Response to the call for evidence for the Mental Health Strategy for England

10th July 2026

1. Hospital to community

Effective partnership working at a community level is essential for the provision of person-centred care. These partnerships address the broad range of factors which can influence a person's mental health recovery, such as:

- *physical health*
- *employment*
- *housing*
- *addiction*
- *social care*

We are piloting 6 community-based mental health centres across England to understand how services can better work together at a local level to improve people's outcomes. We would like to hear practical insights that support wider transformation of mental health care in communities.

We welcome practical examples and evidence on how mental health services can work more effectively across:

- *the wider NHS, including new neighbourhood health centres*
- *services to support people with co-occurring mental health and neurodevelopmental conditions*
- *different sectors, including education, employers, local authorities and the voluntary, community and social enterprise (VCSE) sector*

How can mental health services work more effectively across these areas? Please provide examples of cross-sector pathways in practice. (Optional, maximum 300 words)

Social Prescribing Link Workers and equivalent roles can play a key role in neighbourhood health centres and in connecting NHS services with other sectors.

Link workers provide relational, personalised support through a ‘what matters to you’ approach, using motivational interviewing to create personalised plans that connect people to support – including local groups and activities, debt and housing support, training, employment advice and other NHS services. In practice, their role is to address social determinants that affect mental health and to provide the ‘glue’ between the NHS and the vast range of services and opportunities in local communities.

Link workers have been recruited nationally in primary care since 2019. There are now more than 3,300 link workers across England and there were more than one million referrals to link workers in 2023, primarily from GPs; they typically have 4-12 appointments with each patient*.

There are no diagnostic thresholds for referrals to link workers, but they typically work with people facing loneliness, low-moderate mental health problems and complex social needs. A referral to a link worker can take place alongside other interventions, such as talking therapy or antidepressant prescriptions.

There is strong evidence demonstrating the impact:

- UCL research shows "consistent and sizeable improvements across different wellbeing domains in the 1–6 months following initial referral to social prescribing"
- The national evaluation of the link worker roll-out showed that having an additional link worker in a PCN was associated with improved perception of support from local services and improved ability for patients to manage their own mental health.
- There is strong evidence for many of the interventions link workers connect people to (e.g. physical activity, arts and culture, heritage and nature, advice and information, faith-based projects.)*

*References to evidence: www.socialprescribingacademy.org.uk/evidence

Later answers will address factors that enable link workers to be most effective.

We welcome views or evidence on what further support, in addition to NHS services, should be provided for people with severe and enduring mental illness to:

- *help them stay well*
- *maintain participation in education, work and community life*
- *avoid crisis and/or hospital admission*
- *reduce length of stay in inpatient units*

What further support should be provided for people with severe and enduring mental illness? (Optional, maximum 300 words)

There is a wealth of evidence demonstrating the benefits of non-medical approaches such as nature and gardening, arts therapy and physical activity sessions for people with severe and enduring mental illness*.

Social Prescribing Link Workers in primary care connect people to this kind of non-medical support, based on what matters to each individual. Link workers can also connect people to support related to housing, benefits, debt and other social needs, which can exacerbate existing mental health problems.

One ethnographic study suggests that social prescribing for people with enduring mental health problems leads to: increased self-confidence, self-esteem, sense of purpose/meaning, sense of achievement and experience of pleasure; increased social support, sense of community and belonging; and increased independence.*

Almost all link workers support people with mental health problems on a regular basis and 77% say that they have supported someone with severe mental illness.*

However, there are key challenges that prevent link workers supporting this cohort more routinely:

- Average annual caseloads for Link Workers are around 340 people per year, above the NHS guidance of a maximum of 250 patients per year*. To ensure that those with severe mental illness can benefit from social prescribing, link workers need more time to support those with complex needs, as well as access to specialist training and clinical supervision.
- A need for more specialist link workers in secondary care for mental health, to supplement generalist link workers in primary care.
- A need for sustainable funding for community-based support for voluntary sector organisations providing arts, culture, nature, heritage and physical activity interventions for people with enduring mental illness. Long-term funding is essential to avoid abrupt endings to support.

- Improved training, guidance, support and connections to NHS systems for voluntary sector organisations working with people with enduring mental illness.

* References at www.socialprescribingacademy.org.uk/evidence

What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

Please provide examples from either side of the transition and outline how these barriers could be effectively addressed. (Optional, maximum 300 words)

One barrier faced by people with co-existing mental and physical health problems is a lack of coordination between NHS services and wider social support. For example, cardiovascular disease is closely associated with deprivation, insecure employment and housing instability – all of which are also associated with poor mental health.

However, if someone is admitted to hospital after a heart attack, they are likely to be discharged without significant recognition of wider circumstances that affect their physical and mental health.

A pioneering scheme at Barts Health Centre has embedded Social Prescribing Link Workers in the heart attack pathway, with social prescribing provided for patients experiencing deprivation.

Before social prescribing, 65% of patients rated their concerns at 5 or 6 on the MyCAW scale (where 6 represents "as bad as it can be"). After social prescribing, this proportion fell to 36%. Following support, the proportion reporting severe negative wellbeing decreased, particularly among those with the highest baseline scores. (https://integratedcarejournal.com/embedding-social-prescribing-in-the-barts-heart-attack-pathway-what-new-data-means-for-commissioners-and-clinicians/)

There is clear evidence to show benefits of link workers and equivalent roles in other secondary care and disease-specific pathways, where they can provide connections between support for physical health and support for mental health and wider social factors. (https://socialprescribingacademy.org.uk/what-is-social-prescribing/social-prescribing-and-long-term-conditions/)

However, recruitment of link workers in hospitals is currently funded through charitable schemes or small-scale local initiatives. There needs to be further investment in this approach at national and regional level, in order to improve transitions and prevent unnecessary readmission or escalation of mental health problems. Roles with a connecting function should also be a key part of secondary mental health pathways.

2. **Analogue to digital**

It's important that children and adults can benefit from the opportunities that digital technology can offer to boost mental health and wellbeing. However, this must be balanced with safety and protection from risks to mental health. We understand that many people would like:

- *more personalised, tailored mental health support available digitally*
- *digital tools to be neuroinclusive (accessible and effective for people with neurodevelopmental conditions)*

A 2025 report from Mental Health UK stated that people are also increasingly turning to AI chatbots for mental health advice.

We welcome evidence and innovative examples of how digital and AI tools can be safely used for adults and children to:

- *improve mental health and wider societal outcomes*
- *support access to effective mental health support*
- *complement relational care*

What evidence and innovative examples are there of digital and AI tools being used to achieve these outcomes? Please provide examples. (Optional, maximum 300 words)

There are wide range of apps, websites and online databases that provide signposting to services that support mental health – from local NHS and Local Authority-funded websites to national mental health-specific databases like Hub of Hope, to sector-specific websites like Music Can or Prescribe-Arts.

The Ten Year Health plan envisages that "My Care will increasingly link to services outside the NHS - in the voluntary sector, from social enterprises, social care, community groups or local government. It will be a digital social prescriber."

While signposting apps and databases can provide useful support for people's mental health, there are a range of challenges with online 'social prescribing' tools:

- National apps/websites that offer links to opportunities and services need significant investment to stay up to date and comprehensive.
- There is often duplication and crossover between different apps and databases, and unclear user journeys between them, particularly for people who are not confident online.
- There is a need for improved coordination between different directories. E.g. Social Prescribing Link Workers are likely to have an excellent

knowledge and record of local services and opportunities, but this knowledge may not be available through a public directory.

Crucially, apps cannot easily address many of the main barriers to participation – including costs, means of travel, disabilities, caring responsibilities or anxiety about trying something new.

That is why there is also a need for Social Prescribing Link Workers and similar roles, who have time to learn what matters to a patient, understand the barriers they face, and actively help them overcome these.

Health Connections Mendip provides an example of an integrated social prescribing service, in which online directories and telephone helplines complement the work of specialist link workers and volunteers: https://healthconnectionsmendip.org/

How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples. (Optional, maximum 300 words)

There is strong evidence to show that social prescribing can benefit mental health and wellbeing (see previous answers).

However, at the moment, most referrals to social prescribing services are via GPs, based on who attends primary care appointments. This may mean that some people who would most benefit from social prescribing are not being reached.

Proactive, data-driven social prescribing can identify patients who would most benefit based on analysis of local needs (e.g. aimed at patients experiencing long-term health conditions and deprivation, who are not currently in touch with health services - and who are likely to be at high risk of poor mental health).

There is evidence to show the effectiveness of this data-driven approach (for example: https://socialprescribingacademy.org.uk/resources/ways-to-wellness-long-term-conditions-service/ and https://socialprescribingacademy.org.uk/resources/proactive-social-prescribing-service-for-people-with-respiratory-problems/)

Proactive social prescribing has previously been a requirement of the GP contract and could be again, in order to drive this approach.

There is also a need for more effective and consistent data collection to show who benefits from social prescribing, how and in what circumstances.

The Social Prescribing Information Standards enable social prescribing support to be recorded collaboratively between patients, link workers and health and care professionals.

The NHS guidance for link workers includes ONS4 as the recommended outcomes measure: https://www.england.nhs.uk/long-read/social-prescribing-reference-guide-and-technical-annex-for-primary-care-networks/ However, from NASP's survey with Social Prescribing Link Workers, only around 40% use ONS4 and there is a clear call for additional and more appropriate outcomes measures.

There is also an opportunity to link data more effectively between NHS and voluntary, community and faith sector organisations and improved coordination on outcomes monitoring, in order to understand the impact of the full social prescribing pathway.

NASP is currently exploring how to support link workers to use outcome measures and ensure that measures are relevant and meaningful.

3. **Sickness to prevention**

The incidence and severity of mental health conditions has risen in recent decades, with young adults in particular now reporting substantially poorer mental health. Data from NHS England's Survey of mental health and wellbeing, England 2023 to 2024 stated that 25.8% of young people are estimated to have a common mental health condition, up from 17.5% in 2007.

Many of the solutions to mental health problems involve education, employment, housing and participation in community life. Therefore, if prevention is to be effective, we need to think beyond the realms of clinical care and across the life course.

We are especially interested in how we can identify distress earlier and support people to maintain participation in education and work. Preventative approaches include:

- *primary prevention - stopping mental health problems before they start*
- *secondary prevention - supporting those at higher risk of experiencing mental health problems*
- *tertiary prevention - helping people living with mental health problems to stay well*

We encourage examples of good practice within and beyond the health system, including in work and education settings where people with a co-occurring mental health and neurodevelopmental condition may particularly benefit.

Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (Optional, maximum 300 words)

Many community-based interventions across arts, heritage, nature, physical activity and faith have a strong evidence base for primary and secondary prevention. (www.socialprescribingacademy.org.uk/evidence). For example, the cross-Government Green Social Prescribing programme demonstrated significant improvements in wellbeing and mental health and a positive social return on investment (https://socialprescribingacademy.org.uk/resources/green-social-prescribing-improves-your-mental-health/).

NHS social prescribing services are a way of enabling people to access this support. They are targeted at people with low-moderate mental health needs, people facing loneliness and people experiencing complex social needs. Patients do not need to meet a diagnostic threshold to be referred to social prescribing.

On average, patients have low wellbeing when they are referred and move to average wellbeing scores after the completion of support from link workers (based on a UCL study using SWEMWBS: https://www.nature.com/articles/s44360-026-00099-w). Other research shows similarly positive outcomes. (e.g. https://socialprescribingacademy.org.uk/resources/cost-effectiveness-of-social-prescribing-a-case-study/)

However, it is important that there is not a one-size-fits-all approach, and that referrals to non-clinical support are based on what matters to each person. This is why the link worker role is crucial, using motivational interviewing techniques to find out about people's preferences and helping them overcome barriers to participation.

In order to maximise the impact of social prescribing and community-based services that can support mental health, it is important to:

- Grow the number of link workers (which requires mechanisms to support recruitment and training)
- Create guidance and practical support to connect the NHS with local organisations
- Ensure that voluntary, community and faith sector groups that support mental health have long-term, sustainable funding – for example through pooled Community Health and Wellbeing Funds or Community Chests (https://socialprescribingacademy.org.uk/resources/towards-a-national-community-health-and-wellbeing-fund/).

How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? Please provide examples. (Optional, maximum 300 words)

Social prescribing is well placed to support the "missing middle", providing help to people for loneliness and social issues that affect mental health without need for a diagnosis. On average, waiting lists are short after a referral (typically four weeks or less) and patients typically receive 4-12 contacts with a link worker.*

Social prescribing is part of the Government fit note pilots, with link workers providing holistic support to people whose mental health is affected by wider social needs. Emerging evidence suggests that social prescribing can reduce the number of fit notes, with more people feeling well enough to work after a referral.* Research in Italy and Portugal showed social prescribing can support the health and wellbeing of young people not in education or employment (https://copeproject.eu/new-study-by-cope-partners-shows-social-prescribing-improves-mental-health-for-neet/?utm_source=copilot.com).

Social prescribing can also provide support for children and young people with a mental health need who do not meet the threshold for NHS services.

The Wellbeing While Waiting research programme by UCL showed that social prescribing led to increased resilience, pro-social behaviour and coping mechanisms for children and young people on CAMHS waiting lists. Other evidence shows the benefits of social prescribing for children and young people at different stages of mental health need – including prevention and intervention, with programmes based in schools and local communities. (https://socialprescribingacademy.org.uk/what-is-social-prescribing/social-prescribing-for-children-and-young-people/).

However, there is need to:

- Maintain and grow the Link Worker workforce through national and regional mechanisms (e.g. GP contract, NHS Workforce Plan, neighbourhood health guidance)
- Improve training and development for link workers, as well as recognition of the role
- Ensure sustainable funding for voluntary sector providers
- Carry out more research into social prescribing for specific groups – including children and young people.

* References at www.socialprescribingacademy.org.uk/evidence

Too often, we hear that services are hindered by administrative barriers that prevent innovative, integrated and person-centred care. We are interested in the underlying enablers of good practice around the country, and the role national government can play in creating the conditions for reformed models of mental health support. We are particularly keen to understand how access can be improved, for example through therapeutic support for certain groups such as women and girls subject to violence and/or child sexual abuse.

What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? Please provide examples. (Optional, maximum 300 words)

Previous answers have demonstrated the benefits of Social Prescribing Link Workers for wellbeing and mental health.

Link workers and other connecting roles are commissioned through a range of mechanisms, including funding from the Additional Roles Reimbursement Scheme (ARRS) in primary care, ICBs, local authorities, voluntary sector schemes and programmes based in hospitals.

ARRS funding has successfully enabled an expansion in the number of link workers to around 3,300 across England. While this is significant progress, it falls well short of the target of 9,000 link workers by 2036/37 in the previous NHS Long Term Workforce Plan.

Increased local variation around how ARRS funding is used could also inadvertently create a risk of fewer link workers being recruited: there has been a slow but steady decline in the number of link workers over the last 18 months.

Therefore, there is a need for a national mechanism to maintain the recruitment of link workers across the country, which could be through the GP contract or neighbourhood health guidelines. These connecting roles, who forge links with local voluntary sector organisations, are crucial to the success of the Government's plans to introduce a neighbourhood health service.

There should also be mechanisms to ensure that there are roles with a connecting function in community mental health trusts and in wider secondary care.

In order to support the spread and scale of social prescribing, there is also a need for effective training, supervision and support, improved evidence for what works, and stronger connections between the NHS and other sectors that promote good mental health.

NASP’s movement on prescription programme with Sport England provides an example of how connected pathways between social prescribing, primary care and activity providers can support better understanding of and access to community assets that improve health.