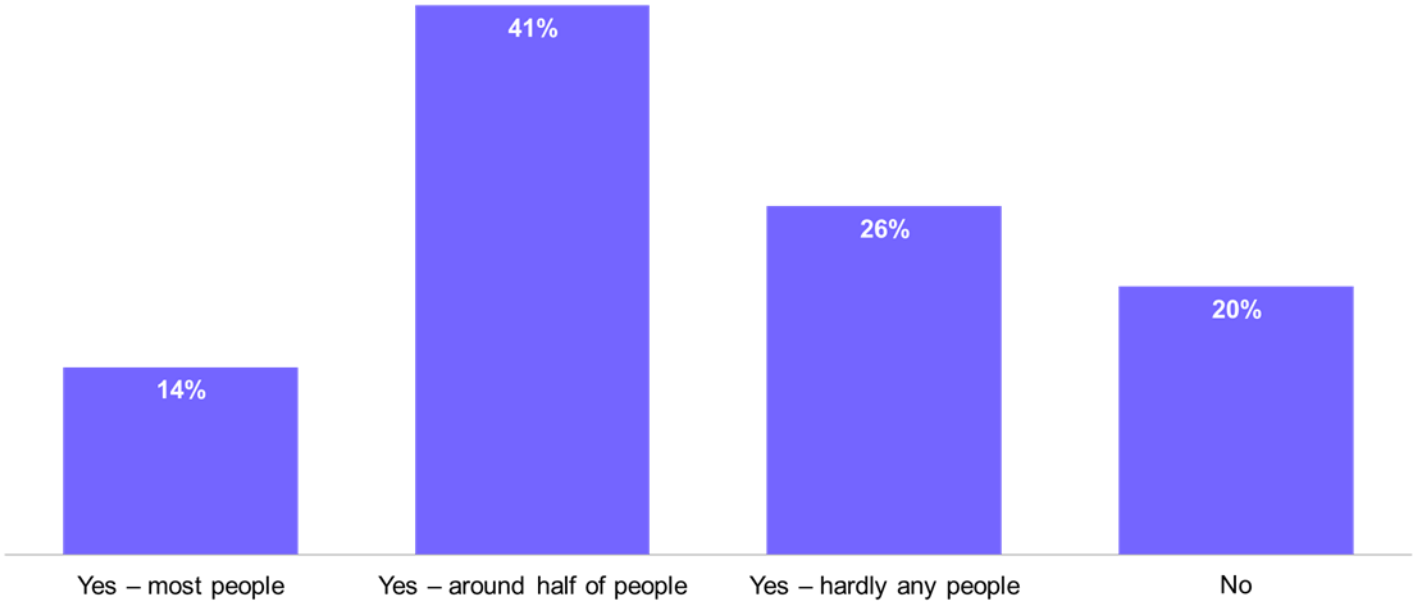
Base: All young people aged 14-15 (n=1,072)

Girls (aged 14-15) are more likely than boys to say that their mental health in general is poor or very poor (17% vs. 6%), and they are also more likely to say this when thinking about the last 4 weeks specifically (20% vs. 6%). Among young people aged 14-15 who have experienced (but not been diagnosed with) a mental health problem such as depression or anxiety, the proportion saying that their mental health in general is poor or very poor rises to 26%. This is even higher amongst those who have been formally diagnosed with a mental health problem (43%).

Awareness of mental health problems among others

Highlighting the prevalence of mental health problems among young people, such as depression and anxiety, the majority (80%) of young people (aged 14-15) say they know people in their age group who have experienced these: most people (14%), half of people (41%) and hardly any people (26%).

Figure 18: Whether young people know others experiencing mental health problems



Base: All young people aged 14-15 (n=1,072)

Girls (aged 14-15) are more likely than boys to say that they know of people in their age group experiencing mental health problems (86% vs. 74%), with one in five (20%) girls saying that this is the case for most people (vs. 8% of boys).

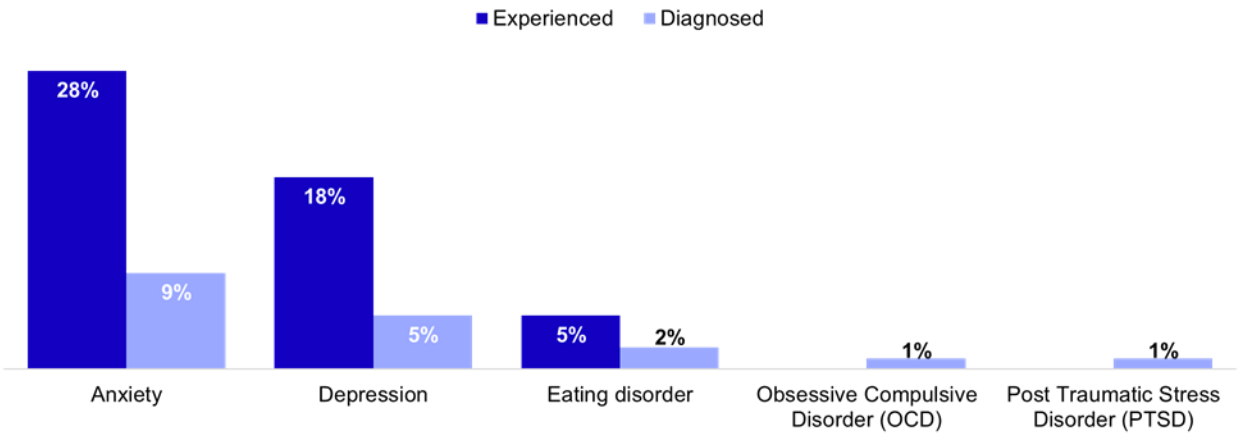
Young people (aged 14-15) who have experienced a mental health problem themselves are more likely to say that most people in their age group have experienced mental health problems (26%). Among those with a formal diagnosis, this rises to 38%, which could be due to them having higher awareness of the signs of mental health issues, and perhaps be more open in talking about them.

Direct experience of mental health problems

Two in five (39%) young people (aged 14-15) surveyed say that they have experienced a mental health problem, such as depression or anxiety. Twelve percent say that they have been formally diagnosed with one. Girls are much more likely than boys to say they have experienced a mental health problem (50% vs. 29%), and been diagnosed with one (16% vs. 9%).

Young people (aged 14-15) are most likely to say they have experienced anxiety (28%) or depression (18%), and these are also the conditions that they are most likely to have been diagnosed with (anxiety – 9% and depression – 5%). A lower proportion (5%) say they have experienced an eating disorder, with 2% having a formal diagnosis.

Figure 19: Mental health problems young people have experienced or been diagnosed with



Base: All young people aged 14-15 (n=1,072)

Girls (aged 14-15) are more likely than boys to say they have experienced anxiety (37% vs. 19%), depression (22% vs. 13%) or an eating disorder (6% vs. 3%), and they are also more likely to have been formally diagnosed with anxiety (12% vs. 5%) or an eating disorder (3% vs. 0%).

Young people (aged 14-15) from households in lower social grades are more likely to say they have experienced depression (but not been diagnosed with it) than those in higher social grades (22% C2DE vs. 16% ABC1), and they are more likely to have been formally diagnosed with anxiety (12% C2DE vs. 8% ABC1).

8 Mental health and substance misuse

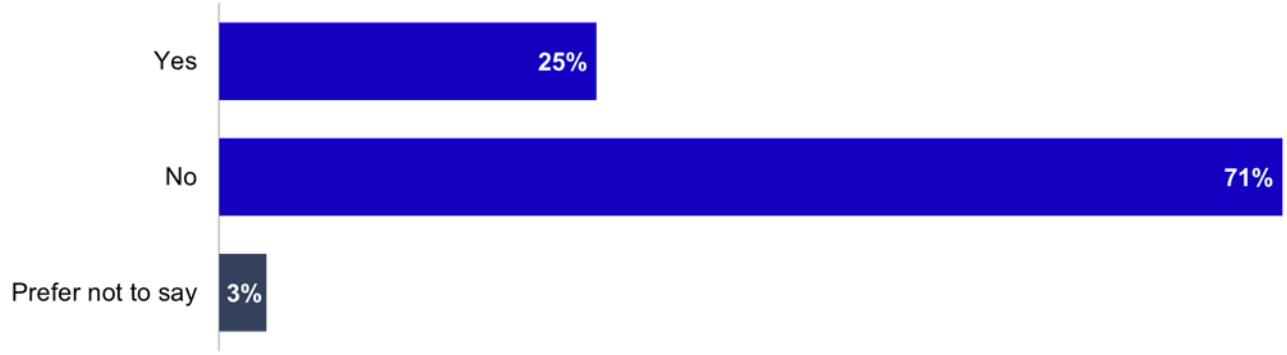
Chapter summary

Amongst adults with lived experience of a mental health problem, a quarter say they have personally experienced substance misuse. There is also a notable link between substance misuse and trauma, with those who have experienced trauma being nearly twice as likely as those who have not to report substance misuse. Of those who have experienced substance misuse, over half have experienced barriers as a result when accessing treatment, support or advice for their mental health. The issues most commonly experienced are: being blamed for health issues due to substance misuse; healthcare professionals attributing wider mental health issues to substance misuse, and stigma related to substance misuse.

Experience of substance misuse

Adults with lived experience of a mental health problem were asked if they have ever personally experienced substance misuse issues, including use of alcohol, recreational, or prescription drugs. In response, a quarter (25%) say they have experienced substance misuse issues while the majority (71%) have not.

Figure 20: Experience of substance misuse such as alcohol, recreational and prescription drugs



Base: All adults with lived experience of a mental health problem (n=4,139)

As indicated by the data in this research, substance misuse appears to be more common in the middle age years. For example, three in ten (31%) 35-54 year olds say they have experienced substance misuse, higher than for 16-34 year olds (21%) and those aged 55+ (23%). There is also a difference in the proportion of men and women (with lived experience of a mental health problem) reporting experiencing substance misuse issues. Three in ten (32%) men indicate that they have experience of substance misuse, while women are less likely to report this (21%).

The data highlights the link between substance misuse and trauma. Those who have experienced trauma are nearly twice as likely as people who have not experienced a traumatic event to report experiencing substance misuse issues (30% vs. 16%). The data also displays a link between income and the likelihood to experience substance misuse. A third (32%) of those living in poverty (a household income of less than £20,000 per annum) say they have experienced substance misuse issues, higher than for those in households with higher incomes (22%).

The qualitative findings highlight that many participants were dealing with the impacts of their mental health problem by 'self-medicating' through abusing alcohol and drugs, which in turn impacted their mental health even further.

"I ended up using drugs, alcohol and food to help numb the feeling, developed an eating disorder, a drug habit and a problem with alcohol, all things contributing to an already bad mental health issue." (Black African-Caribbean woman, 31-40)

"Alcohol was a crutch I became reliant upon while at the same time acknowledging that alcoholism in itself is an illness. This self-destructive logic led to other types of self-harm, though alcohol was the only form to hospitalise me" (Man, living in poverty, 31-40)

Issues experienced due to substance misuse when accessing treatment, support, or advice for mental health

Among those who have experienced substance misuse issues, over half (54%) say that they experienced one or more of the issues listed when accessing treatment, support or advice for their mental health. Of these issues, the three most common are: being 'blamed' for health issues due to substance misuse (28%), HCPs attributing wider mental health issues to substance misuse (23%) and stigma related to substance misuse (22%). While these three are the most common, there is no individual issue where a majority have experienced it in relation to their substance misuse.

Figure 21: Issues experienced due to substance abuse when accessing treatment, support, or advice for mental health

Base: Adults with lived experience of a mental health problem and experience of substance misuse issues (n=1,053)

Certain issues appear more prevalent among different demographics groups. However, when comparing men and women, there is little or no difference in issues experienced. This is also the case when looking at different ethnic groups. Among different age groups there is no definitive pattern in issues experienced, however there are some individual differences. One in five (22%) 16-24 year olds with experience of substance issue have difficulty in taking medication for mental health regularly or consistently as a result. This age group is more than three times as likely to report this as an issue when compared with those aged 55+ (6%). Difficulty moving between addiction services and mental health services appears to be more of an issue for 35-54 year olds (13%) when compared with 16-34s (7%) and those aged 55+ (8%).

Income appears to be a more of consistent factor in issues experienced. Higher earners, those earning £60,000 and above, are more likely to answer ‘none of these’ when presented with this list of potential issues relating to substance misuse than those earning up to £20,000, implying they occur less frequently for this income group. For example, those earning £60,000 and above are less likely than people earning up to £39,000 to experience being ‘blamed’ for their mental health issues due to substance misuse (19% vs. 30%). Moreover, the income groups who earn £20,000 to £39,000 (24%) or £40,000 to £59,000 (31%) are more likely to report that healthcare professionals attribute wider or underlying mental health issues to substance misuse than higher earners (15%).

More consistently, there is a clear link between experiences of trauma and mental health support services and substance misuse. Those who have experienced a traumatic event in their lives are more likely to have experienced ‘any’ issues when accessing mental health support than people who have not experienced trauma (57% vs. 48%). Of the issues listed in the chart above, people who have experienced trauma are more likely to have experienced several of them. One example is healthcare professionals not understanding substance misuse, with people who have experienced a traumatic event twice as likely as those who have not (21% vs. 10%) to say this is an issue. Another issue those who have experienced trauma are more likely to report is being ‘blamed’ for their mental health issues, due to their substance misuse (30% vs. 21%).

9 Mental health and the workplace

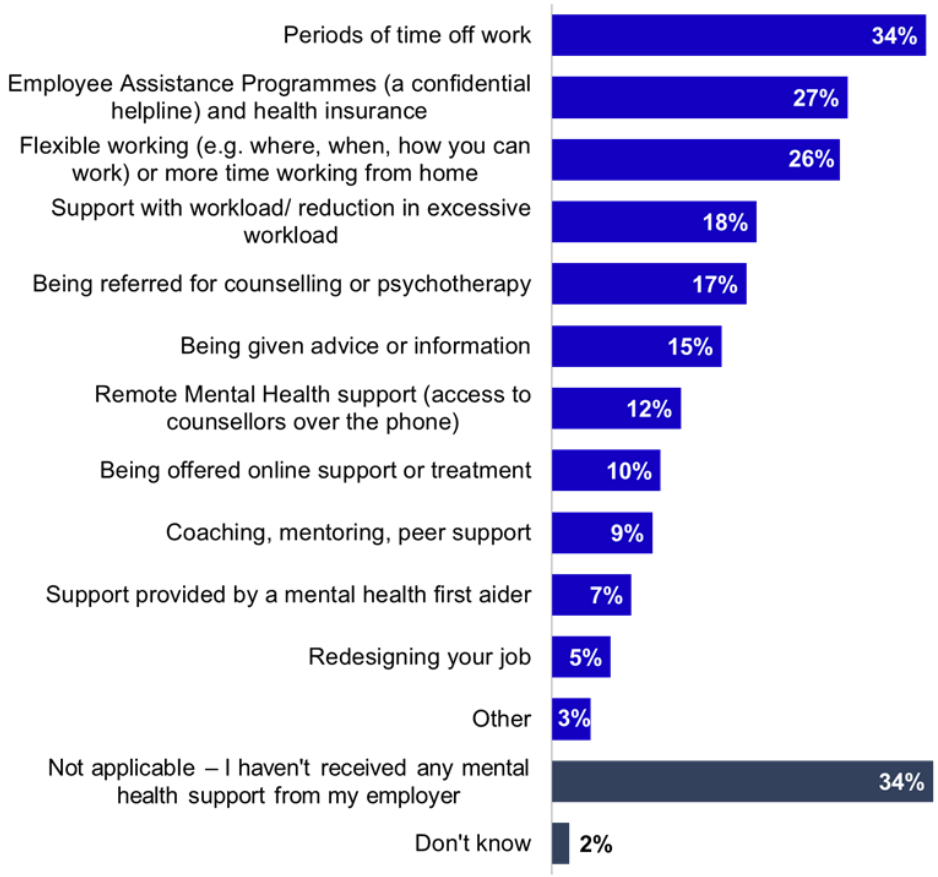
Chapter summary

Most of those with lived experience of a mental health problem who are currently employed have received some form of support from their employer for their mental health. Most commonly this is being allowed time off work, followed by accessing Employee Assistance Programmes and flexible working. Nonetheless, there is still strong demand for more employer support, with most employees saying that one or more forms of support would be beneficial. The qualitative research shows that experience and attitudes of mental health problems in the workplace are mixed, and also that mental health tends to impact all aspects of employment, from finding a job to performance. Additionally, it was found that those who have severe and enduring mental health problems are more likely to be out of work for an indefinite period of time.

Experience of mental health support in the workplace

Those with lived experience of a mental health problem who are currently employed were asked a series of questions relating to support for mental health in the workplace. Among this group, being allowed periods of time off work is the most common form of support for their mental health they have received from their employer (34%), followed by Employee Assistance Programmes (27%) and flexible working (26%).

Figure 22: Forms of mental health support received from employer



Base: Adults with lived experience of a mental health problem and are currently employed (n=1,978)

Looking at different age groups, 25-34 year olds (67%) and 35-44 year olds (70%) are the most likely to have received any kind of mental health support from their employer, with 16-24 year olds (49%) the least likely. Looking at individual forms of support, there are some notable differences between age groups. 35-44 year olds are more likely than 16-24 year olds to have received time away from work (39% vs. 24%). Three in ten (31%) 25-34 year olds have been given the opportunity to work flexibly in comparison to 15% of those aged 55+. 16-24 year olds are half as likely as 35-44 year olds to have received support from an Employee Assistant Assistance programme (15% vs. 32%).

The data indicates a link between social grade and income, and the types of support received. For example, two-thirds (66%) of those in ABC1 social grades have received any kind of mental health support from their employer, which is higher than C2DEs (57%). One example is having an Employee Assistance Programme; three-in-ten ABC1s (30%) have received support from this, in comparison to 18% of C2DEs. Those with lived experience of a mental health problem and in C2DE social grades are less likely to report having received support with an excessive workload than ABC1s (14% vs. 20%).

Linked to social grade, those in higher household income groups appear to have more mental health support from their employer. For example, people in the lowest income group (up to £20,000) are less likely than all other income groups to have received support from their employer (53%). This is twenty percentage points lower than the top income bracket (£60,000+ per year) (73%). Those in the highest household income bracket are three times more likely to have received support from an Employee Assistance Programme compared with the lowest household income group (38% vs. 13%). Being referred for counselling or psychotherapy is also more common for people in the highest income bracket (23% vs. 11% of those in the lowest income group). These findings may reflect different roles, sectors or types of employer which apply to those in different income categories.

The qualitative research demonstrates that experiences of mental health in the workplace, structures in place, and attitudes, are mixed. Mental health also tends to impact all aspects of employment, from finding a job, to job performance and in-work support. For those with severe and enduring mental health problems, they are more likely to be out of work.

Others are currently looking for employment but find the application process difficult to navigate when suffering with depression and social anxiety, which impacts both on motivation during the job search, and interview performance.

“I am unemployed and because I have autism, it makes it very challenging to go to interviews and travel to different places that I'm unfamiliar with. Also I just really find the whole process really stressful, from finding a job to preparing for it and doing the interviews. I have social anxiety and I find it really challenging.” (Young person with a learning disability, 18-25)

The challenges of living with a mental health problem can extend to being in the workplace too, impacting on productivity, and responses to high-pressure situations.

"My mental health I do think affects other aspects of my life, like my ability to concentrate on my work." (Black African-Caribbean man, 18-30)

The extent to which employers support those employees with mental health problems and have provisions in place is mixed. Some find that whilst their workplaces appear to champion the importance of mental health, the reality of how the employers conduct themselves is very different.

"It feels like people say that they are interested in mental health and disability awareness and such, but what they say is different to how they act." (Young man with a learning disability, 18-25)

Others face overt mistreatment in their workplaces because of their mental health:

"I would never discuss any mental health issues with my manager for fear it would go against me in my annual performance - as it has done in the past." (Man, LGBTQI+, 41-50)

However, some also do feel supported within their workplaces and content with the current support available, many of whom have moved into a role where they are better supported by their company with their mental health problem. Some have support available that they do not necessarily need, but are comforted knowing it is accessible to them, should they need it.

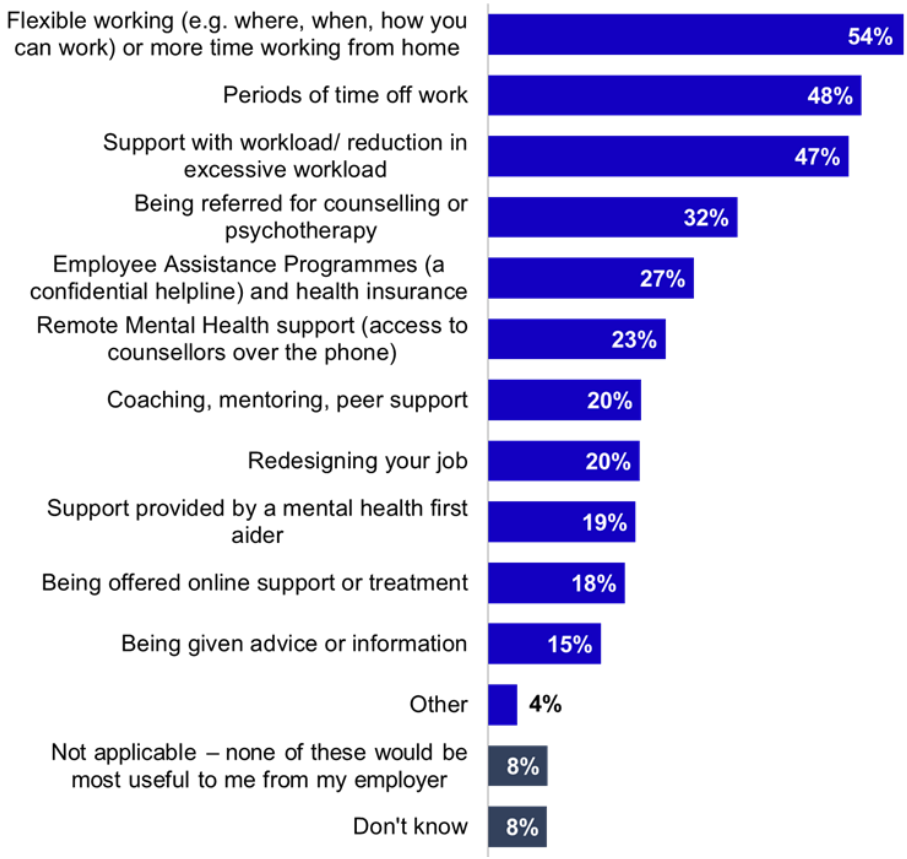
"We've got an external service that you can reach out to for free counsellors and there is a lot of guidance and mental health by HR. It is all very positive, and it feels like if you had a genuine mental health problem, raising it would not be an issue…they would just support you. At the minute we are doing annual PDR reviews, and within that, you can have a separate review for managing your mental wellbeing too." (Young man with a learning disability, 18-25)

"My line manager is great and makes me feel included and I would be comfortable raising any mental health concerns if they were affecting me." (Man with severe mental illness, 18-30)

Demand for mental health support in the workplace

Considering what forms of support employees would find beneficial, there is a perception that flexible working would be most useful (54%), followed by being allowed periods of time off work (48%). The third most desired form of employer mental health support is help with or a reduction in excessive workload (47%).

Figure 23: Forms of mental health support which would be most useful if received from employer



Base: Adults with lived experience of a mental health problem and are currently employed (n=1,978)

Young people (aged 16-34) are more likely to say they would benefit from many of the forms of support. For example, flexible working is more likely to be a form of support that 16-34 year olds would like in comparison to those aged 55+ (58% vs. 42%). Another example is that half (51%) of 16-34 year olds would like periods of time off work, which is much higher than for those aged 55+ (37%).

Those in the lowest income bracket (a household income up to £20,000) (75%) are much less likely than people an income above this threshold (85%) to want 'any' kind of employer-provided mental health support. Flexible working, in particular, is more desired among people with a household income above £20,000 than those who earn up to £20,000 (58% vs. 40%). Moreover, approximately half (48%) of people in the £20,000+ category would like support with an excessive workload, in comparison to four-in-ten (39%) people with a household income below £20,000.

Those surveyed also were also asked unprompted what employers can do to support and protect the mental health of their employees. Many of the responses reflected the most common forms of support those with lived of experience of a mental health problem say they would like their employers to provide.

This includes the desire for more flexible working patterns:

"Offer a wider range of reasonable adjustments and flexibility. Perhaps offering part-time roles instead of expecting 40 hours a week from everyone." (Woman, LGBTQI+, 16-24)

"Understanding that there may be periods of time where things may be a little harder (e.g. completing tasks on time) and to accommodate that - for example more flexible work hours, working from home." (Woman, 16-24)

Employers enabling staff to take time away from their work:

"Show compassion and understanding, allow time off work and make accommodations wherever possible." (Young woman with experience of trauma, 16-24)

"By giving them time off when needed to visit their GP or support worker." (Man, 16-24)

And a reduction or help with workload:

"By checking in with them. Making sure they take time off/ not staying late. Check they can cope with workload. Explain and check they understand any new procedures." (Woman, living in poverty, 55-64)

"Not expect employees to work beyond their contracted hours as a normal thing. Not expecting them to cope with a huge workload and massive amounts of stress." (Woman, living in poverty, 45-54)

Reducing stigma, although not reflected in Figure 23 as it is not a direct form of support, was mentioned unprompted many times:

"De-stigmatising mental health and making it an open conversation people are comfortable having. Not treating people with mental health issues like they are made out of glass but enquiring what they can do to help." (Woman with severe mental illness, 25-34)

"Making the workplace an open and inclusive place where mental health is not stigmatised. Having HR trained in recognising mental health problems and not treating people with mental health issues as disciplinary issues." (Woman, 65+)

10 Crisis care

Chapter summary

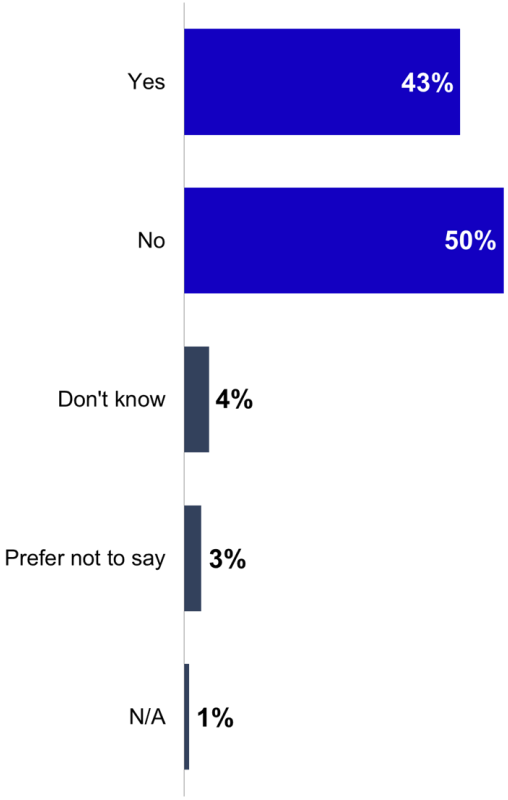
The final chapter presents data about mental health crises and crisis care. In this context a mental health crisis is defined as when someone feels at breaking point and needs urgent help. This could include feeling extremely anxious and having panic attacks or flashbacks, feeling suicidal or self-harming, having an episode of hypomania or mania, and psychosis.

Around two-fifths of adults with lived experience of a mental health problem say they have experienced a mental health crisis. This is more common among those in lower income groups and those with a background of trauma. The three most helpful ways to support those in need of crisis care are shorter waiting times, better treatment and support before reaching crisis point, and increased treatment or support options available.

Experience of mental health crisis

When asked, over four-in-ten (43%) adults with lived experience of a mental health problem say they have experienced a mental health 'crisis', whilst half (50%) say they have not.

Figure 24: Whether a mental health crisis has been experienced



Base: Adults with lived experience of a mental health problem (n=4,139)

Gender and age appear not to be factors which particularly affect the likelihood of having experienced a crisis, with no significant differences between men and women or between different age groups.

However, social grade and household income are factors. Forty-six percent of those in C2DE social grades say they have experienced this, compared with four-in-ten (40%) ABC1s. The differences by household income levels are more pronounced. Among those in the lowest income bracket (up to £20,000), half (50%) have experienced a mental health crisis. This is significantly more than the third (34%) of those in the highest income bracket (£60,000 and above) who have experienced this.

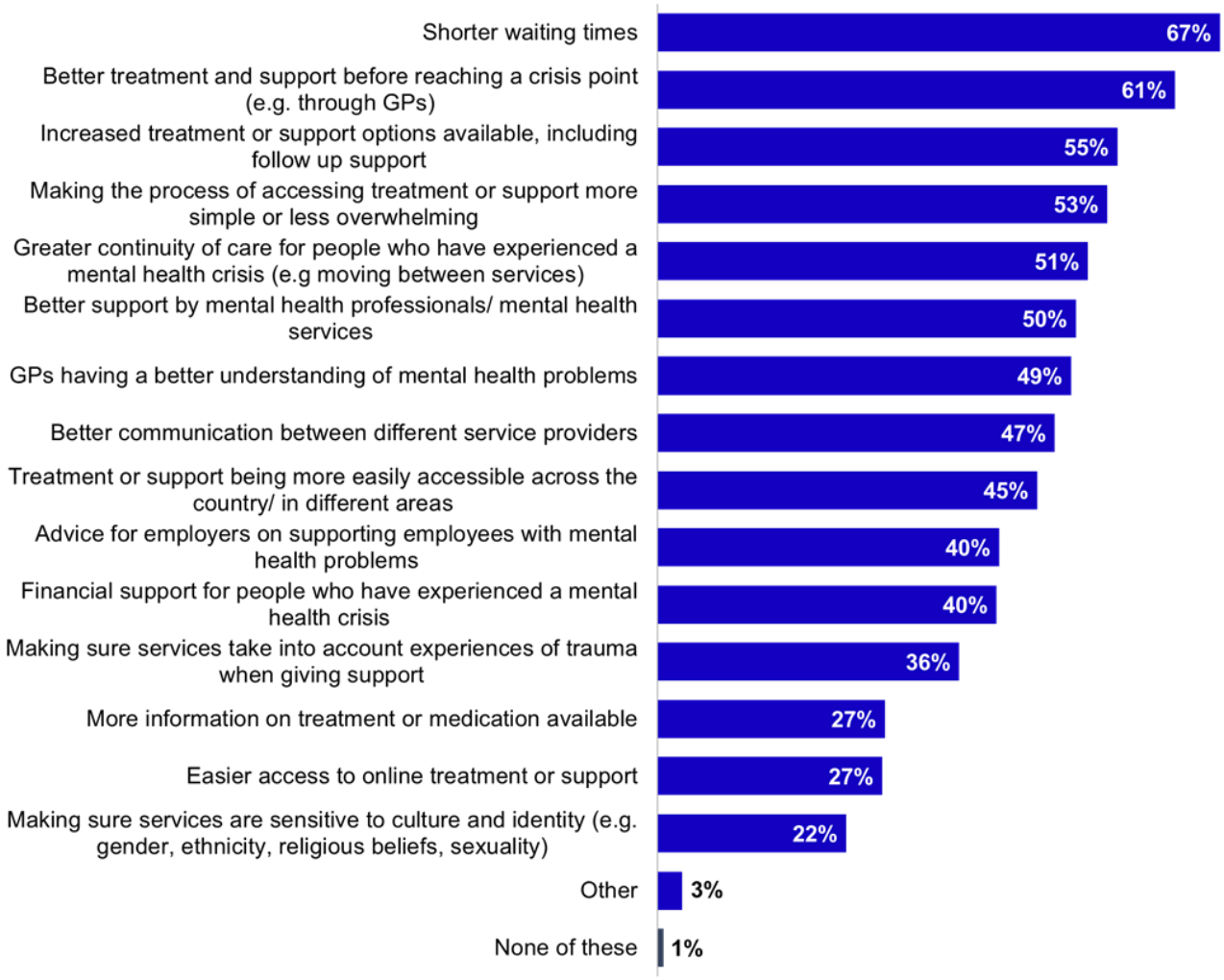
The data also demonstrates that experience of trauma has an effect on likelihood to experience a mental health crisis. People with lived experience of a mental health problem and who have experienced a traumatic event in their lives are more likely than those who have not to have had a crisis (50% vs. 29%).

Experiences of a mental health crisis are also more common among members of the LGBTQI+ community (50% vs. 40% of those not in this category), while half (51%) of young women who have experienced trauma also report this, compared with 29% of respondents who have not experienced trauma.

Way to improve crisis support

The improvements people with lived experience of a mental health problem most wanted to see are: shorter waiting times (67%), better treatment and support before reaching a crisis point (61%), and increased treatment or support options available, including follow up support (55%).

Figure 25: Ways to improve the support given to those in a mental health crisis



Base: Adults with lived experience of a mental health problem (n=4,139)

There is a notable difference by gender, with women more likely to select each form of crisis support as being helpful than men, except for financial support where there is no statistically significant difference. An example of this is more than half (55%) of women support greater continuity of care for people who have experienced a mental health crisis in comparison to forty-four percent of men. Women are also more likely to think better communication between different service providers would be helpful (51% vs. 41%).

There is no clear or consistent pattern in terms of which age groups think the different forms of crisis care would be helpful. Nonetheless, there are still some interesting differences when looking at the individual forms of support. One example is that 16-34 year olds are much more likely to think that making sure services are sensitive to culture and identity would be helpful than 35-54 year olds and 55+ year olds (30% vs. 19% and 18% respectively). The younger age group (16-34) are also more likely to think that making sure services take into account experiences of trauma when giving support is helpful (40% vs. 34% and 34%). Similarly, 55+ year olds (20%) are less likely than their younger counterparts to cite easier access to online treatment and support when compared to 35-54 year olds (27%) and especially 16-34 year olds (32%).

Among some forms of crisis care, household income appears to be a factor in how helpful they are thought to be, particularly for those in the lowest income group (less than £20,000). Understandably, for people in this income bracket, financial support is a more important form of crisis support when comparing to people with a household income of £60,000 and above (45% vs. 35%). The lower household income group are also more likely than the £60,000+ group to select ‘better support by healthcare professionals/mental health services’ (53% vs. 46%).

Those who have experienced trauma are more likely to think most types of crisis support is helpful than those who have not. For example, 57% of those who have experienced trauma think ‘making the process of accessing treatment or support more simple or less overwhelming’ would be helpful, compare with just under half (48%) of those with no experience of trauma. Unsurprisingly, people with experience of trauma are more than twice as likely to think that crisis care better taking into account experiences of trauma when giving support would be helpful (44% vs. 20%). Interestingly, young women with experience of trauma are even more likely to think this (53% vs. 44% of everyone who has experienced trauma).

Understandably, people who have experienced a mental health crisis are more likely than those who have not to think each form of support listed would be helpful to improve the provision of support for those experiencing a mental health crisis. Some notable examples include nearly six-in-ten (57%) of those who have experienced a mental health crisis citing greater continuity of care as helpful, compared with under of half (47%) of people who have not experienced a mental health crisis before. Similarly, by around ten percentage points, more people who have had a mental health crisis think better support by healthcare professionals/mental health services would be helpful than those who have not had a crisis (55% vs. 45%).

Members of the LGBTQI+ community express particularly strong support here: across all types of mental health crisis support listed, they are significantly more likely than respondents not in this category to say this would be helpful for people experiencing a mental health crisis.

Participants were also asked unprompted in what ways health services could improve crisis support. These open text responses reinforce the most common themes emerging from the survey.

This includes shorter waiting times:

"Not having a 12 week waiting time. Mental health issues need to be believed and to supported immediately." (Woman, 55-64)

Better treatment and support before reaching a crisis:

"I found often NHS cannot act until someone does something drastic, there should be more support to pre-emptively help people who are suffering, not waiting until they have hurt themselves before acting." (Young woman with experience of trauma, 25-30)

And increased treatment or support options available, including follow up support:

"Having more options available in how to treat someone having a crisis. Maybe safe spaces that aren't a hospital, that people can go to for an immediate therapy session. A non-threatening, neutral, calming environment where somebody like a counsellor can give them time to talk and get through the toughest moments of their crisis, then an aftercare plan be made/provided for asap." (Young woman with experience of trauma, 25-30)

"I think it needs to include follow up contacts to ensure the individual feels recognised and that there's a safety net." (Woman, 65+)

11 Conclusions and recommendations

Many factors can affect mental health, both positively and negatively, and promoting good wellbeing in general is likely to have a positive impact on mental health. Most commonly, people cite relationships, traumatic experiences and loneliness and isolation as factors which can negatively affect mental health, while many also mention physical health, body image and employment issues. Stigma and discrimination is a factor for those in relevant minority groups such as Black people and LGBTQI+ people. Any actions to address these areas generally, such as promoting healthy relationships, promoting good physical health, and combating stigma and discrimination, are also likely to have a beneficial impact on mental health.

Across the priority groups, preventative measures such as early support and quick diagnostic processes were preferred over reactive solutions and treatment that tended to come once that their mental health had worsened. This highlights a need for preventative, holistic and compassionate care. Given the varied experiences of those with lived experience of a mental health problem, there is a necessity for a tailored approach for individuals, as opposed to 'one-size-fits-all'. This is particularly key for people with co-occurring conditions and health problems, those who have experienced trauma, and marginalised groups.

For Black African-Caribbean and LGBTQI+ people, support needs to be culturally sensitive with an understanding of how they may have been marginalised in other facets of their lives due to their identities. Whilst faith-based organisations and charities are helpful for some groups with mental health problems, they are not always suitable for these groups, either due to stigma around mental health in the Black community, or due to a fear of discrimination based on sexual orientation – significantly reducing the level of support available. Additionally, due to a lack of clarity around support needed in crisis situations, the police service is often called upon for assistance. The presence of uniformed police officers can often create a hostile situation and a great deal of distress, particularly for those in the Black community where there is historic tension with and institutional racism within the police force.

Additionally, support for those in poverty with mental health problems needs to be tailored with awareness of the multiple stressors that are exacerbating their mental health problems, such as housing and employment pressures. Signposting to other support organisations is crucial, with a multi-pronged approach to ensure that once mental health support is provided, individuals do not simply relapse due to the pervasiveness of financial issues.

For young women who have experienced trauma, or for people with severe and enduring mental health problems, they particularly need longer term support, beyond the regimented 6-12 weeks provided by the NHS or various mental health charities. Many report having used various forms of treatment, advice and support before, suggesting the role of long-term support in mental health treatment is paramount. Given that mental health is a long-term and highly personal problem, individuals often access a wide variety of treatment and support services before finding what works for them (which can be one or a combination of different things). Equally, due to the nature of their illness or the experiences they have been exposed to, there is not necessarily a 'solution' for treatment, some may need consistent support for the rest of their lives, emphasising the necessity for a dedicated, long-term approach.

When accessing mental health treatment, advice and support, the most common issues are long waiting times, being embarrassed or ashamed to reach out for treatment and support, a lack of treatment and support options available, and support available not being relevant or suitable. This highlights the potential value in producing communications that inform people about mental health treatment and support and how it could be relevant to them, as well as increasing awareness of treatment services and their suitability for different types of people. Furthermore, there is a need to address systemic issues such as waiting times, societal stigma and discrimination in relation to mental health problems.

There is complex interaction between mental and physical health, with both of these able to negatively or positively affect the other. Many respondents feel that improving the ability to discuss physical health alongside their mental health would have a positive impact on their physical wellbeing, along with greater continuity of care. The findings suggest that the distinction between mental and physical health can be experienced as restrictive or unhelpful by patients, and it would be beneficial to consider different aspects of health more holistically.

Those with additional needs or vulnerabilities, such as learning disabilities or severe and enduring mental health problems, are more likely to have a negative experience with mental health treatment due to lack of tailored options, and strained services which mean that health care professionals do not have the extra time needed to dedicate to understanding their situation, helping them to feel heard. This highlights a need to ensure sufficient time is allocated to those living with disabilities, in order to better explain medication and ensure understanding.

Access to care (specifically waiting times) is seen to be the key issue to address in relation to crisis care. However, many of the recommendations outlined above can also be expected to contribute to the improvement of crisis care. A more tailored, personal and holistic approach in primary care may act preventatively, making it less likely that a crisis point will be reached. Similarly, delivering care with a more long-term focus and with more follow-up, may also assist with this.

Case study: Annie*, Young Woman with a Learning Disability

Their mental health

Annie was diagnosed with anxiety during school and experiences stress in social situations. She has developed coping strategies for the days when she feels low - avoiding going out outside and socializing. On these days, she prefers listening to music to let out emotions.

I have a lot of coping strategies, I kind of know what tends to work for me.

If I'm having a particularly low day. Then I won't want to kind of go out and socialise just because I know that might kind of tip me over the edge a little bit.

Mental health services

Annie trusts her partner and mum for support and advice when it comes to her mental health as she has mixed opinions on health services. She has had experiences where she was talked down to, not listened to, or had to wait for a long time to see a professional. She also feels that she was ashamed of accessing mental health support due to her age. However, her social network, and friends have always supported her to seek help.

Narratives around mental health

Annie thinks that discussion on mental health has become more open, some groups are still reluctant to access help. She also believes that younger people are more open than middle-aged ones.

I feel like in the working-class circles, there is not a stigma, but a kind of 'just get on with it' attitude. Where I grew up on a council state, that very much seemed to be the vibe. You just kind of have to keep pushing, rather than necessarily access help.

Intervention

She believes early education on mental health, accessibility, and funding are the most important issues which needs to be addressed by the government. She feels being listened to, being understood, and being taken seriously are critical when accessing support.