THE READING AGENCY

Reading Well for mental health: evidence review

Executive summary

This paper provides an overview of evidence and considerations for a new Reading Well Books on Prescription scheme for adults' mental health. The paper reviews key areas of consideration relevant to the development and implementation of the proposed new collection focusing on the prevalence, evidence of need, relevant policy and clinical guidance.

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1. Introduction

As part of its successful Reading Well Books on Prescription programme, The Reading Agency is developing a new scheme to support adult mental health. It will include a list of helpful reading available from public libraries and other relevant locations.

This new scheme will update and replace Reading Well for mental health, which launched in 2018. It will add to the Reading Well portfolio using up-to-date guidance and best practice, with a new list of recommended books and supporting digital resources on mental health targeted at adults (18+).

The list will be created and delivered with relevant health partners and library stakeholders and co-produced with people with lived experience. Reading Well is a key strand of the Public Library Universal Health and Wellbeing Offer, a national strategy that promotes the role that libraries can play in the health and wellbeing of local communities. See Appendix 1 for an overview of the Reading Well programme.

1.1 The development process

Reading Well is an evidence-based, quality-assured programme. The Reading Agency follows an established, best practice process which includes evidence mapping, expert consultation, co-production and a thorough review of submitted titles against a book selection framework.

Co-production underpins all aspects of Reading Well development. Each scheme is supported by a co-production partner and bespoke co-production panel. The panel focus on key areas of development including the structure of the list, the use of language, review of shortlisted titles and the launch and promotion of the scheme.

1.2 Evidence base for Reading Well Books on Prescription

There is a strong evidence base that reading can improve health and wellbeing. Through external research, annual evaluation of Reading Well and case studies, evidence shows the positive impact of reading and Reading Well for individuals.

2. Language and terminology

There is a wide range of language and terminology used in relation to mental health and the language used has evolved over time. Alongside this, different people have different perspectives and preferences on the language used. Within the context of Reading Well for mental health, we are using the following terminology:

- **Mental health** is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community. It has intrinsic and instrumental value and is a basic human right[1].
- **Mental health problems** are difficult experiences that make it harder for us to get on with our lives. They include the painful feelings and thoughts that we all have at times – including periods of sadness, hopelessness and fear[2].
- **Common mental health conditions (CMHCs)** comprise different types of depression and anxiety disorder. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. CMHCs are usually less disabling than major psychiatric disorders[3].
- **Severe mental illness** is a clinical definition used by the NHS in England to refer to individuals who have a diagnosis of psychosis, schizophrenia or bipolar disorder[4].

We have referred to a range of guidelines on mental health language, including:

- Mind "Mental health language"
- Mental Health Foundation "Why the language we use to describe mental health matters"
- Sussex Health & Care "Changing the language: a guide to language for mental health"

Please note: the terminology used in the Evidence of need section reflects the language used in the sources cited.

3. Rationale for development

Mental health is a national policy priority across the UK and there is an identified need for evidence-based, community delivered information and support with a focus on early intervention and prevention.

The cost of mental ill health in England in 2022 was calculated to be £300 billion, almost double the NHS's entire budget in England for that same year (£153 billion)[5].

The current Reading Well for mental health collection launched in 2018, as an update to the original 2013 Reading Well for mental health scheme. Since 2018, there have been a wide-range of developments relating to mental health including the COVID-19 pandemic, cost-of-living challenges and wider policy developments. Alongside this, the Reading Well programme has evolved as new schemes have been developed.

The Reading Agency has also received feedback from health professionals and library staff in relation to the age and availability of titles from the current Reading Well for mental health collection.

This means there is a need to develop a new and fully updated Reading Well for mental health collection. The new collection should focus on topics where books and reading can have the most impact focusing on early intervention and prevention, acknowledging the programme is delivered in the community with limited support and aims to support people outside of clinical settings.

The following themes have been identified as principles to underpin the new Reading Well for mental health collection, based on usage data and evidence mapping:

- Early intervention and prevention – the need for recommendations which encourage proactive, preventative, community-based care aligned to the Fit for the Future 10-year health plan shift "from sickness to prevention". This aligns with the relative popularity of "Therapies and approaches" titles in the 2018 collection, which can provide information on evidence-based tools that are practical and actionable.
- Commonly experienced mental health problems – the need for information to support awareness of the prevalence of common mental health problems such as anxiety, depression, stress, sleep problems and anger and increased awareness of how these intersect and can contribute to poor mental health. This aligns with the relative popularity of the "Common feelings and experiences" titles in the 2018 collection and evidence demonstrates demand for resources to support the self-management of these experiences.
- Tackling stigma – there is increasing recognition of the importance of tackling the stigma associated with mental health problems. This is reflected with the relative popularity of the "Personal stories" titles in the 2018 collection, which provide real-life stories, creating communities linked by experience and destigmatises mental health problems through lived experience narratives.

See Appendix 2 for detailed analysis the 2018 Reading Well for mental health scheme usage data.

4. Recommendations

All Reading Well schemes focus on early intervention and prevention. In defining the scope of each scheme, priority is given to topics where it is known that access to evidence-based information outside clinical settings is appropriate and helpful, as well as to areas of need where books and reading can have the greatest impact.

For the new Reading Well for mental health collection, we are proposing to focus on the awareness, understanding and management of common mental health problems and experiences. We aim to focus on prevalence and the relevance of book-based interventions, all with reference to the needs of identified at-risk populations.

Within this context, we are proposing the following areas of focus:

- Common mental health conditions, including anxiety disorders and depression
- Common feelings and experiences which can negatively impact mental health including anger problems, bereavement and loss, loneliness, sleep problems and stress
- Self-help approaches including CBT and mindfulness
- Resources for identified at-risk populations
- Resources for family and carers

We are **not** proposing to include resources on:

- Severe mental illness
- Post-traumatic stress disorder (PTSD)
- Personality disorders
- Self-harm
- Suicide

See Appendix 3, for an overview of prevalence, clinical guidelines and evidence for book-based interventions which has informed this approach.

The final scope of the collection will be agreed via professional consultation and with the expert book selection panel.

5. Evidence of need

The following section outlines key areas of consideration for the new scheme and highlights evidence and information related to need.

N.B.

- Language used in this section reflects the language used in the sources cited.
- Perinatal mental health has been intentionally excluded from the evidence mapping for the adult mental health scheme refresh, as it is addressed by Reading Well for families.

5.1 Mental health in the UK

- 1 in 4 people will experience a mental health problem of some kind each year in England[6] and in 2023/24, 1 in 5 adults in England had a common mental health problem[7].
- In Wales, almost 25% of registered general practice patients were recorded as having any* mental health condition as of 1 April 2025[8].
- Approximately 1 in 4 people in Scotland will face a mental health problem during their lifetime[9].
- 1 in 5 adults in Northern Ireland have a probable mental illness[10].
- The number of people with common mental health problems went up by 45% between 1993 and 2023/24[11].
- In 2023, mental health services in England received a record 5 million referrals, an increase of 33% since 2019[12].
- Certain groups of people are at greater risk of experiencing poor mental health, including adults living in more deprived areas, adults experiencing poverty, ethnic minority communities, unemployed / economically inactive, those in receipt of benefits, people who are socially isolated, rural communities, people living with one or more long-term condition, neurodivergent people, LGBTQ+ people, disabled people and carers[13,14,15,16].
- Research demonstrates an association between literacy and mental health with those with lower literacy having greater mental health difficulties[17].
- If left untreated common mental health conditions can lead to long-term physical, social and occupational disability[18]and premature mortality[19]. They can also be relapsing conditions (meaning that symptoms may return or worsen), especially when the factors that caused them continue to exist[20].
- There are increasing challenges around stigma and awareness in relation to mental health with declining public understanding and acceptance of mental problems[21].

5.2 UK mental health in context

This section outlines how contextual factors, including the lasting impact of the COVID-19 pandemic, the cost-of-living crisis and climate change, are impacting on mental health in the UK.

5.2.1 COVID-19

- The onset of the COVID-19 pandemic led to a deterioration of mental health in the UK compared with pre-COVID-19 trends[22] and in the first year of the COVID-19 pandemic, global prevalence of anxiety and depression increased by 25%[23].
- Evidence indicates that wellbeing and mental health were poorer across the general population during the pandemic, and as the crisis eased population wellbeing improved.

*This includes dementia, mental health conditions recorded on the mental health disease register, depression, low mood and anxiety disorder.

However, there were significant variations with some groups experiencing worse mental health outcomes, including older people, children and young people, young adults, racialised communities, LGBT+ communities, autistic people and people with existing mental health conditions[24].

- Evidence shows levels of mental ill health have risen over the last decade and the COVID-19 pandemic has contributed to many of the risk factors people experience[25].

5.2.2 Cost-of-living crisis

- In the British Association for Counselling and Psychotherapy's 2025 member survey, 64% of therapists said that the public's mental health had deteriorated since the previous year, and 93% perceived financial concerns and the cost of living as contributing factors[26].
- A recent study found that 60% of British adults reported that the cost-of-living crisis had a negative impact on their mental health. The study did find that people are seeking support, particularly people whose mental health has been most impacted. 15% of people with a mental health condition reported seeking out self-help resources for emotional and health support, compared with 11% of the general population[27].
- The Mental Health Foundation identified a Cost-of-Living Crisis paradox, whereby behaviours that are protective of mental health (such as getting enough sleep and maintaining social connections) are the very behaviours that people are reducing to cope with the increased cost of living[28].

5.2.3 Climate change

- The health impacts of climate change are well known, and climate change is negatively impacting mental health and wellbeing, with those most impacted likely to be those already experiencing poor health or health inequalities[29] .
- According to a poll from the Royal College of Psychiatrists, 84% of the British public think the climate and ecological emergency will affect their mental health[30].
- There is some evidence that Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT) and dynamic psychotherapy-based interventions for psychological distress associated with climate change awareness can reduce PTSD, depression, anxiety, stress and insomnia[31].

5.2.3.1 Eco-anxiety

- Eco-anxiety is a term used to describe feelings of distress and worry caused by the awareness and threat of climate change[32].
- A survey found 26% of young people in the UK said eco-anxiety impacts on their daily functioning. Mental health service providers have also reported a rise in the number of clients who say that worry about climate change is negatively impacting on their mental wellbeing[33].
- It's important to note that there is disagreement over whether eco-anxiety is independent from other mental health conditions, and there exist no validated measurement scales for eco-anxiety. Studies suggest a correlation between higher rates of eco-anxiety and other symptoms of mental health problems, including depression, anxiety, stress, insomnia and psychological distress[34].

6. Mental health conditions

There are 33 mental health conditions listed on the NHS website[35] – agoraphobia, anorexia nervosa, binge eating disorder, bipolar disorder, body dysmorphic disorder, borderline personality disorder, bulimia, claustrophobia, cyclothymia, depression, dissociative disorders, eating

disorders, fabricated or induced illness, generalised anxiety disorder (GAD), health anxiety, hoarding disorder, Munchausen syndrome, obsessive compulsive disorder (OCD), panic disorder, personality disorder, phobias, postnatal depression, postpartum psychosis, post-traumatic stress disorder (PTSD), psychosis, psychotic depression, schizophrenia, seasonal affective disorder (SAD), selective mutism, skin picking disorder, social anxiety (social phobia), stress, trichotillomania (hair pulling disorder).

Alongside these conditions are a range of symptoms and experiences related to mental health including anger, loneliness, self-esteem, sleep problems, grief and bereavement and trauma which are often included within mental health information.

Within the context of a Reading Well scheme, alongside prevalence and evidence in relation to book-based approaches, consideration should be given to the nature of the programme. It is designed to be accessed in the community, outside of formal support and is not a replacement for clinical care. Previous Reading Well for mental health collections have focused on common mental health conditions and experiences considered through an early intervention and prevention perspective.

6.1 Anxiety disorders

- Anxiety disorders are amongst the most common mental health problems in the UK, with research finding generalised anxiety disorder is present in 1 in 12 adults in England[36].
- In Scotland, the proportion of adults that reported two or more symptoms of anxiety was 17% in 2021/22, an increase from 9% in 2010/11[37].
- Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, post-traumatic stress disorder (PTSD), social anxiety disorder, obsessive compulsive disorder (OCD), health anxiety and phobias[38,39].
- Anxiety disorders have a significant impact on quality of life, including physical and emotional health, occupational and social functioning and financial independence[40].
- Meta-analysis of self-help interventions compared with waiting list for individuals diagnosed with an anxiety disorder showed a significant difference in favour of self-help[41].

6.1.1 Body dysmorphic disorder

- Body dysmorphic disorder (BDD), also known as body dysmorphia, is an anxiety disorder related to body image. It is closely related to obsessive-compulsive disorder (OCD)[42].
- BDD is relatively common, with a prevalence of about 2% in the general population[43].
- In the UK, estimates suggest around 1 in 50 adults are living with BDD, although this is likely to be an underestimate[44].
- Approximately two-thirds of individuals develop BDD before 18[45].
- Roughly one third of individuals with BDD lack insight into their difficulties or experience delusional beliefs[46].
- Symptoms of BDD vary from person to person. Common symptoms include obsessive worries about the body and compulsive and repetitive behaviours[47].
- The Causes of BDD are not well known. Factors identified as contributing to its development include[48 49]:
    - Genetics and a family history of mental illness.
    - Having an anxiety disorder or personality disorder.
    - Personality traits.
    - Childhood trauma or abuse.
- Common co-morbidities for BDD include major depressive disorder, anxiety disorders, OCD, eating disorders and substance use[50].

- Treatment for BDD depend on how severe the symptoms are. Someone with mild symptoms should be offered cognitive behavioural therapy (CBT), someone with moderate symptoms should be offered either CBT or a selective serotonin reuptake inhibitor (SSRI) and someone with severe symptoms should be offered combined CBT and a SSRI[51].
- The Body Dysmorphic Disorder Foundation suggest self-help books may help people with BDD who are not ready to engage with therapy, as an additional resource during CBT and for family members[52].
- The impact of BDD is profound and is associated with poor quality of life[53]. It often leads to other mental health conditions including depression and substance misuse, and approximately one in four people with BDD attempt suicide[54].

6.1.2 Generalised anxiety disorder

- Generalised anxiety disorder (GAD) is characterised by excessive worry about everyday issues that are disproportionate to any inherent risk[55].
- Across the UK prevalence rates for GAD are reported to be 5.9%[56].
- A range of factors have been shown to increase someone's risk of developing GAD, including[57]:
    - Being female, it is twice as common in women than men.
    - Having another anxiety disorder e.g., panic disorder.
    - Having a family history of mental health conditions.
    - Childhood adversity including parental mental health problems, domestic violence and neglect.
    - Having a history of physical, sexual or emotional trauma.
    - Being unemployed or living in an area of deprivation.
    - Having a long-term physical condition such as cardiovascular disease or cancer.
- Symptoms of GAD vary from person to person and can include both psychological and physical symptoms such as feeling restless or worried, having trouble concentrating or sleeping, dizziness or heart palpitations[58].
- Evidence suggests more than 80% of people with GAD have a co-morbid mental health condition, with major depressive disorder being the most common[59] and the presence of both is associated with poorer health outcomes, poorer quality of life and a higher suicide risk than either disorder on its own[60].
- Treatment for GAD includes lifestyle approaches (e.g., exercise, stopping smoking), self-help resources, talking therapies and medication[61 62].
- Research has demonstrated low-intensity CBT, including unguided self-help, was effective for reducing anxiety, depression and worry amongst adults with GAD[63].
- Evidence suggests adults with GAD experience worse quality of life including poorer health, challenges at work, difficulties maintaining activities and higher healthcare use than adults without GAD[64].

6.1.3 Health anxiety

- Health anxiety is a recognised anxiety disorder where an individual is often preoccupied with thoughts about their health and it starts to take over their life[65].
- Approximately 5% of the general population experience severe health anxiety[66] and reports suggest up to 19.9% of English medical patients have experienced significant health anxiety[67].
- There is no single cause for health anxiety, however, some factors may influence whether someone develops it, including[68]:
    - Experience of a serious illness amongst someone close to you.

    - Having a parent who experienced health anxiety.
    - Exposure to distressing stories or information relating to health and illness.
    - Experience of a serious illness or medical condition.
- Symptoms of health anxiety include[69]:
    - Constantly worrying about your health.
    - Frequently checking for signs of illness.
    - Worrying a clinician has missed something.
    - Acting as if you have a health condition.
- Evidence suggests females and younger adults are more commonly affected by health anxiety[70].
- Treatment for health anxiety includes self-management (e.g., mindfulness, keeping a diary and keeping busy), a talking therapy such as CBT or a medication for anxiety[71].
- Health anxiety is associated with mental health comorbidities including depression and anxiety, as well as having a negative impact on quality of life and increased use of healthcare services[72].

6.1.4 Obsessive compulsive disorder (OCD)

- OCD is a mental health condition where a person has obsessive thoughts and compulsive behaviours[73].
- OCD is thought to affect 750,000 people in the UK, around 1.2% of the UK population[74].
- It's not clear what causes OCD, but a range of factors may affect whether someone develops OCD, including[75]:
    - Family history.
    - Differences in the brain, either unusually high activity in the brain or low levels of serotonin
    - Life events, including being bullied, abused or neglected
- There are three main elements to OCD[76]:
    - Obsessions – unwanted, intrusive and distressing thoughts, images and urges.
    - Emotions – a feeling of anxiety or distress related to the obsession.
    - Compulsions – repetitive mental acts or behaviours that the person is driven to.
- OCD is associated with a range of comorbid psychiatric conditions with 90% of individuals with OCD meeting the criteria for at least one additional psychiatric disorder. Anxiety disorders, mood disorders, impulse-control disorders and substance use disorders are the most prevalent comorbid conditions[77].
- OCD is underdiagnosed and undertreated, despite growing awareness[78].
- Treatment for OCD depends on the impact it is having. The two main treatments are talking therapy (usually a type of CBT) or medicine (usually a selective serotonin reuptake inhibitor (SSRIs)[79].
- Evidence suggests unguided self-help psychological interventions demonstrate potential effectiveness in alleviating OCD symptom severity post-intervention[80].
- The World Health Organization (WHO) lists OCD as one of the ten most disabling illnesses in terms of loss of earning and reduced quality of life, and it is frequently cited as the fourth most common mental disorder globally after depression, substance abuse and social phobia[81].

6.1.5 Panic disorder

- Panic disorder is an anxiety disorder where people regularly have sudden attacks of panic or fear[82].

- In England, the prevalence of panic disorders is 1% for adults[83].
- The exact cause of panic disorder is not known. However, it is thought to be linked to certain factors including[84]:
    - A traumatic life experience.
    - Having a close family member with panic disorder.
    - An imbalance of neurotransmitters in the brain.
- The symptoms of panic disorder include anxiety and panic attacks[85].
- It can be quite common for people with panic disorder to experience other mental health problems including depression and agoraphobia (a fear of being in situations where escape might be difficult or where help wouldn't be available if things go wrong)[86].
- Evidence supports treatment based on CBT for panic disorder[87] and offering people non-facilitated self-help for mild to moderate panic disorder[88].
- Panic disorder can have a significant impact of quality of life and may lead to worse health outcomes, increased use of healthcare services, challenges at work and financial difficulties[89].

6.1.6 Phobias

- A phobia is an extreme form of fear or anxiety, triggered by specific situations or objects[90].
- Phobias are divided into two main categories[91]:
    - Specific or simple phobias – these are based around a certain object, animal situation or activity. They often develop in childhood and may become less severe as people get older. Examples include animals, environmental, situational, bodily and sexual phobias.
    - Complex phobias – these are often more disabling than simple phobias and usually develop during adulthood. They are often associated with deep-rooted fear or anxiety. The two most common are agoraphobia (a fear of being in situations where escape might be difficult or where help wouldn't be available if things go wrong) and social phobia (also known as social anxiety disorder).
- In the UK, an estimated 10 million people have phobias[92].
- There doesn't seem to be a single cause for phobias, however, there are associated factors including[93]:
    - A particular incident or trauma.
    - A learned response from someone close to the person in their early life e.g., a parent.
    - Genetics, evidence suggests some people are more likely to develop a phobia.
- Symptoms of phobias can be both physical (e.g., feeling dizzy, nauseous, trembling) and psychological (e.g., a fear of fainting or dying). In some cases, phobias can trigger panic attacks[94].
- Treatment for phobias includes self-help techniques, talking treatments and medication[95].
- Phobias, especially complex phobias, can impact daily activities and cause severe anxiety and depression. They often have a detrimental effect on a person's everyday life and wellbeing[96].

6.1.7 Post-traumatic stress disorder (PTSD)

- PTSD is a mental health condition caused by very frightening, stressful or distressing events[97].
- PTSD is estimated to affects about 1 in every 3 people who have a traumatic experience[98] and the estimated population prevalence of PTSD in adults in the UK is around 1 in 20[99].

- Any situation a person finds traumatic can cause PTSD[100]. Traumatic events which may lead to PTSD include serious accidents, physical or sexual assault, abuse, work-related exposure to trauma, serious health problems, war, conflict and torture[101].
- PTSD can be described as mild, moderate or severe based on the impact of symptoms[102].
- Some people may develop complex PTSD, often because of experiencing recurrent or long-term traumatic events, for example, prolonged domestic violence or living in a war zone[103].
- The symptoms of PTSD can be mental and physical, they may start right after an event, or they may develop later. Common symptoms include[104]:
    - Reliving what happened
    - Feeling on edge
    - Avoiding feelings or memories
    - Difficult feelings
    - Physical symptoms including headaches, pain, exhaustion and shaking and trembling.
- People with complex PTSD have similar symptoms to PTSD as well as additional symptoms including[105]:
    - extremely negative beliefs about themselves
    - problems regulating emotions and emotional responses
    - difficulties sustaining relationships
- PTSD commonly co-exists with other mental health disorders including depression, anxiety disorders, gambling-related harms and substance misuse[106].
- Treatment for PTSD depends on the severity of symptoms and how soon they occur after the traumatic event[107]. Treatment approaches include[108]:
    - Watchful waiting – waiting to see if symptoms get better on their own.
    - Talking therapies – including trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR)
    - Antidepressants – these may be offered if the person has another mental health problem, is unable to try talking therapy or talking therapy hasn't been helpful.
- PTSD UK include information about bibliotherapy for PTSD on their website, including information about when it may be appropriate and a list of titles recommended by PTSD UK supporters[109].
- PTSD is associated with significant impairments in relation to work, social and psychological wellbeing which have a substantial negative impact on quality of life[110 111].

6.1.8 Social anxiety disorder

- Social anxiety disorder, also known as social phobia, is a long-term overwhelming fear of social situations[112].
- Social anxiety disorder is one of the most common anxiety disorders with estimates of lifetime prevalence of 12% of adults[113].
- There isn't always a clear cause for social anxiety, and it likely develops from a combination of factors, including[114]:
    - Social reasons e.g., being bullied or embarrassed by a social situation in the past
    - Psychological reasons e.g., poor social skills or thinking you're being judged by others
    - Biological reasons e.g., if someone in your family is also socially anxious
- Someone with social anxiety feels overly worried before, during and after social situations. Symptoms include[115]:
    - Worry about everyday activities

    - Avoiding social activities
    - Worry about doing something embarrassing
    - Finding it difficult to do things when others are watching
    - Physical symptoms such as sweating or palpitations
    - Panic attacks
- Treatment for social anxiety includes self-help approaches (e.g., understanding more about the anxiety and breathing exercises), CBT, guided self-help and antidepressants. CBT is generally considered the best treatment for social anxiety disorder[116].
- There is some evidence that unguided self-help through bibliotherapy can provide benefit for people with social anxiety disorder, up to 12 months post intervention[117].
- People with social anxiety disorder are at hight risk for other comorbid mental health problems including anxiety, depression and substance use. It is associated with severe impairment in daily functioning including reduced quality of life, difficulties with relationships and difficulties at work[118].

6.2 Depression

- Depression is characterised by a loss of interest and enjoyment in ordinary things and experiences, low mood and a range of associated emotional, cognitive, physical and behavioural symptoms[119].
- About 280 million people worldwide have depression[120] and in 2022 around 1 in 6 adults in Great Britain experienced moderate to severe depressive symptoms[121].
- The symptoms of depression will vary from person to person and are often grouped into psychological, physical and social symptoms. They can include low mood, low self-esteem, lack of energy, disturbed sleep and avoiding contact with friends and family. It may be classified as less severe or more severe based on symptoms, how long it lasts and its impact on daily life[122].
- The underlying cause of depression is unknown but is likely a result of a complex interaction of genetic, environmental, biological, cultural and psychological factors[123].
- Risk factors for depression include[124]:
    - Female sex
    - Being older
    - History of depression and other mental health conditions
    - Family history of depression
    - Chronic physical health conditions e.g., diabetes, COPD and epilepsy.
    - Personal, social and environmental factors including relationship issues, bereavement, unemployment and social isolation.
- A range of conditions can coexist with depression including anxiety, neurological conditions, substance misuse, long-term and other medical conditions[125].
- Treatment for depression usually involves a combination of self-help, talking therapies and medicines. The treatment pathway will depend on the type and severity of depression. For less severe depression treatment includes guided self-help, exercise and talking therapies (including CBT and counselling). For more severe depression people may be prescribed an antidepressant and combination therapy (antidepressants and talking therapy)[126].
- Evidence suggests self-guided interventions are effective in treating adult depression[127].
- Evidence demonstrates that bibliotherapy can be an effective intervention for depression[128, 129] and research has shown participants with symptoms of depression not receiving

treatment who engage in book-based self-help experienced a reduction in depression and an increase in wellbeing[130].

- Depression can cause difficulties in all areas of a person's life including school and work, relationships and people with depression are at increased risk of suicide[131].

6.3 Eating disorders

- Eating disorders are serious mental illnesses and are characterised by persistent disturbance of eating or eating related behaviour which can significantly impact a person's health and wellbeing[132].
- There are different types of eating disorder, including[133]:
    - Anorexia nervosa – where people limit how much they eat or drink[134].
    - Bulimia nervosa – where people experience a cycle of binge eating and purging[135].
    - Binge eating disorder – where people overeat on a regular basis until they're uncomfortably full[136].
    - Other Specified Feeding or Eating Disorder (OSFED) – where people 's symptoms don't exactly fit the expected symptoms for other eating disorders. This accounts for the highest percentage of eating disorders. Examples include atypical anorexia, purging disorder and night eating syndrome[137].
- Atypical eating disorders are the most common subtype, followed by binge eating disorders, bulimia nervosa and anorexia nervosa being the least common[138].
- The estimated number of people with an eating disorder in the UK varies between over 725,000 (NICE[139]) and at least 1.25 million (Beat[140]).
- The proportion of adults screening positive of a brief self-report screening tool for possible cases of anorexia nervosa and bulimia nervosa (the SCOFF) increased from 6.4% in 2007 to 9.1% in 2023/24[141].
- The cause of eating disorders is not fully understood but is thought to involve a combination of genetic, biological and psychological factors, including[142] [143]:
    - Female sex
    - History of sexual abuse
    - Family history of eating disorders, depression or substance misuse
- The symptoms of eating disorders will depend on the type of eating disorder, but can include[144]:
    - Worrying about your weight and body shape
    - Restricting how much you eat
    - Making yourself sick or taking laxatives after eating
    - Exercising too much
    - Changes in mood
    - Physical symptoms including feeling cold or dizzy, palpitations and problems with digestion.
- Adults with a common mental health condition (such as anxiety or depression) were more likely to have an eating disorder than those without a common mental health condition[145].
- Treatment for eating disorders depends on the type of eating disorder but usually includes a talking therapy[146].
    - Anorexia nervosa treatment usually involves a talking therapy and supervised weight gain. Talking therapies include CBT, Maudsley anorexia nervosa treatment for adults (MANTRA), specialist supportive clinical management (SSCM) and focal psychodynamic therapy[147].

    - Bulimia nervosa treatment usually involves talking therapies such as a self-help booklet or online programme, support from a dietitian and medication for any other conditions closely linked to bulimia e.g., anxiety or depression[148].
    - Binge eating disorder treatment usually involves guided self-help initially followed by CBT if self-help doesn't help. Medication may be offered in combination with therapy of self-help treatment to help with the management of other conditions e.g., anxiety or OCD[149].
    - Treatment for Other Specified Feeding or Eating Disorder (OSFED) is based on the diagnosis that most closely matches symptoms[150].
- Self-guided interventions may be an effective, low intensity intervention for individuals at high risk of developing an eating disorder or for binge-eating disorders[151].
- Reading self-help books with or without guidance seems to generate minor to moderate positive effects on people with an eating disorder[152].
- Research found that reading fiction about eating disorders can be perceived as broadly detrimental to mood, self-esteem, feelings about the body, diet and exercise[153].
- Eating disorders are associated with other health problems, both related to mental health (e.g., anxiety disorders, mood disorders, substance abuse disorders, and post-traumatic stress disorder) and physical health (e.g., involving the skeletal, neuroendocrine, gastrointestinal, and dental systems)[154 155].
- People with a current or former eating disorder are at risk of increased and premature mortality, higher years lived with disability and reduced quality of life, as well as significantly impacting social and family life both for the individual and their family and carers[156].

6.4 Severe mental illness

- Severe mental illness (SMI) refers to a group of conditions that are typically long-lasting and significantly impact an individual's ability to carry out everyday activities. The definition usually includes schizophrenia, bipolar disorder or other psychotic disorders[157].
- A local modelled prevalence estimate for SMI reports that for people aged 14 and over in England in 2023 the prevalence of SMI is 1.16%, an estimated over 550,000 people. It also found[158]:
    - There is higher prevalence of SMI in the north of England, and in urban and more deprived areas.
    - Schizophrenia and other psychosis are more common in deprived and urban areas; bipolar disorder is more evenly distributed across England.
- Data suggests the prevalence of SMI, schizophrenia and other psychosis is higher in males and bipolar disorder is more prevalent in females. Alongside this SMI, schizophrenia and other psychosis have the highest prevalence in the Black ethnic group, while bipolar disorder has the highest prevalence in the White ethnic group[159].

6.4.1 Bipolar disorder

- Bipolar disorder is a serious long-term mental illness characterised by extreme mood changes between depression, mania, hypomania and mixed episodes[160].
- In the Adult Psychiatric Morbidity Survey 1.9% of participants screened positive for bipolar disorder equating to an estimated 890,000 adults living in private households in England[161].
- The exact causes of bipolar are unknown, however, it is thought to be an interplay between genes and environment. People are more likely to have bipolar if a parent, brother or sister has bipolar disorder. Factors that can increase the likelihood of developing bipolar include[162]:

    - Childhood trauma or abuse
    - A stressful life event e.g., abuse or the death of someone close to you
    - Recreational drug use
    - A parasite called toxoplasma gondii
- The symptoms of bipolar are linked to the mood the person is experiencing[163]:
    - Depression symptoms include feeling down, agitated or suicidal, having problems concentrating and with sleep and losing your appetite.
    - High mood symptoms are classed as severe (mania) or mild (hypomania) and can include feelings of elation, self-importance, increased alertness and being easily irritated. It can also make people do things with harmful consequence or that are out of character.
- Treatment for bipolar disorder is medication and talking therapies. The exact combination will depend on a person's current circumstances. Talking therapies could include CBT, interpersonal therapy, behavioural couples therapy, individual psychoeducation, group psychoeducation and family-focused therapy[164].
- Bipolar disorder is one of the leading causes of disability in the world and it leads to significant psychosocial impairment. It is often comorbid with poor physical health, substance misuse, personality disorders, ADHD and anxiety disorders[165].
- The risk of suicide amongst people with bipolar disorder is approximately 10-30 times greater than in the general population[166].
- Many people with bipolar are misdiagnosed or untreated and they often experience discrimination and stigma[167]. Stigma about bipolar disorder can lead to negative consequences including stereotyping, prejudice and discrimination[168].

6.4.2 Psychosis

- Psychosis describes a number of symptoms associated with significant alterations to a person's perceptions, thoughts, mood and behaviour[169]. It describes symptoms of some mental health problems or an experience of mental health problems and is not a diagnosis itself[170].
- Research suggests psychosis has a prevalence of around 1%[171].
- Psychosis can be caused by a psychological condition e.g., schizophrenia or bipolar disorder, a general medical condition e.g., a brain tumour or neurological condition, or substance misuse[172].
- The symptoms of psychosis will vary depending on the individual, but there are three main symptoms associated with a psychotic episode[173]:
    - Hallucinations e.g., seeing or hearing things that appear real to the person but only exist in their mind
    - Delusions – believing things that are untrue
    - Confused and disturbed thoughts e.g., constant speech or a sudden loss in train of thought
- People with psychotic disorder often have other physical and mental health conditions[174].
- Treatment for psychosis involves a combination of antipsychotic medication, talking therapies including CBT and family intervention and social support[175].
- People experiencing psychosis are reported to be one of the most stigmatised groups in society and evidence consistently shows people experiencing psychosis have a poorer quality of life than people not experiencing psychosis[176].

6.4.3 Psychotic depression

- Psychotic depression is a serious mental illness where a person experiences a combination of depression and psychosis[177].
- Estimates suggest around 10% of adults with major depressive disorder may experience psychotic symptoms[178].
- It's not known why some people develop psychosis as part of severe depression[179].
- A person with psychotic depression will experience symptoms of depression and symptoms of psychosis including delusions and hallucinations. People with psychotic depression have an increased risk of thinking about suicide[180].
- Treatment for psychotic depression includes medication (a combination of antipsychotics and antidepressants), talking therapies (one-to-one CBT) and social support.[181]
- Psychotic depression is associated with significant disability during an episode and evidence demonstrates people with psychotic depression experience poorer quality of life compared to those with severe non-psychotic depression[182].

6.4.4 Schizophrenia

- Schizophrenia is a severe mental illness that affects how people experience the world around them[183]. It is often described as a type of psychosis[184].
- According to the World Health Organization approximately 1 in 230 adults are affected by schizophrenia[185].
- The causes of schizophrenia are not well known, however, there are some risk factors which make it more likely to develop, including[186]:
    - Genetic factors
    - Having a relative with a severe mental illness
    - Differences in the brain
    - Drug and alcohol use
    - Stress
    - Abuse or neglect
- People often have episodes of schizophrenia where their symptoms are severe, followed by periods with few or no symptoms. Symptoms are grouped as[187]:
    - Positive symptoms – any change in behaviour or thoughts such as hallucinations or delusions
    - Negative symptoms – where people withdraw from the world around them e.g., not looking after their needs or avoiding friends and family
- Black people are more likely to have a diagnosis of schizophrenia than white people, this is likely due to racial inequality as there's no evidence being Black means you're more likely to have schizophrenia[188].
- People with schizophrenia die nine years earlier than the general population, usually due to physical illnesses e.g., cardiovascular or infectious diseases[189].
- Treatment for schizophrenia is usually individually tailored and includes talking therapy (CBT, Family therapy or Arts therapy) and antipsychotic medication[190].
- People with schizophrenia experience significant stigma and misinformation which causes social exclusion, impacts relationships and leads to discrimination which can impact access to health care, education, housing and employment[191]. It has also been found to negatively impact self-esteem, quality of life, help-seeking and increase suicide risk[192].

6.5 Other

6.5.1 Hoarding disorder

- Hoarding disorder is a mental health condition where someone collects lots of things and finds it challenging to get rid of them, even if it's impacting on their life[193].
- Approximately 2 in every 100 people in the general population meet the criteria for hoarding disorder[194].
- It's not known what causes hoarding disorder and until recently it was thought to be a form of OCD. Experiences that have been identified which may increase the likelihood of someone having hoarding disorder include[195]:
    - Negative childhood experiences
    - Grief after a bereavement or loss
    - Having a close family member who also hoards.
- The symptoms can be different for different people, but the main symptoms include[196]:
    - Keeping or collecting so many things it affects your life
    - Not being able to manage the things collected and being unable to get rid of them
    - Becoming attached to the collected things
- Hoarding can be a symptom of physical and mental health problems and may be more likely if a person is neurodivergent[197].
- The main treatments for hoarding disorder include talking therapies, usually guided CBT, and an antidepressant[198].
- High levels of hoarding at home can create serious environmental and personal safety risks, as well as negatively impacting relationships with friends, family and neighbours[199].
- Hoarding is associated with significant physical, psychological and social challenges leading to reduced quality of life[200].

6.5.2 Personality disorders

- Personality disorders are described as a group of mental health conditions featuring patterns, feelings and behaviours that significantly deviate from cultural expectations[201].
- Historically, different types of personality disorder were referred to e.g., borderline personality disorder and antisocial personality disorder, however, now personality disorders are organised by how severe they are and how someone presents with one or more personality trait[202].
- There can be disagreement about the term personality disorder and how it's diagnosed[203].
- It is estimated around 4% of people in the UK have a diagnosable personality disorder[204].
- It's not clear what causes personality disorders but it's thought they result from a combination of genetics and early environment influences e.g., adverse childhood experiences[205].
- The symptoms of personality disorder depend on how it presents but can include[206]:
    - Disordered thinking
    - Impulsive behaviour
    - Feeling empty and emotionally distressed
    - Difficulties maintaining stable and close relationships
- People experiencing personality disorders are at risk of poor future mental health and serious relational difficulties[207].
- Treatment includes talking therapies including dialectical behavioural therapy (DBT), mentalisation-based therapy (MBT) and cognitive analytic therapy (CAT), medication including antidepressants, antipsychotics or mood stabilisers[208].
- People with personality disorder often experience enduring difficulties with relationships, as well as social difficulties, poor general health and reduced life expectancy. They are also more likely to be unemployed and experience socioeconomic adversity[209].

- Public awareness of personality disorder is low and stigma from healthcare services can be particularly damaging for people experiencing personality disorder[210].

6.5.3 Self-harm

- Self-harm is defined as self-poisoning or injury irrespective of the apparent purpose of the act[211].
- There are at least 14 million episodes of self-harm a year, representing a global rate of approximately 60 per 100,000 people per year and studies suggest a lifetime prevalence of around 3% in adults[212].
- Rates of self-harm are higher in females and highest in people under 25[213].
- There are lots of reasons why people self-harm and it is different for everyone. Some reasons for self-herm, include[214]:
    - Expressing or coping with emotional distress
    - Trying to feel in control
    - Punishing themselves
    - Relieving emotional distress
    - A response to intrusive thoughts
- Risk factors for self-harm include socioeconomic disadvantage, social isolation, stressful life events, bereavement by suicide, mental health problems, substance abuse and involvement in the criminal justice system[215].
- The majority of people who self-harm do not present to healthcare services for self-harm[216].
- Overall self-harm is associated with an elevated suicide risk, although the relationship between self-harm and suicide is complex[217].
- Some groups are at substantially higher risk of self-harm including people diagnosed with a mental health condition, particularly borderline personality disorder, depression, anxiety, alcohol misuse and eating disorders. Marginalised groups including LGBTQIA+ people, ethnic minority groups, veterans, prisoners and migrants are also at risk[218].
- A self-harm assessment can identify the best treatment and support. Depending on the assessment a person may be offered advice on self-help and managing any underlying causes. If treatment is offered it can include talking therapies such as CBT and DBT and medication if the person has been diagnosed with a condition e.g., depression or schizophrenia[219].
- Self-harm is associated with high levels of distress for the person and those around them[220].
- There are high levels of stigma around self-harm including in relation to why people self-harm which can enhance feelings of shame[221].

7 Feelings and experiences

7.1 Anger problems

- Anger is a normal, healthy human emotion which everyone experiences[222]. However, if we're unable to express our anger or deal with it in a healthy way it can become a problem and can cause harm to us and the people around us[223].
- In the UK, more than one in ten people (12%) say that they have trouble controlling their own anger, and more than one in four people (28%) say they worry about how angry they sometimes feel[224].
- The way people react to feelings of anger can be affected by factors including childhood and upbringing; past experiences (e.g. trauma); current circumstances (e.g. stress, bereavement); and health and wellbeing (e.g. pain, mental health problems)[225].

- Whilst not a mental health condition, anger that is out of control can negatively impact on mood, mental health and self-esteem, and can lead to destructive behaviours such as violence, self-harm and substance misuse[226].
- The NHS recommends self-help cognitive behavioural therapy (CBT) techniques to help with anger through managing unhelpful thoughts, reframing situations, solving problems and dealing with stress[227].

7.2 Bereavement and loss

- Most people will be bereaved at some point in their lives following the death or loss of someone important to them. Other types of loss include the end of a relationship or losing a job or home[228].
- In the UK, over 600,000 people die every year, leaving more than six million people bereaved. These figures are expected to increase substantially due to our aging population and the rise in chronic and often complex health conditions[229].
- Grief is the range of feelings and emotions that a person may go through when they experience loss and is a very common experience. These emotions can include sadness or depression, shock or numbness, confusion, anxiety and panic, anger, overwhelm and relief. People may also experience sleep problems when grieving[230].
- Most people find that feelings of grief get less intense and they can adapt to life after loss over time. However, if a person is unable to cope with feelings of grief after many months or years they may be experiencing prolonged grief disorder or complicated grief[231].
- Approximately 1 in 10 people are thought to develop prolonged grief disorder following deaths from natural causes and 1 in 2 following unnatural deaths[232].
- Evidence supports CBT as an effective treatment for people experiencing prolonged grief symptoms[233].
- For supporting people bereaved by suicide, NICE recommends providing practical information expressed in a sensitive way that helps people to cope and signposts to other services[234].
- A recent survey found that 71% of people want bereavement support in the form of written information. The survey found people were interested in general information about what grief can look like and simple recommendations on how to cope[235].

7.3 Loneliness

- Loneliness is defined as 'a subjective, unwelcome feeling of lack or loss of companionship. It happens when there is a mismatch between the quantity and quality of the social relationships that we have, and those that we want.'[236]
- Everyone is affected by loneliness at some point in their lives. Some people feel lonely occasionally, whereas others may feel lonely all the time, which is sometimes referred to as chronic loneliness[237].
- A study found that 1 in 4 adults (24%) in Great Britain feel lonely "often, always or some of the time", and loneliness was most commonly reported by younger adults aged 16-29[238].
- Some people are more likely to experience loneliness than others. Groups at increased risk include young people; people with poor mental wellbeing; people with a disability or long-term health condition; people who live alone; people who are LGBTQ+; people on lower incomes; people who are out of work; and women[239].

- There is a bi-directional relationship between loneliness and mental health; experiencing loneliness can lead to poor mental health and experiencing a mental health condition can increase feelings of loneliness[240].
- There is some evidence to suggest that loneliness increases stress, and there is a link between loneliness and an increased risk of mental health problems including depression, anxiety, low self-esteem and sleep problems[241].
- 19% of readers say that reading stops them from feeling lonely[242]. This is backed up by a study analysing social connectedness which found that reading books significantly reduces feelings of loneliness for people aged 18-64[243].
- Participation in shared reading groups is linked to enhanced relaxation, calmness, concentration, quality of life, confidence and self-esteem, as well as feelings of shared community and common purpose[244].

7.4 Sleep problems

- There is a close relationship between sleep and mental health. Some mental health problems can cause sleep problems, and poor sleep can negatively impact on mental health[245].
- Sleep problems are common in the general population. Approximately 1 in 3 adults reports occasional sleep difficulties and 10-20% of people experience chronic insomnia[246].
- Women are 1.5-2 times more likely to experience insomnia than men, with 25% women affected during perimenopause[247].
- Insomnia can affect people at any age, but it is most common in older adults and more likely to be a long-term issue for this group[248].
- People with insomnia are 10 times more likely to experience depression and 17 times more likely to experience anxiety. Poor sleep has also been associated with post-traumatic stress disorder, eating disorders, and psychosis spectrum experiences such as delusions and hallucinations[249].
- Interventions that successfully improve sleep quality can improve mental health outcomes with clear evidence that improving sleep reduces depression, anxiety and stress[250].
- Cognitive behavioural therapy is recommended by NICE for the treatment of insomnia[251].
- There is some evidence that self-helps books are an effective intervention for sleep difficulties, including reduced use of hypnotic medication and reduced symptoms of anxiety[252].

7.5 Stress

- Stress is a natural human response to feeling under pressure or threatened. Common causes of stress include work, family and relationships, money problems and health problems[253].
- Symptoms of stress can be physical (e.g. headaches, muscle tension/ pain, digestive problems) and mental (e.g. difficulty concentrating and making decisions, constant worrying, overwhelm), and stress can alter the way we behave (e.g. being more irritable, sleep problems, over or under eating, increased smoking or drinking)[254].
- Whilst it isn't typically defined as a mental health condition, stress is closely linked to mental health. Excessive stress can have a negative impact on mental health and can lead to developing mental health conditions such as anxiety, depression or post-traumatic stress disorder. Living with a mental health condition can also cause stress[255].
- Stress is a common experience. A recent survey found 91% of UK adults reported experiencing high or extreme levels of pressure or stress in the past year. The same survey

found that adults aged 25–34 are the age group most likely to experience high or extreme levels of stress[256]. A nationally representative study found that just over 1 in 6 UK adults cited stress as an everyday occurrence[257].

- In 2025, a survey found that stress was the fourth most common cause of both short- and long-term workplace absence in the UK[258]. Recent estimates suggest that work-related stress and burnout cost the UK economy £28bn a year[259].
- Another potential impact of stress is loneliness. A survey found 37% of adults who reported feeling stressed also reported feeling lonely because of stress[260]. The negative impact of loneliness on mental health and quality of life is well documented[261].
- Guided Cognitive Behavioural Therapy is known to be helpful for improving stress[262], as is mindfulness[263] and there is some evidence that bibliotherapy may help to manage stress[264].

8 At risk populations

Along with the general evidence of need there is evidence that certain populations are more likely to experience poor mental health outcomes. The following section considers at-risk populations within the context of the new Reading Well scheme.

8.1.1 Carers

- There are 5.8 million unpaid carers in the UK[265]. Nearly 60% of carers are women, and the largest group are in their late 50s[266]. 13% of carers in the UK care for someone with a mental illness[267].
- Evidence demonstrates a negative effect of providing care on both mental and physical health, especially for female caregivers and caregivers providing intense care, such as living in the household with the person requiring care[268].
- Carers are at a greater risk of experiencing poor mental and physical health, including anxiety, depression, stress, loneliness and poor quality of life[269].
- The negative health consequences of caregiving take place over many years affecting the physical and emotional health of carers, with informal carers at increased risk of experiencing psychiatric disorders, of which anxiety disorders seem to be the most prevalent[270].
- The State of Caring 2025 report by Carers UK found that 74% of carers have felt stressed or anxious, 40% feel depressed, and 35% reported their mental health was bad or very bad[271].
- Recent research found that 1.2 million unpaid carers are living in poverty in the UK, with 400,000 in deep poverty[272]. As noted below, poverty is known to be highly detrimental to mental health.

8.1.2 Disabled people

- Evidence shows that disabled people are at greater risk of poor mental health than non-disabled people[273].
- Disabled people frequently experience stigma, which can result in mental health issues as well as social isolation[274].
- Recent data found that four times as many disabled people report feeling lonely than non-disabled people[275].
- Lack of inclusion and participation in activities can cause and exacerbate mental health problems, low self-esteem, and a sense of isolation for disabled people[276].
- Poverty rates are higher among families where at least one member is disabled, with these families accounting for approximately 48% of all people in relative poverty after housing costs in 2023/24[277].

8.1.3 Employment

- Decent work can support good mental health by providing a livelihood, a sense of purpose and achievement, an opportunity for developing positive relationships and community. For people living with a mental health condition, it can contribute to recovery and inclusion and improve social functioning[278].
- People can also experience risks to their mental health from work, including excessive workloads, unsafe working conditions, harassment or bullying and job insecurity[279].
- Mental health and unemployment are closely linked. Mental health problems can make finding and retaining a job difficult, and unemployment can have a negative impact on a person's mental health, leading to problems including stress, anxiety, depression and low self-esteem[280].
- 1.87 million people in the UK were unemployed in November 2025 to January 2026 (323,000 more than the previous year), and the unemployment rate stood at 5.2% (compared to 4.4% a year before)[281].
- Approximately 630,000 people in the UK were economically inactive (of working age and neither employed nor actively seeking work) due to mental health conditions between 2022-23[282].
- In 2024, mental health conditions (including stress, depression, anxiety and serious mental health problems) were the fourth most common reason given for sickness absence from work in the UK[283].

8.1.4 LGBTQ+ community[†]

- People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people, and the gap is greater for older adults (over 55 years) and those under 35[284].
- People who identify as LGBTQIA+ are more likely to experience poor mental health and are at higher risk of suicidal behaviour and self-harm[285].
- Evidence shows a link between experiences of prejudice, stigma, discrimination, violence, and assumptions of cis-heteronormativity and experiences of poor mental health and wellbeing in LGBTQ+ people[286].
- Half of LGBT people (52%) said they have experienced depression in the last year, and three in five (61%) have suffered from anxiety, rates which are far higher than in the general population. One in eight LGBT people aged 18-24 (13%) said they've attempted to take their own life in the last year. Almost half of trans people (46%) have thought about taking their own life in the last year, 31% per cent of LGB people who aren't trans said the same[287].
- Almost one in four LGBT people (23%) have witnessed discriminatory or negative remarks against LGBT people by health care staff, and one in seven (14%) of LGBT people have avoided health treatment because of worries about discrimination[288].
- Many older LGBTQIA+ adults report higher levels of loneliness and unresolved trauma from stigma experienced over their lives[289].

8.1.5 Long-term conditions

- Nearly a third (29.3%) of the population in England has at least one long-term health condition, and nearly 15% are living with multiple long-term conditions[290].

[†] The acronyms used in this section reflect the acronyms used in the sources cited.

- In Scotland, data indicates 23.3% of the population is living with multiple long-term conditions[291].
- In Wales, 46% adults are living with long-term conditions, and 19% are living with multiple long-term conditions[292].
- People living with physical health conditions are more likely to develop a mental health condition and vice versa[293].
- Depression is two or three times more likely in people who have two or more chronic conditions compared to people who don't have two or more chronic conditions[294].
- Around 40% of people with depression and anxiety disorders also have a long-term condition (LTC) such as cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes and musculoskeletal disorders. Around 30% of people with an LTC and 70% with medically unexplained symptoms, such as IBS or chronic fatigue syndrome, also have mental health comorbidities[295].
- Self-care/ self-help can help people living with two or more chronic health conditions cope with the effects of health conditions, treatment burden, polypharmacy, psychosocial issues and stress. Positive outcomes associated with self-care include self-efficacy, independence, quality of life and improved depression scores[296].

8.1.6 Men

- Although women are more likely to be diagnosed with a common mental health disorder, men experience unique challenges in relation to mental health[297].
- Figures show that men are around 3 times more likely to die by suicide than women.[298]
- Almost double the rate of men die from alcohol-specific causes than women[299].
- Evidence indicates that norms for men and boys to appear strong, in control and reluctant to show vulnerability can hinder emotional expression and help-seeking, contributing to poorer mental health and potentially putting them at risk of suicide[300].
- Men from Black or Black British ethnic groups experience the highest rates of detentions under the Mental Health Act, a rate that is over 4 times higher than for men from White ethnic groups[301].

8.1.7 Neurodivergent adults

- People who are neurodivergent may have one or more neurodevelopmental conditions, such as autism, ADHD, dyslexia or Tourette's syndrome[302].
- Research indicates neurodivergent people are more likely to experience mental health issues than neurotypical people[303].

8.1.7.1 Autism

- In the UK, autism spectrum disorder affects about 1.1% of adults (over 1 in 100)[304].
- Approximately a third of autistic people report having a diagnosed mental health condition[305].
- There is increasing evidence of an association between autism and mental health outcomes in adulthood, with autism being statistically linked to schizophrenia, various mood disorders, a range of anxiety disorders and personality disorders[306]. Middle-age and older adults with high autistic traits have a 5 to 6-fold increase in the likelihood of self-harming and suicidality[307].
- Possible reasons for autistic people having a mental health condition include negative attitudes from others, differences in interacting with the world, misdiagnosis and

experiencing difficulties getting the right support[308]. Autistic masking, whereby autistic people suppress natural forms of autistic interaction and behaviour in order to 'pass' as non-autistic, is also associated with greater depression and anxiety symptoms, along with lower self-esteem[309]

- There exists a lack of community-based mental health interventions for autistic individuals[310]. Many autistic adults are unable to access effective mental health care and as a result experience high degrees of unmet health needs and poorer mental health outcomes[311].

8.1.7.2 ADHD

- In the UK, ADHD affects approximately 3-4% of adults, with a male-to-female ratio of approximately 3:1[312].
- It is estimated that over 2.5 million people in England have ADHD, including those without a diagnosis. Of these, 1.8 million are adults aged 24+[313].
- Mental health problems are more prevalent among adults with ADHD than in the general population, with a recent meta-analysis indicating that internalising problems, like anxiety and depression, are among the most common psychiatric comorbidities[314].
- Up to 80% of adults with ADHD (18-35) report at least one episode of depression throughout their lifespan compared with and age/sex matched individuals with neurotypical development[315].
- ADHD and anxiety disorders have a 25% comorbidity rate with each other[316].
- ADHD is an independent risk factor for suicidal spectrum behaviours, even after controlling for common psychiatric comorbidities (e.g. depression, anxiety, personality disorders). Symptoms of emotional dysregulation – a core component of ADHD – can increase ADHD symptom severity, and a systematic review of the literature suggests emotional dysregulation is a central factor in the increased risk of self-harm and suicidality[317].

8.1.8 Older people

- The UK population is ageing. Between 2016 and 2041 it is predicted there will be a 60% increase in older adults. For people in later life across the whole population, mental health has a greater impact on life satisfaction than physical health[318].
- Older people have better mental health than other age groups, but around 1 in 10 have a common mental health condition[319].
- Depression affects 22% of men and 28% of women aged 65+, 40% of men and 43% of women aged 85+, and 40% of older people in care homes[320].
- Older adults, when compared with other age groups, are more likely to experience several risk factors for poor mental health. They are more likely to be living with one or more long-term condition, more likely to experience frailty, which is associated with depression and lower health-related quality of life, and they are more likely to be socially isolated. Other risk factors affecting older people include health inequalities, poverty, bereavement, caregiving responsibilities and living in a care home setting where there are high rates of depression and acute mental and neurological illness in older residents[321].
- Mental health problems in later life are often dismissed or normalised by health services[322].
- Age-specific barriers to accessing mental health support include issues relating to physical limitations to mobility, including living with frailty, reduced access to means of transport, and isolation[323].

- Evidence demonstrates psychological interventions, particularly CBT is effective for treating anxiety, depression and comorbid depression and anxiety disorders in older adults. Despite this, older adults underutilise mental health services with some evidence over 50% of older adults with a clinical mood or anxiety diagnosis do not receive help[324].

8.1.9 People from minority ethnic backgrounds‡

- In the UK, people from ethnic minority groups have worse mental health, and poorer access to mental healthcare, than White British people. People from ethnic minority groups are also more likely to have undiagnosed mental health difficulties and follow involuntary pathways into care[325].
- A review of ethnic inequalities in the NHS Talking Therapies programme in England found that, in comparison with White British people, people from minoritised ethnic groups experienced worse outcomes from mental health services, waited longer for assessment and were less likely to receive a course of treatment following assessment[326].
- Those groups less likely to access mental health services at an early stage are more likely to access treatment when they are very unwell or in crisis[327]. NHS Benchmarking data shows that people from some ethnic minority groups are over-represented in services for people with a high acuity of illness such as secure care, and under-represented in other areas of care[328]. This is most notable for Black people who comprise 4% of the adult population, but 7% of those in inpatient beds, 10% of those who were admitted compulsorily, and 16% of those in medium secure services. By contrast Black people comprised less than 1% of those in eating disorder beds and in older adult wards[329].
- Black people are nearly four times more likely than White people in England to be sectioned under the Mental Health Act, and they are over eight and a half times more likely to be given a Community Treatment Order that limits their freedoms when they leave hospital[330].

8.1.10 People in prison

- In 2024, there were around 87,300 prisoners in England and Wales. This figure is expected to increase to around 100,000 by 2030. The figure was around 8,200 in Scotland and 1,900 in Northern Ireland.[331]
- Many people in prison have experience of known risk factors for mental health problems, including childhood trauma, domestic violence and substance use disorder. Being in prison, specifically the environment, regime and sentence type, can also contribute to poor mental health.[332]
- Approximately 1 in 7 people in prison have a treatable mental health disorder.[333]
- A recent evidence review found that globally most "mental disorders" were at least twice as prevalent amongst people in prison than the general population. The same review found that 11% of people in prison were diagnosed with depression, 10% with PTSD, 4% were affected by psychotic illness, 24% had an alcohol use disorder and 39% had a drug use disorder. Approximately half of people in prison with depression or psychotic illness also had a substance use disorder.[334]
- Rates of self-harm in prison are at the highest level since records began in 2012, and almost 9 times higher amongst the female population than the male.[335]

‡We have used NHS Inclusive content guidelines on Ethnicity, religion and nationality (2023) to inform how we refer to ethnicity in this section

- Supporting mental health in prisons is good for society as a whole. Evidence suggests that the better a person's mental health in prison, the lower the probability of them reoffending on release.[336]

8.1.11 People with a learning disability

- Approximately 2.16% of adults in the UK are believed to have a learning disability and there are approximately 1.2 million adults with a learning disability across the UK[337].
- People with a learning disability tend to experience poorer mental health than people without a learning disability[338].
- Population-based estimates suggest in the UK suggest that 40% (28% if problem behaviours are excluded) of adults with learning disabilities experience mental health problems at any point in time[339].
- Mental health problems may remain unrecognised in people with learning disabilities, especially if the person is not able to describe or express their distress and/or they have coexisting physical health problems[340].
- People with a learning disability are more likely to experience poor mental health for a number of reasons, including biological factors such as physical ill health and medication; an increased incidence of negative life events; lack of social support and coping skills; and stigma and discrimination[341].

8.1.12 Poverty

- Around 2 in every 10 working-age adults (7.9 million) are in poverty in the UK. Pensioner poverty affects 3 in 20 pensioners[342].
- Around 1 in 8 people are now living below the Happiness Poverty Line (a score of 5 or less out of 10 on life satisfaction)[343].
- 1 in 4 people with a mental health problem is also in debt and 1 in 2 adults with debts has a mental health problem[344].
- Poverty is the single biggest driver of poor mental health, and people living in poverty carry a higher risk of suicide[345]. Children and adults living in households in the lowest 20% income bracket in Great Britain are two to three times more likely to develop mental health problems than those in the highest[346].
- Poverty increases the risk of mental illnesses, including schizophrenia, depression, anxiety and substance addition. It can act as both a causal factor and a consequence of mental illness[347].
- People who are socioeconomically disadvantaged or who live in areas of socioeconomic deprivation have an increased risk of suicidal behaviour[348].

8.1.13 Wider determinants of health and health inequalities

- The risk of developing any mental health condition is inextricably linked to our life circumstances[349].
- People exposed to more unfavourable social circumstances are at greater risk of poor mental health[350].
- Social determinants of mental health include income, employment, socioeconomic status, education, food security, housing, social support, discrimination, childhood adversity, the wider neighbourhood conditions people live in and the ability to access health care[351].
- Marginalised groups are often exposed to numerous intersecting social risk factors[352].

- Social and structural inequality in society means that those who face the most significant disadvantages in life also face the greatest risks to their mental health[353].

8.1.14 Women

- Women consistently exhibit worse mental health than men, reporting higher levels of depression, anxiety and irritability[354].
- Nearly 1 in 4 women experience a common mental health problem in any given week, compared to nearly 1 in 7 men[355].
- In England, data collected in 2023/24 found that women were more likely than men to have a CMHC (24.2% vs 15.4%) – specifically General Anxiety Disorder and depression[356].
- Women of colour have higher rates of common mental disorders, but lower rates of treatment and diagnosis[357].
- Women's mental health is impacted by a range of social, economic and structural factors including unpaid care responsibilities, lower levels of income, increased likelihood of sexual harassment and gender-based violence.[358]
- Studies reveal a high prevalence of mental health issues around the menopause transition[359], with one recent study found that menopause is associated with increased levels of anxiety, depression, and sleep difficulties[360].
- Census data across all four nations shows that women are more likely to provide unpaid care than men. A higher proportion of female current and former carers said they had struggled to look after their health and wellbeing (37%) compared with male current and former carers (27%) [361].
- There is some evidence that women are more likely to prefer self-help literature as a treatment for depression than men[362].

8.1.15 Young adults[§]

- The proportion of 16- to 24-year-olds with a common mental health condition rose from 17.5% in 2007 to 25.8% in 2023/4[363] and 1 in 3 (34%) of people aged 18-24 are reporting symptoms of common mental health conditions[364].
- Rates of mental ill health are twice as high for girls and young women aged 17-25, compared to their male counterparts[365].
- Younger adults were more likely to report lifetime non-suicidal harm and to screen positive for disordered eating symptoms, PTSD and ADHD than older age groups[366].
- For many young people, emerging mental health needs are missed, or they do not receive appropriate interventions – in 2014 only 22.7% of 16 to 24 year olds with symptoms of a common mental health problem were receiving any form of treatment, compared to an all-age average of 39.2%[367].
- Young adults not in education, employment or training (NEET) are at increased risk of mental health issues and of experiencing lower wellbeing[368].

Evidence has identified additional at-risk populations who are at risk of worse mental health outcomes. Consideration should be given to whether Reading Well is able to meet the needs of these groups. Additional at-risk populations include:

[§]There are varying ages used in definitions of young adults, although the target audience of the list is 18+, the unique challenges identified around young adults' mental health is considered relevant for the list and included in this section.

- People who have experience of domestic abuse.
- Gypsy, Roma and Traveller Communities
- Asylum seekers and refugees

8.2 Protective factors

According to the World Health Organisation, "protective factors [that influence mental health] occur throughout our lives and help build resilience. They include individual social and emotional skills, positive social interactions, access to quality education, decent work, safe neighbourhoods and strong community ties."[369]

9 NICE Guidelines and Quality Standards

NICE guidelines are evidence-based recommendations for health and care in England and Wales. In Northern Ireland, the Department of Health reviews NICE guidelines to see if they are applicable locally. In Scotland, the use of NICE guidelines depends on priorities and infrastructure.
The below section details NICE guidelines relevant to Reading Well for mental health.

Topic	Guidelines and Quality standards
Anxiety	Generalised anxiety disorder and panic disorder in adults: management [CG113]** (2011)
	Post-traumatic stress disorder [NG116] (2018)
	Social anxiety disorder: recognition, assessment and treatment [CG159] (2013)
	Obsessive-compulsive disorder and body dysmorphic disorder: treatment [CG31] (2005) *This guideline is currently undergoing an update, expected publication February 2027.*
	Anxiety disorders [QS53] (2014)
Depression	Depression in adults: treatment and management [NG222] (2022)
	Depression in adults with a chronic physical health problem: recognition and management [CG91] (2009)
	Depression in adults [QS8] (2011)
Eating disorders	Eating disorders: recognition and treatment [NG69] (2017)
	Eating disorders [QS175] (2018)
Severe mental illness	Bipolar disorder: assessment and management [CG185] (2014)
	Psychosis and schizophrenia in adults: prevention and management [CG178] (2014)
	Psychosis and schizophrenia in adults [QS80] (2015)

**In 2026, more than 70 mental health organisations and cross-party parliamentarians have signed a letter urging NICE to review this guideline to ensure it reflects current clinical practice, increases patient choice and addresses barriers for marginalised communities. The submitted letter and full joint position statement are available online.

Personality disorders	Antisocial personality disorder: prevention and management [CG77] (2009)
	Borderline personality disorder: recognition and management [CG78] (2009)
Self-harm	Self-harm: assessment, management and preventing recurrence [NG225] (2022)
Mental health services	Mental health problems in people with learning disabilities: prevention, assessment and management [NG54] (2016)
	Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services [CG136] (2011)
Other related topics	Attention deficit hyperactivity disorder: diagnosis and management [NG87] (2018)
	Autism spectrum disorder in adults: diagnosis and management [CG142] (2012)
	Menopause: identification and management [NG23] (2015)
	Mental wellbeing at work [NG212] (2022)
	Supporting adult carers [NG150] (2020)
	Autism [QS51] (2014)
	Learning disability: identifying and managing mental health problems [QS142] (2017)

Appendix 4 contains a detailed overview of relevant NICE guidelines and Quality Standards, including relevant recommendations.

9.1 SIGN Guidelines

SIGN produces evidence-based, collaboratively developed clinical guidelines applicable to Scotland. The below section highlights relevant SIGN guidelines for Reading Well for mental health.

Topic	Guideline
Eating disorders	SIGN 164: Eating disorders (2022)
Schizophrenia	SIGN 131: Management of schizophrenia (2013)

Autism	SIGN 145: Assessment, diagnosis and interventions for autism spectrum disorders (2016)

10 Policy framework

This section provides an overview of some of the policy and guidelines relevant to the new Reading Well for mental health scheme. It should be noted that current health policy, especially in England, is going through a period of significant change. There are a range of areas of delivery that are still being reviewed and implemented, and the long-term nature of the reforms mean that it is likely mental health related policies and guidelines will change and evolve over the next few years. There are also likely to be changes and updates across Wales and Scotland following the 2026 elections.

Given the scale and nature of change expected this section will be reviewed throughout the development process.

10.1 England

Policy	Overview
Fit for the future: 10 Year Health Plan (2025)	Sets out the ambitions for the NHS over the next 10 years. The plan is making three big shifts to how the NHS works: • From hospital to community – more care available on people's doorsteps and in their homes. • From analogue to digital – new technology to improve delivery and enable people to manage their care. • From sickness to prevention – supporting people to make healthy choices and reaching people earlier. Within the plan there are a range of proposals for mental health across the three shifts, including dedicated mental health emergency departments, expansion of assertive outreach and mental health support teams.
Neighbourhood health framework (2026)	Sets out the next steps for the NHS, local government and civil society to develop neighbourhood health services as part of the 10-year health plan. Outlines five main aims of neighbourhood health, including: • Improving people's health and care outcomes, reduce health inequalities and help them stay well at home. • Organising services around the person, with more convenient, personalised and joined-up care. It also outlines national NHS goals, objectives and metrics, including: • Goal 1: improve health outcomes, with a specific focus on high priority cohorts including those with mental health conditions.

	It also sets out reform agendas as the building blocks of neighbourhood health that need to be in every community, including: • Reform agenda 2: improve proactive care for people to support people to stay healthier for longer.
NHS Medium Term Planning Framework – delivering change together 2026/27 to 2028/29 (2025)	Sets out national priorities and targets for local systems for the next three years. Includes a range of requirements ICBs and mental health providers must deliver, including meeting existing commitments to expand NHS Talking Therapies and Individual Placement and Support.
Mental Health Act 2025	Makes significant changes to the Mental Health Act 1983 and aims to strengthen the patient voice. Will be implemented in phases and may take up to 10 years fully implement.
Health and Social Care Committee: Community Mental Health Services (2024)	Found that community mental health services are fragmented, inconsistently funded and poorly integrated with people's wider social needs. Called for a fundamental reimagining of mental health care as trauma informed and person-centred.
Independent review into mental health conditions, ADHD and autism (2025)	Aims to understand the prevalence, trends and inequalities associated with mental health conditions, ADHD and autism in England. The review aims to examine: • Factors behind trends in prevalence • Impact of clinical practice, including social and cultural factors and the risks and benefits of medicalisation • Ways to promote the prevention of mental ill health • Ways to create resilience and improve early intervention The review will support the implementation of the 10 Year Health Plan. An interim report was published in March 2026. Key finding include: • Increase in common mental health conditions and psychological distress, particularly among younger people, with younger adults now reporting higher levels of distress than older age groups. • Continuing concerns around mental health under-recognition and unmet need among older adults. • A substantial increase in referrals and waiting lists for ADHD, particularly amongst adolescents and young adult females. • There are significant gaps in data around autism, including prevalence and diagnosis rates with population surveys showing a relatively stable

	prevalence but sharply rising diagnosis, identification and service demand. The final review is due to set out conclusions and recommendations for the Department of Health and Social Care and is due to be published in Summer 2026.
Prevention Concordat for Better Mental Health (2024)	Promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. It presents a public mental health informed approach to prevention.
All Our Health: personalised care and population health (2024)	The All Our Health programme is a collection of resources on critical public health topics. It aims to support public health action around preventing illness, protecting health, promoting wellbeing and reducing health inequalities. Within the 'improving the wider determinants of health' topics there is a focus on mental health and wellbeing. Wellbeing and mental health: Applying All Our Health (2022) provides information to support health and care professionals use their trusted relationships to improve mental health and wellbeing. Core principles include: • meet mental health and wellbeing needs • help identify those at risk of poor mental health • prevent mental health problems from developing or worsening • prevent suicide. Other topics covered by All Our Health relevant to Reading Well for mental health include: • Health disparities and health inequalities: applying All Our Health (2022) • Workplace health: applying All Our Health (2022) • Healthy ageing: applying All Our Health (2022) • Social prescribing: applying All Our Health (2022) • Community-centred practice: applying All Our Health (2022)
Men's Health Strategy for England (2025)	Sets out to ensure the ambitions of the 10-year health plan transform the health and wellbeing of men and boys. Three broad aims around men's health: • Ensuring health services engage and are responsive to the needs of men and boys • Building structures to empower men and boys to maximise their health and wellbeing • Creating the conditions in which men and boys' health and wellbeing can thrive. Underpinned by six levers – improving access to healthcare, supporting individual behaviours, developing healthy living and working conditions, fostering strong social, community and family networks, addressing societal norms and tackling health challenges and conditions.

The Renewed Women's Health Strategy for England (2026)	Sets out how the government will improve women's health and healthcare over the next 10 years. The strategy includes a focus on investing in and transforming services which have differential or disproportionately high impacts on women
Keep Britain Working Review (2025)	An independent review of the role of employers in tackling health based economic inactivity and promoting health and inclusive workplaces. Proposes a shift to health being a shared responsibility between employers, employees and health services, with a focus on employers doing more, especially in relation to prevention and rehabilitation.
Core20plus5	A national NHS England approach to inform action to reduce health inequalities at national and system level. Severe mental illness is one of the five clinical areas of focus for adults.
5 Ways to Wellbeing	Developed by the New Economic Foundation, the Five Ways to Wellbeing are a set of practical actions aimed at improving mental health and wellbeing. The five ways to wellbeing are: • Be active • Connect • Give • Keep learning • Take notice

Working definition of trauma-informed practice (2022)	The purpose of trauma-informed practice is to address barriers people affected by trauma can experience when accessing health and social care services.
	Sets out a working definition of trauma-informed practice to address the lack of consensus across the health and social care sector about what it is and how it can be built into services and systems.
	• The working definition covers:
	  ○ Understanding that exposure to trauma can affect individuals, groups and communities
	  ○ Awareness of how trauma can negatively impact individuals and communities and aims to create culturally sensitive, safe services.
	  ○ Seek to avoid re-traumatisation
	It is underpinned by 6 principles – safety, trust, choice, collaboration, empowerment and cultural consideration.

10.2 Wales

Policy	Overview
A Healthier Wales: our Plan for Health and Social Care (2024)	Focuses on joined up working between health and social care, shifting services from hospitals to communities, prevention, measuring impact, supporting Welsh health and social care staff and bringing health care systems together.
The Mental Health and Wellbeing Strategy 2025 – 2035 (2025)	Sets out key mental health priorities for the next 10 years to achieve the overarching mission statement: 'People in Wales will live in a country which promotes, supports and empowers them to improve their mental health and wellbeing, and will be free from stigma and discrimination' Delivery is focused around four mission statements: • There is action to make sure the building blocks are in place to support good mental health and wellbeing • Everyone has the knowledge, opportunities and confidence to protect and promote good mental health and wellbeing • There is a connected system where all people receive the appropriate level of support wherever they reach out for help • There are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay.
Well-being of Future Generations (Wales) Act 2015 (2015)	Requires public bodies in Wales to work better with others and take a more joined-up, long-term approach so that decisions have a positive impact now and in the future. The Act has two main parts: • The Well-Being Goals – sets out seven goals for public bodies to work to, including a healthier Wales • The Ways of Working – principles that public bodies must demonstrate including prevention, collaboration and involvement.
Social Services and Well-being (Wales) Act 2014 (2016)	Provides the legal framework for improving the well-being of people who need care and support, including carers who need support, and transforming social services in Wales.
Age-friendly Wales: our strategy for an ageing society (2021)	Sets out a vision for an age friendly Wales that support people of all ages to live and age well. Sets four national aims including enhancing well-being, improving local services and building and retaining people's own capability. Includes a commitment under enhancing well-being to improve access to mental health services.

Working Together for a Healthier Wales (Public Health Wales) (2023)	Sets out the vision for achieving a healthier future for people in Wales by 2035. Outlines six priorities: • Influencing the wider determinants of health • Promoting mental and social well-being • Promoting healthy behaviours • Supporting the development of a sustainable health and care system focused on prevention and early intervention • Delivering excellent public health services to protect the public and maximise population health outcomes • Tackling the public health effects of climate change
National Strategy for Unpaid Carers 2026 [DRAFT] (2026)	Outlines eight key priorities and actions to support unpaired carers in Wales, including: • Recognition and awareness: increase public and professional recognition of unpaid carers • Mental health and wellbeing: enhance carer's mental health support through local review of support groups, carer-informed generic services, and increased professional awareness.

10.3 Scotland

Health priorities in Scotland focus on enabling people to live longer, healthier and more fulfilling lives with a focus on prevention, early intervention and quality services. Improving mental health remains a priority for the Scottish Government. The vision is for a Scotland, free from stigma and inequality, where everyone fulfils their right to achieve the best mental health and wellbeing possible.

Policy	Overview
The Mental Health (Care and Treatment) (Scotland) Act 2003 (2005)	The Act applies to anyone with a 'mental disorder' including mental illness, personality disorder or learning disability and is designed to strengthen and safeguard the rights of service users to ensure that they receive appropriate care and treatment, based on the principle of least restrictive intervention.
Mental Health and Wellbeing Strategy (2023)	Lays out the long-term vision and approach to improving the mental health and wellbeing of everyone in Scotland. Focuses on achieving a number of different population-level and process outcomes for mental health and wellbeing, including: • improved overall mental wellbeing and reduced inequalities • improved quality of life for people with mental health conditions, free from stigma and discrimination

	• improved knowledge and understanding of mental health and wellbeing and how to access appropriate support • better equipped communities to support people's mental health and wellbeing • increased availability of timely, effective support, care and treatment that promote and support people's mental health and wellbeing To deliver the outcomes, there is a focus on three key areas: • Promote positive mental health and wellbeing for the whole population, improving understanding and tackling stigma, inequality and discrimination • Prevent mental health issues occurring or escalating and tackle underlying causes • Provide mental health and wellbeing support and care
Scotland's Population Health Framework 2025-2035 (2025)	Sets out a shift in culture to a prevention focused, whole systems approach to improving health. The guiding principles of the framework include prioritising creating and maintaining good health, and preventing ill health, focusing supporting on people and communities who need it the most, changing systems and environments to support individuals stay healthy and delivering through a whole system approach.
Women's health plan (2021)	Underpins actions to improve women's health inequalities by raising awareness around women's health, improving access to health care and reducing inequalities in health outcome for girls and women, both for sex-specific conditions and in women's general health.
Public Health Scotland: Together we can create a Scotland where everybody thrives. Our 10-year strategy to 2035 (2026)	Sets a direction to deliver improvements in health and wellbeing in Scotland, including championing mental health and wellbeing, ensuring mental health is valued, support is available, and stigma is reduced.

10.4 Northern Ireland

Health priorities in Northern Ireland include a long-term focus on addressing health inequalities and improving the long-term health and wellbeing of people across Northern Ireland with attention on prevention and investing in community care.

Policy	Overview
Mental Health Strategy 2021-2031 (2021)	Sets out the priorities for mental health over the decade grouped into three themes: • Promoting mental wellbeing – supporting good mental health, resilience and wellbeing throughout society

	• Providing the right support at the right time – ensuring timely access to appropriate services • Developing new ways of working – transforming how mental health services are designed and delivered.
Making Life Better – A Whole System Framework for Public Health 2013 -2023 (2013)	Provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. Improved mental health and wellbeing, and reduction in self-harm and suicide is a key long-term outcome as part of activity focused on empowering healthy living.

10.5 Local authorities and public libraries

Local Authorities

Local authorities across the UK support and implement national guidance and programmes focused on mental health. Local authorities will also have their own priorities, including public health, for supporting mental health in their areas.

Public libraries

UK libraries offer a range of activities to support community mental health and wellbeing, including health information, events and community engagement. Libraries provide a safe space where people can go to meet others and access information and support around mental health.

Across England and Wales, mental health is a core part of the Public Library Universal Health and Wellbeing Offer, a national strategy that promotes the role that libraries can play in the health and wellbeing of local communities.

In Scotland, A Collective Force for Health and Wellbeing supports libraries to become hubs for trusted health and wellbeing information in their communities.

In Northern Ireland, LibrariesNI deliver a range of services to support the health and wellbeing of local communities, including information, support and events.

10.6 Health professional bodies

This section outlines relevant reports and guidelines from UK-wide health professional bodies. Given the depth and breadth of the topic area, this section aims to provide an overview rather than detailed information on all relevant reports and guidelines. Further input will be sought from organisations involved in the development of the new collection.

Royal College of General Practitioners

- Mental health in primary care – currently under review.
  Sets out the position of the RCGP on the provision of mental health care in primary care

Royal Society of Public Health

- Public mental health: Evidence, practice and commissioning (2019)
  Sets out the concept of public mental health and support the delivery of public mental health activity.
- A Place For Health: Building Health Across Society (2025)
  Sets out the need for every part of society to play its part in improving health outcomes.

Royal College of Psychiatrists

- Loneliness and social isolation (PS06/19) (2019)
  Sets out how professionals can help to identify older people experiencing loneliness and ensure they can access appropriate support.
- Menopause and mental health (PS02/26)
  Examines how menopause affects mental health and the implications across the UK, including calling for greater awareness of menopause's links to mental health.
- Social prescribing (PS01/21) (2021)
  Sets out the value for social prescribing and the importance of a range of social prescribing services being available in all localities.
- Suffering in silence: age inequality in older people's mental health care (CR221) (2018)
  Highlights the need for action to address poorer outcomes experienced by older people in mental health services, including the need for preventive strategies for older people at risk and improving public awareness of older people's mental health.

British Psychological Society

- BPS Briefing: Improving support for mental health
  Takes a lifespan approach to considering current mental health provision, specifically focusing on children and young people, parents and older adults.
- BPS Briefing: House of Commons debate on mental health and long-term conditions
  Presents evidence on the integration between mental and physical health and the experience of older people in relation to mental health and long-term conditions.

10.7 Mental health organisations

This section outlines relevant reports and guidelines from UK-wide mental health organisations. Given the depth and breadth of the topic area, this section aims to provide an overview. Further input will be sought from organisations involved in the development of the new collection.

- Mental Health Foundation and LSE Care Policy and Evaluation Centre (CPEC), The economic case for investing in the prevention of mental health conditions in the UK (2022)
  Provides an economic case for the prevention of poor mental health, outlining well evidenced interventions that have the potential to prevent mental health problems in all stages of life

- Mental Health Foundation, Pathways to Prevention: Ending Scotland's public mental health emergency (2025)
  Sets out a manifesto for the 2026 Scottish Parliament Election, calling for the Scottish government to invest in prevention, support early years and enhance wellbeing.

- Mental Health Foundation, Tackling mental health inequalities in the UK: expert consensus on priority areas (2025)
  Identifies six key factors likely to have the greatest impact on reducing rates of poor mental health and mental health inequalities including financial insecurity, social connection and access to mental and physical health support.

- Mind and Centre for Mental Health, The Big Mental Health Report 2025
  The report explores the current state of mental health in England and Wales; what's driving poor mental health; experiences of support; and mental health stigma and discrimination.

Calls for urgent action from English and Welsh Governments to improve timely access to mental health support, targeted interventions to tackle mental health stigma and discrimination and address the social factors which contribute to poor mental health.

- Mind Cymru, Mental health is everything: Mind Cymru's priorities for the next Welsh Government (2025)
  Calls for the next Welsh Government to prioritise mental health including making mental health a priority within the next Programme for Government.

- Rethink Mental Illness, Right Treatment, Right Time 2025 The true cost of delays in care and treatment for people living with mental illness (2025)
  This report details how people continue to face life-threatening waits for mental health treatment, and there is a worsening human and societal cost.

- Scottish Action for Mental Health (SAMH) Taking Action for Scotland's Mental Health: SAMH's Manifesto for the 2026 Scottish Parliament election
  Calls for the next Scottish Government to take radical action and increased investment to ensure the system meets the needs of people across Scotland.

- Wales Alliance for Mental Health: Priorities for the Next Welsh Government 2026 (2025)
  Calls for a person-centred, recovery-oriented, and rights-based mental health system in Wales. Sets out nine actions for the next Welsh Government including prioritising mental health, increasing investment in prevention and tackling the causes of poor mental health.

11 Health partners

Partner organisations relevant to the new Reading Well for mental health list include:

Adferiad; ADHD UK; Age UK; Ambitious About Autism; Anxiety UK; Autistica; Beat; British Association for Behavioural and Cognitive Psychotherapies; British Association for Counselling and Psychotherapy; British Dyslexia Association; British Psychological Society; Carers Trust; Carers UK; Centre for Mental Health; Cruse Bereavement Support; Diverse Cymru; Everyturn; Faculty of Public Health; Institute of Health Equity; Joseph Rowntree Foundation; Men's Minds Matter; Mencap; Mental Health First Aid England; Mental Health Foundation; Mind; MindOut; MQ Mental Health Research; National Academy for Social Prescribing; National Autistic Society; National Centre for Creative Health; NHS England; NHS Wales/ Improvement Cymru; OCD Action; Office for Health Improvement and Disparities; Papyrus; Patient Information Forum; Platfform; Public Health NI; Public Health Scotland; Queerwell; Rethink Mental Illness; Royal College of General Practitioners; Royal College of Nursing; Royal College of Psychiatrists; Royal Society for Public Health; Samaritans; Sane; Scottish Association for Mental Health; Self Care Forum; Social Prescribing Network; Sue Ryder; The Health Foundation; The King's Fund; The Sleep Charity; With You

12 Audience and Accessibility

The focus of the list is adults. There are a wide range of people who may benefit from a new Reading Well list focusing on mental health, we are proposing the collection focuses on the following primary audiences:

- People coping with difficult emotions and experiences affecting their mental wellbeing
- People living with mental health problems
- Wider family and support networks

The Reading Agency works to ensure Reading Well lists are as accessible as possible including ensuring a diverse range of formats and types of books, providing information in Plain English and following accessible design principles.

To ensure the list is as accessible to as many people as possible consideration should be given to the accessibility of materials for:

- people experiencing, or at risk of experiencing, mental health problems, including through the provision of practical information about mental health and other forms of support including personal stories.
- people with sensory impairments, low levels of literacy and/or English as an additional language.
- people with learning support needs including dyslexia and neurodivergence and needs related to living with a mental health condition including lack of motivation, social isolation and loneliness.
- people with additional needs linked to being an at-risk population (as identified above).
- people at risk of, or experiencing, health inequalities and inequal access to care, as well as quality of care.

Alongside considerations around accessibility the list should ensure that it is representative of a wide range of people who may need information and support related to mental health, including those populations identified as at risk of poorer outcomes identified in the At risk populations section.

The Reading Well scheme is just one source of information alongside booklets, web materials, and face-to-face support from organisations and health professionals, and the collection should be seen as a means of enhancing both the quality and choice of resources available through a co-produced, quality-assured approach.

13 Conclusion

Given the evidence of need and policy priorities associated with mental health, there is an identified need for a new Reading Well scheme for adult mental health. It would support public awareness and supplement information and resources available for individuals and family members. It would also address key priorities such as improving access to quality mental health information and signposting to support people affected by mental health problems, as well as address gaps in provision for at-risk populations. In addition, it could be used by professionals to help people understand and manage their health and wellbeing. It would also sit alongside other Reading Well schemes, including Reading Well for families, Reading Well for children, Reading Well for teens, and Reading Well for dementia, providing a whole life-course prevention and early intervention focused approach.

Appendix 1: Reading Well Books on Prescription

Reading Well is a national books on prescription scheme delivered through public libraries. It helps people understand and manage their health and wellbeing using books endorsed by health professionals and people with lived experience. The books are free to borrow from public libraries across England and Wales. People can be recommended a Reading Well title by a professional, or they can visit their local library and choose a book to borrow.

There are currently five Reading Well schemes:

- Reading Well for adult mental health – Provides information and support for managing common mental health conditions or dealing with difficult feelings and experiences. **This list will be replaced by the new scheme.**
- Reading Well for families – Provides information and support to help parents and carers to look after their wellbeing in pregnancy and the early years (from conception to aged two).
- Reading Well for teens – Provides information, advice and support for teenagers aged 13-18 years old to help them better understand their feelings, handle difficult experiences and boost their confidence.
- Reading Well for children – Provides information, advice and stories, for children aged 7-11 years old and families, focused on coping with feelings and worries, daily life and tough times.
- Reading Well for dementia – Provides information and support to help people understand more about dementia including people living with dementia, carers and family members.

Reading Well is supported by over 40 partners from across the health and voluntary sectors, including NHS England, Royal College of General Practitioners, Royal College of Nursing, Royal College of Psychiatrists and British Psychological Society, as well as leading health organisations including Mind, Alzheimer's Society and the Mental Health Foundation.

Over 4.2 million Reading Well books have been borrowed from public libraries since 2013. Reading Well is endorsed by GPs, mental health professionals and government ministers as a helpful community-based health service. Evaluation of the scheme shows significant benefit, with 92% of respondents finding their book helpful and 81% reporting their book helped them to understand more about their health needs. 90% of health professionals surveyed said the books helped to support people outside of consultation time and to feel more confident about self-managing their symptoms.

Appendix 2: Review of Reading Well for mental health 2018

This section provides a brief overview of the existing Reading Well for mental health collection and details why an update is needed.

Launched in 2018, Reading Well for mental health recommends books and reading to help people understand and manage their mental health and wellbeing. It focuses on common mental health conditions and experiences. The collection features 37 titles, many of which were published before 2018.

There have been 755,136 loans[††] from Reading Well for mental health for the period 2019-2025. Figures 1 and 2 below provide an overview of lending activity within Reading Well for mental health over this six-year period, including the distribution of loans by topic category[‡‡]. The scheme category with the highest number of loans is 'Self-help books to support mental health', followed by 'Personal stories' and 'Common feelings and experiences'.

Figure 1: Total loans from the current Reading Well for mental health scheme by reporting year

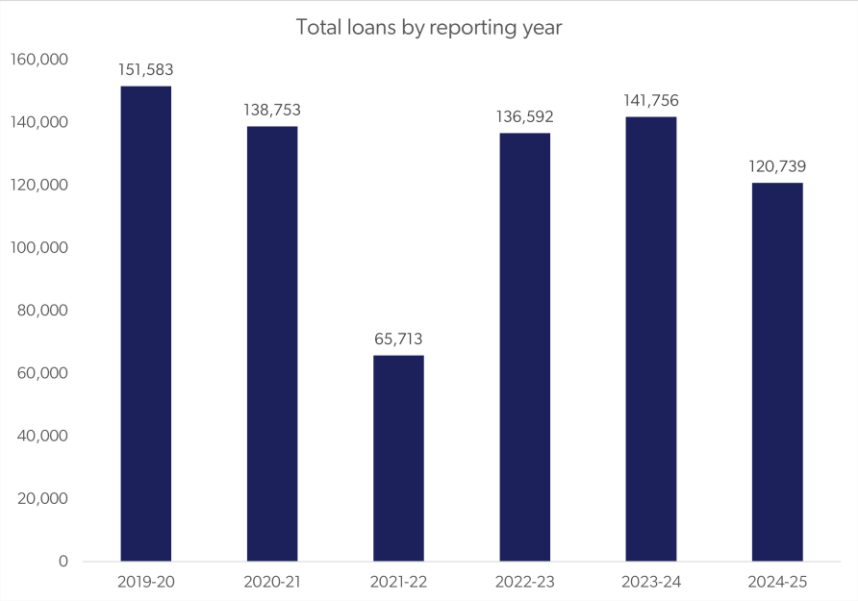
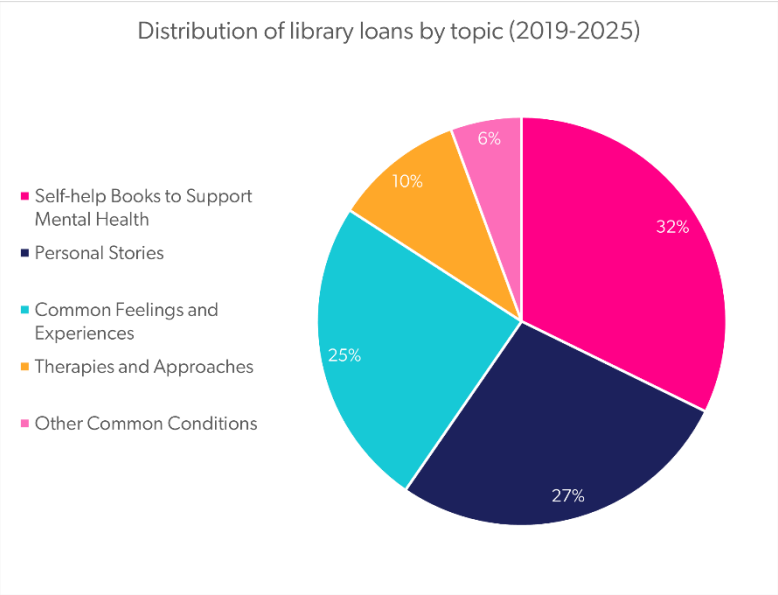


Figure 2: Distribution of loans from the current Reading Well for mental health scheme by topic category



[††] Loans data sourced from the British Library Public Lending Right (PLR) scheme. PLR loans estimates are produced by the British Library using sampled library loans and national grossing methods.

[‡‡] The drop in loans data for 2021-22 is reflective of the impact of COVID-19 on public libraries during 2020-21.

However, usage patterns suggest borrowing is shaped by the current composition of the scheme. The table below shows the number of titles available in each category, total loans, and average loans per title, alongside each category's share of overall titles and loans.

Figure 1: Loans by topic category in the current Reading Well for mental health scheme, 2019-2925. Categories are ordered by average loans per title (highest to lowest).

Topic category	Number of titles	Total loans (2019-25)	Avg loans per title	Share of all titles (%)	Share of all loans (%)
Therapies and approaches	2	77,421	**38,711**	5%	10%
Personal stories	8	206,434	**25,804**	22%	27%
Common feelings and experiences	8	185,331	**23,166**	22%	25%
Self-help books to support mental health	13	243,573	**18,736**	35%	32%
Other common conditions	6	42,377	**7,063**	16%	6%

The data show particularly strong demand for 'Therapies and approaches' which, despite comprising only two titles (5% of the current list), account for 10% of all loans and have the highest average loans per title. 'Personal stories' also stand out: they make up 22% of all available titles but 27% of total loans and have the second-highest average loans per title. Taken together, the data suggest pressure on some topic categories, highlighting the potential value of reviewing and rebalancing the list to better reflect reader needs and engagement.

Other reasons why an update is needed can be grouped into the following categories:

- Changes to the mental health priorities and needs, especially in relation to significant societal challenges including the long-term impact of COVID-19, cost-of-living challenges and wider socioeconomic challenges linked to global events.
- Supply issues – five of the existing 37 titles are out of print and four of the Welsh language titles are out of print. Alongside this many titles are now too old to meet library collection requirements.
- Limited titles on popular topics including sleep, stress and obsessive-compulsive disorder
- Increase in published content on mental health, including in diverse and accessible formats.
- Changes to the development of Reading Well, including:
    - Increased awareness and inclusion of personal stories based on co-production insights.
    - Inclusion of digital signposting
    - Joint English and Welsh policy mapping, the original scheme was developed focusing on English policy and later adapted to Welsh needs

Despite these challenges, Reading Well for mental health is maintaining a consistent level of loans, demonstrating the value and need of the programme.

Appendix 3: Overview of evidence for topics

Condition	Prevalence	NICE guidelines	Book-based self-help evidence	**Recommended for inclusion**
Common mental health conditions[§§]				
Generalised Anxiety Disorder	7.5% (around 3.5 million people)	Generalised anxiety disorder and panic disorder in adults: management [CG113][***] Step 2: Diagnosed GAD that has not improved after education and active monitoring in primary care • Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups	Yes	**Yes**
Depressive episode	3.8% (around 1.7 million people)	Depression in adults: treatment and management [NG222] 1.1.2 Provide people with depression with up-to-date and evidence-based verbal and written information about depression and its treatment, appropriate to their language, cultural and communication needs. Depression in adults with a chronic physical health problem: recognition and management [CG91] **1.2 Stepped care** Step 1: All known and suspected presentations of depression	Yes	**Yes**

[§§] Data sourced from **Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4** which provides data on the prevalence of treated and non-treated mental health conditions in England's adult population (age 16 and over) living in residential households

[***]In 2026, more than 70 mental health organisations and cross-party parliamentarians have signed a letter urging NICE to review this guideline to ensure it reflects current clinical practice, increases patient choice and addresses barriers for marginalised communities. The submitted letter and full joint position statement are available online.

		• Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions Step 2: Persistent subthreshold depressive symptoms; mild to moderate depression • Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions		
Phobias	2.6% (around 1.2 million people)	N/A	Yes	Yes
OCD	2.2% (around 1 million people)	Obsessive-compulsive disorder and body dysmorphic disorder: treatment [CG31] *This guideline is currently undergoing an update, expected publication February 2027.*	Yes	Yes
Panic disorder	1% (around 470,000 people)	Generalised anxiety disorder and panic disorder in adults: management [CG113]*** Step 2: Diagnosed GAD that has not improved after education and active monitoring in primary care • Low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psychoeducational groups	Yes	Yes
Other anxiety disorders				
Social anxiety disorder	12% lifetime prevalence†††	Social anxiety disorder: recognition, assessment and treatment [CG159] **Planning treatment for adults diagnosed with social anxiety disorder** 1.2.9 After diagnosis of social anxiety disorder in an adult, identify the goals for treatment and provide	Yes	Yes

††† Based on the proportion of a population who, at some point in life has ever had the characteristic.

		information about the disorder and its treatment including: • the nature and course of the disorder and commonly occurring comorbidities • the impact on social and personal functioning • commonly held beliefs about the cause of the disorder • beliefs about what can be changed or treated • choice and nature of evidence-based treatments.		
Body Dysmorphic Disorder	Around 2% of the adult population[‡‡‡]	Obsessive-compulsive disorder and body dysmorphic disorder: treatment [CG31] *This guideline is currently undergoing an update, expected publication February 2027.*	Yes	Yes
Health Anxiety	Approximately 5% of the general population[§§§]	N/A	Yes	Yes
PTSD	5.7% (1 in 20 adults screened positive for PTSD in the past month)[§§]	Post-traumatic stress disorder [NG116] **Involving and supporting families and carers** 1.4.3 When providing information and support to family members and carers of people with PTSD, think about covering: • the treatment and management of trauma-related psychological and behavioural problems, including the person's possible risk to themselves and others how they can support the person to access treatment, including what to do if they do not engage with, or drop out of treatment.	No	No, unless including information for carers

[‡‡‡] Veale, D. & Bewley, A. (2015) Body dysmorphic disorder. *BMJ* 2015;350:h2278. https://doi.org/10.1136/bmj.h2278
[§§§] NIHR CLAHRC (no date) Coping with distress about your health. [Accessed 08/04/2026]

Other				
Eating disorders	9.1%, the proportion of adults screening positive for possible cases of anorexia nervosa and bulimia nervosa (in 2023/24)[§§]	Eating disorders: recognition and treatment [NG69] **1.3 Treating anorexia nervosa** 1.3.1 Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention. Support should: • include psychoeducation about the disorder	May be effective for individuals at risk of developing an eating disorder	**Maybe**[****]
Hoarding disorder	Around 2.5% using a pooled estimate approach[††††]	N/A	No	**Maybe**
Personality disorders	1 in 50 adults reported antisocial personality disorder traits. 2% of adults 18+ screened positive. Nearly 1 in 50 adults reported borderline personality traits. 1.9% of adults 16+ screened positive. 1 in 7 adults reported general personality disorder traits. 14.9% of adults screened positive. Over a third of adults with a CMHC screened positive for general personality disorder traits[§§].	Borderline personality disorder: recognition and management [CG78] Antisocial personality disorder: prevention and management [CG77]	No	**No, unless including information for carers**
Self-harm	Between 9.7% - 12.1%, equates to around 5 million adults[§§]	Self-harm: assessment, management and preventing recurrence [NG225] **1.1 Information and support**	No	**No, unless including information for carers**

[****] Loans data from 2018 Reading Well for mental health collection suggests eating disorder related titles have not been as popular as other mental health titles.
[††††] Postlethwaite, A., et al. (2019) Prevalence of Hoarding Disorder: A systematic review and meta-analysis. *Journal of Affective Disorders,* 256, pp. 309-316. https://doi.org/10.1016/j.jad.2019.06.004

		1.1.1 Provide information and support for people who have self-harmed. Share information with family members or carers (as appropriate). 1.1.2 Provide information and support for the family members or carers (as appropriate) of the person who has self-harmed.		
Severe Mental Illness				
Bipolar disorder	1.9% equating to an estimated 890,000 adults living in private households in England[§§]	Bipolar disorder: assessment and management [CG185] **1.1 Care for adults, children and young people across all phases of bipolar disorder** **Support for carers of people with bipolar disorder** 1.1.6 Give carers written and verbal information in an accessible format about: • diagnosis and management of bipolar disorder • positive outcomes and recovery • types of support for carers • role of teams and services getting help in a crisis.	No	**No, unless including information for carers**
Psychosis and Schizophrenia (also categorised as psychotic disorders)	Less than one in a hundred adults met diagnostic criteria for a psychotic disorder in the past year in 2007, 2014, and 2023/4[§§]	Psychosis and schizophrenia in adults: prevention and management [CG178] **1.1 Care across all phases** **1.1.4 Support for carers** 1.1.4.1 Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services getting help in a crisis.	No	**No, unless including information for carers**

Feelings and experiences				
Anger problems	More than one in ten people (12%) say that they have trouble controlling their own anger, and more than one in four people (28%) say they worry about how angry they sometimes feel[‡‡‡‡]	N/A	Yes	Yes
Bereavement and loss	Over 600,000 people die every year, leaving more than six million people bereaved[§§§§]	N/A	Yes	Yes
Loneliness	According to the NHS Health Survey for England, 2024 reports 22% of adults felt lonely at least some of the time, including 6% who reported that they often or always felt lonely[*****].	N/A	Yes	Yes
Sleep problems	Approximately 1 in 3 adults reports occasional sleep difficulties and 10-20% of people experience chronic insomnia[†††††]	N/A	Yes	Yes
Stress	A nationally representative study found that just over 1 in 6 UK adults cited stress as an everyday occurrence[‡‡‡‡‡].	N/A	May help to manage stress.	Yes

[‡‡‡‡] Mental Health Foundation (2008) Boiling Point: Problem anger and what we can do about it

[§§§§] Marie Curie (2024) Public attitudes to death, dying and bereavement in the UK re-visited: 2023 survey; Summary report, October 2024

[*****] NHS England (2026) Health Survey for England, 2024.

[†††††] Bjorvatn, B., et al. (2025) A randomized controlled trial comparing sleep hygiene advice with a self-help book focusing on cognitive behavioral therapy for insomnia: a study among patients with prescribed hypnotics from the GP. *Scandinavian Journal of Primary Health Care*, *44*(1), 1–10. https://doi.org/10.1080/02813432.2025.2525423

[‡‡‡‡‡] Forth (2026) UK Stress Statistics 2026: The Great British Stress Epidemic

Appendix 4: Relevant NICE guidelines and Quality Standards

The following section provides an overview of the NICE guidelines and Quality Standards that are relevant to the Reading Well for mental health list. For the full list of guidelines please go to: Published guidance, NICE advice and quality standards | Guidance | NICE

Guidelines	Detail
Anxiety	

Generalised anxiety disorder and panic disorder in adults: management [CG113] (2011)	**1.2 Stepped care for people with GAD**
	1.2.1 Follow the stepped-care model, offering the least intrusive, most effective intervention first. **[2011]**
	• Step 1: All known and suspected presentations of GAD
	  ○ Identification and assessment; education about GAD and treatment options; active monitoring
	• Step 2: Diagnosed GAD that has not improved after education and active monitoring in primary care
	  ○ Low-intensity psychological interventions: individual non-facilitated self-help§§§§§, individual guided self-help and psychoeducational groups
	• Step 3: GAD with an inadequate response to step 2 interventions or marked functional impairment
	  ○ Choice of a high-intensity psychological intervention (cognitive behavioural therapy [CBT]/applied relaxation) or a drug treatment
	• Step 4: Complex treatment-refractory generalised anxiety disorder (GAD) and very marked functional impairment, such as self-neglect or a high risk of self-harm
	  ○ Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
	
	Step 1: All known and suspected presentations of GAD
	
	1.2.10 Following assessment and diagnosis of GAD:
	• provide education about the nature of GAD and the options for treatment, including NICE's information for the public
	• monitor the person's symptoms and functioning (known as active monitoring).
	
	This is because education and active monitoring may improve less severe presentations and avoid the need for further interventions. **[2011]**

§§§§§ Individual non-facilitated self-help: this is a self-administered intervention intended to treat GAD involving written or electronic self-help materials (usually a book or workbook). It is similar to individual guided self-help but usually with minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes.

	Step 2: Diagnosed GAD that has not improved after step 1 interventions **Low-intensity psychological interventions for GAD** 1.2.12 For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer 1 or more of the following as a first-line intervention, guided by the person's preference: • individual non-facilitated self-help • individual guided self-help • psychoeducational groups. **[2011]** 1.2.13 Individual non-facilitated self-help for people with GAD should: • include written or electronic materials of a suitable reading age (or alternative media) • be based on the treatment principles of cognitive behavioural therapy (CBT) • include instructions for the person to work systematically through the materials over a period of at least 6 weeks • usually involve minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes. **[2011]** 1.2.14 Individual guided self-help for people with GAD should: • be based on the treatment principles of CBT • include written or electronic materials of a suitable reading age (or alternative media) • be supported by a trained practitioner, who facilitates the self-help programme and reviews progress and outcome • usually consist of 5 to 7 weekly or fortnightly face-to-face or telephone sessions, each lasting 20 to 30 minutes. **[2011, amended 2018]** 1.2.15 Psychoeducational groups for people with GAD should: • be based on CBT principles, have an interactive design and encourage observational learning • include presentations and self-help manuals • be conducted by trained practitioners • have a ratio of 1 therapist to about 12 participants • usually consist of 6 weekly sessions, each lasting 2 hours. **[2011]** 1.2.16 Practitioners providing guided self-help and/or psychoeducational groups should: • receive regular high-quality supervision

	• use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment. **[2011]** 1.3 Stepped care for people with panic disorder • Step 1 – recognition and diagnosis • Step 2 – treatment in primary care • Step 3 – review and consideration of alternative treatments • Step 4 – review and referral to specialist mental health services • Step 5 – care in specialist mental health services. **Step 2 for people with panic disorder: offer treatment in primary care** The recommended treatment options have an evidence base: psychological therapy, medication and self-help have all been shown to be effective. The choice of treatment will be a consequence of the assessment process and shared decision making. 1.3.9 For people with mild to moderate panic disorder, offer or refer for 1 of the following low-intensity interventions: • individual non-facilitated self-help • individual facilitated self-help. **[2011]** 1.3.10 Information about support groups, where they are available, should be offered. (Support groups may provide face-to-face meetings, telephone conference support groups [which can be based on CBT principles], or additional information on all aspects of anxiety disorders plus other sources of help.) **[2004]**
Obsessive-compulsive disorder and body dysmorphic disorder: treatment [CG31] (2005)	This guideline is currently undergoing an update, expected publication February 2027.
Post-traumatic stress disorder [NG116] (2018)	**Involving and supporting families and carers** 1.4.3 When providing information and support to family members and carers of people with PTSD, think about covering: • the treatment and management of trauma-related psychological and behavioural problems, including the person's possible risk to themselves and others

	• how they can support the person to access treatment, including what to do if they do not engage with, or drop out of treatment. **[2018]**
Social anxiety disorder: recognition, assessment and treatment [CG159] (2013)	**Planning treatment for adults diagnosed with social anxiety disorder** 1.2.9 After diagnosis of social anxiety disorder in an adult, identify the goals for treatment and provide information about the disorder and its treatment including: • the nature and course of the disorder and commonly occurring comorbidities • the impact on social and personal functioning • commonly held beliefs about the cause of the disorder • beliefs about what can be changed or treated • choice and nature of evidence-based treatments. **Initial treatment options for adults with social anxiety disorder** 1.3.4 For adults who decline CBT and wish to consider another psychological intervention, offer CBT-based supported self-help (see recommendation 1.3.15 in the section on delivering psychological interventions for adults). 1.3.15 Supported self-help for social anxiety disorder should consist of: • typically up to 9 sessions of supported use of a CBT-based self-help book over 3 to 4 months • support to use the materials, either face to face or by telephone, for a total of 3 hours over the course of the treatment.
Depression	
Depression in adults: treatment and management [NG222] (2022)	**1.1 Principles of care** 1.1.1 When working with people with depression and their families or carers, ensure steps are taken to reduce stigma, discrimination and barriers for individuals seeking help for depression (for example, reducing judgemental attitudes, showing compassion, parity of esteem between mental illness and physical illness, treating people as individuals). **[2009, amended 2022]** **Providing information and support** 1.1.2 Provide people with depression with up-to-date and evidence-based verbal and written information about depression and its treatment, appropriate to their language, cultural and communication needs. **1.5 Treatment for a new episode of less severe depression**

	1.5.2 Discuss treatment options with people with a new episode of less severe depression, and match their choice of treatment to their clinical needs and preferences Treatment options for less severe depression in order of the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors • Guided self-help • Group CBT • Group behavioural activation • Individual CBT • Individual BA • Group exercise • Group mindfulness and meditation • Interpersonal psychotherapy • Selective serotonin reuptake inhibitors (SSRIs) • Counselling • Short-term psychodynamic psychotherapy (STPP) **1.6 Treatment for a new episode of more severe depression** 1.6.1 Discuss treatment options with people who have a new episode of more severe depression, and match their choice of treatment to their clinical needs and preferences Treatment options for more severe depression in order of the committee's interpretation of their clinical and cost effectiveness and consideration of implementation factors • Combination of individual CBT and an antidepressant • Individual CBT • Individual behavioural activation • Antidepressant medication • Individual problem-solving • Counselling • Short-term psychodynamic psychotherapy (STPP) • Interpersonal psychotherapy • Guided self-help • Group exercise

Depression in adults with a chronic physical health problem: recognition and management [CG91] (2009)	**1.2 Stepped care**
	The stepped-care model provides a framework in which to organise the provision of services, and supports patients, carers and practitioners in identifying and accessing the most effective interventions (see figure 1). In stepped care the least intrusive, most effective intervention is provided first; if a patient does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.
	• Step 1: All known and suspected presentations of depression
	  ○ Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions
	• Step 2: Persistent subthreshold depressive symptoms; mild to moderate depression
	  ○ Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
	• Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression
	  ○ Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
	• Step 4: Severe and complex depression; risk to life; severe self-neglect
	  ○ Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
	
	1.4 Step 2: recognised depression in primary care and general hospital settings – persistent subthreshold depressive symptoms or mild to moderate depression
	
	1.4.1 General measures
	Depression with anxiety
	1.4.1.1 When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the patient has an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guideline for the relevant anxiety disorder (see the NICE topic page on depression) and consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).
	
	Sleep hygiene

	1.4.1.2 Offer patients with depression and a chronic physical health problem advice on sleep hygiene if needed, including: • establishing regular sleep and wake times • avoiding excess eating, smoking or drinking alcohol before sleep • creating a proper environment for sleep • taking regular physical exercise where this is possible for the patient. **1.4.2 Low-intensity psychosocial interventions** 1.4.2.1 For patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, consider offering one or more of the following interventions, guided by the patient's preference: • a structured group physical activity programme • a group-based peer support (self-help) programme • individual guided self-help based on the principles of cognitive behavioural therapy (CBT) • computerised cognitive behavioural therapy (CCBT). 1.4.2.4 Individual guided self-help programmes based on the principles of CBT (and including behavioural activation and problem-solving techniques) for patients with persistent subthreshold depressive symptoms or mild to moderate depression and a chronic physical health problem, and for patients with subthreshold depressive symptoms that complicate the care of the chronic physical health problem, should: • include the provision of written materials of an appropriate reading age (or alternative media to support access) • be supported by a trained practitioner, who typically facilitates the self-help programme and reviews progress and outcome • consist of up to 6 to 8 sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.
Eating disorders	
Eating disorders: recognition and treatment [NG69] (2017)	**1.3 Treating anorexia nervosa** 1.3.1 Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention. Support should: • include psychoeducation about the disorder • include monitoring of weight, mental and physical health, and any risk factors

	• be multidisciplinary and coordinated between services. **1.4 Treating binge eating disorder** **Psychological treatment for binge eating disorder in adults** 1.4.1 Explain to people with binge eating disorder that psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is not a therapy target in itself. Refer to the NICE guideline on overweight and obesity management for guidance on weight loss and bariatric surgery. 1.4.2 Offer a binge-eating-disorder-focused guided self-help programme to adults with binge eating disorder. 1.4.3 Binge-eating-disorder-focused guided self-help programmes for adults should: • use cognitive behavioural self-help materials • focus on adherence to the self-help programme • supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first) • focus exclusively on helping the person follow the programme. 1.4.4 If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED). **1.5 Treating bulimia nervosa** **Psychological treatment for bulimia nervosa in adults** 1.5.2 Consider bulimia-nervosa-focused guided self-help for adults with bulimia nervosa. 1.5.3 Bulimia-nervosa-focused guided self-help programmes for adults with bulimia nervosa should: • use cognitive behavioural self-help materials for eating disorders • supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first). 1.5.4 If bulimia-nervosa-focused guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks of treatment, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED).
Severe Mental Illness	
Bipolar disorder: assessment and management [CG185] (2014)	**1.1 Care for adults, children and young people across all phases of bipolar disorder** **Support for carers of people with bipolar disorder** 1.1.6 Give carers written and verbal information in an accessible format about: • diagnosis and management of bipolar disorder • positive outcomes and recovery • types of support for carers

	• role of teams and services • getting help in a crisis. **[2014]**
Psychosis and schizophrenia in adults: prevention and management [CG178] (2014)	**1.1 Care across all phases** **1.1.4 Support for carers** 1.1.4.1 Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. **[2014]** **1.2.3 Treatment options to prevent psychosis** 1.2.3.1 If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1): • offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in the section on how to deliver psychological interventions) **and** • offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. **[2014]**
Other: Personality disorder	
Antisocial personality disorder: prevention and management [CG77] (2009)	**Future updates:** The current International Classification of Diseases (ICD-11) does not distinguish between the previous separate types of personality disorder, but defines it as a single condition, classified by severity. We are continuing to explore if the existing recommendations can be contextualised in line with ICD-11.
Borderline personality disorder: recognition and management [CG78] (2009)	**Future updates:** The current International Classification of Diseases (ICD-11) does not distinguish between the previous separate types of personality disorder, but defines it as a single condition, classified by severity. We are continuing to explore if the existing recommendations can be contextualised in line with ICD-11.
Other: Self-harm	
Self-harm: assessment, management and preventing recurrence [NG225] (2022)	**1.1 Information and support** 1.1.1 Provide information and support for people who have self-harmed. Share information with family members or carers (as appropriate). Topics to discuss include: • what self-harm is

	• why people self-harm and, where possible, the specific circumstances of the person • support and treatments available • self-care (also see recommendation 1.11.12 in the section on harm minimisation), including when to seek help • how to deal with injuries • how to manage scars • care plans and safety plans, and what they involve • the impact of encountering stigma around self-harm • what to do if they have any concerns • what do to in an emergency. 1.1.2 Provide information and support for the family members or carers (as appropriate) of the person who has self-harmed. Topics to discuss include: • the emotional impact on the person and their family members or carers • advice on how to cope when supporting someone who self-harms • what to do if the person self-harms again • how to seek help for the physical consequences of self-harm • how to assist and support the person • how to recognise signs that the person may self-harm • steps to reduce the likelihood of self-harm in the future • the impact of encountering stigma around self-harm. 1.1.3 Information for people who have self-harmed and their family members or carers should be tailored to their individual needs and circumstances, taking into account, for example: • whether this is a first presentation or repeat self-harm • the severity and type of self-harm • if the person has any coexisting health conditions, neurodevelopmental conditions or a learning disability. 1.1.4 Recognise that support and information may need to be adapted for people who may be subject to discrimination, for example, people who are physically disabled, people with neurodevelopmental conditions or a learning disability, people from underserved groups, people from Black, Asian and minority ethnic backgrounds and people who are LGBTQ+.
Other: Mental Health Services	

Mental health problems in people with learning disabilities: prevention, assessment and management [NG54] (2016)	**1.3 Support and interventions for family members and carers** 1.3.1 When providing support to family members (including siblings) and carers: • recognise the potential impact of living with or caring for a person with learning disabilities and a mental health problem • explain how to access disability-specific support groups for family members or carers. 1.3.2 If a family member or carer also has an identified mental health problem, offer: • interventions in line with the NICE guidelines on specific mental health problems **or** • referral to a mental health professional who can provide interventions in line with NICE guidelines. **1.8 Psychological interventions** **Delivering psychological interventions for mental health problems in people with learning disabilities** 1.8.1 For psychological interventions for mental health problems in people with learning disabilities, refer to the NICE guidelines on specific mental health problems and take into account: • the principles for delivering psychological interventions (see recommendations 1.8.2 to 1.8.4) and • the specific interventions recommended in this guideline (see recommendations 1.8.5 to 1.8.9). 1.8.2 Use the mental health assessment to inform the psychological intervention and any adaptations to it, and: • tailor it to their preferences, level of understanding, and strengths and needs • take into account any physical, neurological, cognitive or sensory impairments and communication needs • take into account the person's need for privacy (particularly when offering interventions on an outreach basis) • agree how it will be delivered (for example, face-to-face or remotely by phone or computer), taking into account the person's communication needs and how suitable remote working is for them. 1.8.3 If possible, collaborate with the person and their family members, carers or care workers (as appropriate) to: • develop and agree the intervention goals • develop an understanding of how the person expresses or describes emotions or distressing experiences • agree the structure, frequency, duration and content of the intervention, including its timing, mode of delivery and pace • agree the level of flexibility needed to effectively deliver the intervention • agree how progress will be measured and how data will be collected (for example, visual representations of distress or wellbeing). 1.8.4 Be aware that people with learning disabilities might need more structured support to practise and apply new skills to everyday life between sessions. In discussion with the person, consider: • providing additional support during meetings and in the planning of activities between meetings

	• asking a family member, carer or care worker to provide support and assistance (such as reminders) to practise new skills between meetings. **Specific psychological interventions** 1.8.5 Consider cognitive behavioural therapy, adapted for people with learning disabilities (see recommendation 1.8.2 on intervention adaptation methods), to treat depression or subthreshold depressive symptoms in people with milder learning disabilities. 1.8.6 Consider relaxation therapy to treat anxiety symptoms in people with learning disabilities. 1.8.7 Consider using graded exposure techniques to treat anxiety symptoms or phobias in people with learning disabilities. 1.8.8 Consider parent training programmes specifically designed for parents or carers of children with learning disabilities to help prevent or treat mental health problems in the child, and to support carer wellbeing.
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services [CG136] (2011)	**1.1 Care and support across all points on the care pathway** **Providing information** 1.1.5 When working with people using mental health services: • ensure that comprehensive written information about the nature of, and treatments and services for, their mental health problems is available in an appropriate language or format including any relevant text from NICE's information for the public • ensure that comprehensive information about other support groups, such as third sector, including voluntary organisations, is made available. 1.1.6 Ensure that you are: • familiar with local and national sources (organisations and websites) of information and/or support for people using mental health services • able to discuss and advise how to access these resources • able to discuss and actively support service users to engage with these resources. **Involving families and carers** 1.1.16 If the person using mental health services wants their family or carers to be involved, give the family or carers verbal and written information about: • the mental health problem(s) experienced by the service user and its treatment, including relevant text from NICE's information for the public • statutory and third sector, including voluntary, local support groups and services specifically for families and carers, and how to access these

	• their right to a formal carer's assessment of their own physical and mental health needs, and how to access this (see NICE's guideline on supporting adult carers). **1.4 Community care** 1.4.3 Support service users to develop strategies, including risk- and self-management plans, to promote and maintain independence and self-efficacy, wherever possible. Incorporate these strategies into the care plan.
Violence and aggression: short term management in mental health, health and community settings [NG10] (2015)	This guideline is currently undergoing an update, expected publication January 2027.
Other related topics	
Attention deficit hyperactivity disorder: diagnosis and management [NG87] (2018)	**Supporting people with ADHD** 1.4.4 Inform people receiving a diagnosis of ADHD (and their families or carers as appropriate) about sources of information, including: • local and national support groups and voluntary organisations • websites • support for education and employment. People who have had an assessment but whose symptoms and impairment fall short of a diagnosis of ADHD may benefit from similar information. **[2018]** 1.4.5 Provide information to people with ADHD (and their families and carers as appropriate) in a form that: • takes into account their developmental level, cognitive style, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems, delays in language development or social communication difficulties • takes into account any coexisting neurodevelopmental and mental health conditions • is tailored to their individual needs and circumstances, including age, gender, educational level and life stage. **[2018]**
Autism spectrum disorder in adults: diagnosis and management [CG142] (2012)	**1.1 General principles of care** **Principles for working with autistic adults and their families, partners and carers**

	1.1.6 All health and social care professionals providing care and support for autistic adults and their families, partners and carers should ensure that they are: • familiar with recognised local and national sources (organisations and websites) of information and/or support for autistic people • able to discuss and advise on how to access and engage with these resources. 1.1.7 Encourage autistic adults to participate in self-help or support groups or access one-to-one support, and provide support so that they can attend meetings and engage in the activities. **Involving families, partners and carers** 1.1.17 Give all families, partners and carer(s) (whether or not the person wants them to be involved in their care) verbal and written information about: • autism and its management • local support groups and services specifically for families, partners and carers • their right to a carer's assessment of their own physical and mental health needs, and how to access this (see the NICE guideline on supporting adult carers). **1.6 Interventions for coexisting mental disorders** **Psychosocial interventions for coexisting mental disorders** 1.6.2 For autistic adults and coexisting mental disorders, offer psychosocial interventions informed by existing NICE guidance for the specific disorder. 1.6.3 Adaptations to the method of delivery of cognitive and behavioural interventions for autistic adults and coexisting common mental disorders should include: • a more concrete and structured approach with a greater use of written and visual information (which may include worksheets, thought bubbles, images and 'tool boxes') • placing greater emphasis on changing behaviour, rather than cognitions, and using the behaviour as the starting point for intervention • making rules explicit and explaining their context • using plain English and avoiding excessive use of metaphor, ambiguity and hypothetical situations • involving a family member, partner, carer or professional (if the autistic person agrees) to support the implementation of an intervention • maintaining the person's attention by offering regular breaks and incorporating their special interests into therapy if possible (such as using computers to present information).

Menopause: identification and management [NG23] (2015)	**1.2 Information and support**
	1.2.1 Share information about menopause with people who have associated symptoms or are approaching menopause, and their family members or carers (as appropriate). This information should include all of the following:
	• what menopause is, including that it is a life transition which:
	  ○ usually takes place in mid-life **and**
	  ○ can also happen earlier because of surgery or medical treatment, an inherited condition, or an unknown cause
	• commonly associated symptoms (see recommendation 1.2.2)
	• interventions, or changes the person can make to support their health and wellbeing. **[2015, amended 2024]**
	1.2.2 Explain that symptoms associated with menopause may vary from minor to severe and be experienced over short or long time periods. As well as changes in menstrual cycle, symptoms may include:
	• vasomotor symptoms (hot flushes and sweats)
	• genitourinary symptoms (for example, vaginal dryness)
	• effects on mood (for example, depressive symptoms)
	• musculoskeletal symptoms (for example, joint and muscle pain)
	• sexual difficulties (for example, low sexual desire). **[2015]**
	
	1.4 Discussing management options with people aged 40 or over
	Cognitive behavioural therapy
	1.4.4 When discussing cognitive behavioural therapy (CBT) as a possible management option for symptoms associated with menopause, explain what CBT is (including menopause-specific CBT) and talk about the available options, taking into account the person's preferences and needs, for example:
	• face-to-face or remote sessions
	• individual or group sessions
	• self-help options. **[2024]**
	
	1.5 Managing symptoms associated with menopause in people aged 40 or over
	Depressive symptoms
	1.5.21 Consider HRT to alleviate depressive symptoms (not meeting the criteria for a diagnosis of depression) with onset around the same time as other symptoms associated with menopause. **[2015, amended 2024]**
	1.5.22 Consider CBT as an option for people who have depressive symptoms (not meeting the criteria for a diagnosis of depression) in association with vasomotor symptoms:

	• in addition to other management options **or** • for people for whom other options are contraindicated **or** • for those who prefer not to try other options. **[2024]** 1.5.23 For people experiencing menopause who are suspected to have or have been diagnosed with depression, follow the recommendations in this guideline alongside the recommendations in NICE's guideline on treating and managing depression in adults to achieve an optimal management plan. **[2024]**
Mental wellbeing at work [NG212] (2022)	1.2 Supportive work environment 1.2.1 Foster a positive, compassionate and inclusive workplace environment and culture to support psychological safety and mental wellbeing by: • ensuring active leadership and management support and engagement • increasing mental health literacy • encouraging and facilitating peer support (for example, using mental health champions and peer mentoring or 'buddying') • supporting people who manage and support employees • encouraging employees to recognise and take action to prevent discrimination in the workplace, for example by establishing and supporting staff networks • being aware that mental wellbeing in the workplace also depends on factors beyond the workplace itself (such as physical health, domestic relationships, home environment and financial circumstances) and also on societal discrimination (such as racism, homophobia and sexism) • promoting good communication and engagement with employees • including mental health awareness in manager training (see the section on training and support for managers). 1.2.4 Ensure that all employees have the opportunity and the means to access interventions (such as private access to the internet and IT equipment for remotely delivered interventions). 1.3 External sources of support 1.3.3 Use local and national resources, and advice from a variety of evidence-informed sources, such as the local Improving Access to Psychological Therapies services offer, the employee's GP, professional bodies, unions and trade organisations (for example, Federation of Small Businesses, ACAS and the Chartered Institute of Personnel and Development [CIPD]).

Supporting adult carers [NG150] (2020)	**Sharing information with carers** 1.1.4 Discuss information with carers as well as giving them written materials. When providing information: • ensure it is plainly worded, clearly presented and free of jargon • be aware that smaller, more manageable chunks of information are easier to remember, and that visual aids or pictures can be useful • encourage the carer to ask questions • ensure that information is consistent. 1.1.5 Make information available in a range of formats to meet carers' needs and preferences, for example written leaflets, links to online and digital resources (including local and national websites and forums and social media) and information in accessible formats or different languages. For more about accessible communication see NHS England's Accessible Information Standard. 1.1.6 Take into account that carers' information needs will change over time and whenever their circumstances or caring role change. Provide information and advice that addresses the carer's individual needs at the time when they need it and that helps them plan and prepare. **1.5 Social and community support for carers** **Community information, advice and support** 1.5.1 Local authorities should ensure carers are kept regularly informed about available community services and other sources of support and advice and how to access them, for example: • local carer support services • self-help groups • community and faith groups • specialist benefits, financial and legal advice • financial support • advice about self-care • where to find reliable information about the health condition of the person they are caring for. **1.7 Psychological and emotional support for carers** **Psychosocial and psychoeducational support** 1.7.1 Consider providing carers with psychosocial and psychoeducational support, which should include: • developing personalised strategies and building carer skills • advice on how to look after their own physical and mental health, and their emotional and spiritual wellbeing

	• information about emotional support services and psychological therapies for carers and how to access them. 1.7.2 Ensure that the range of psychosocial and psychoeducational support offered to carers includes group-based options. **Psychotherapy and counselling** 1.7.6 If a carer has an identified mental health problem, consider: • psychotherapy and counselling interventions in line with existing NICE guidance (see NICE's topic page for mental health and behavioural conditions) **or** • referral to a GP or mental health professional who can provide interventions in line with existing NICE guidance.
Quality Standards	
Anxiety disorders [QS53] (2014)	Statement 2 People with an anxiety disorder are offered evidence-based psychological interventions.
Autism [QS51] (2014)	Statement 2 People having a diagnostic assessment for autism are also assessed for coexisting physical health conditions and mental health problems.
Depression in adults [QS8] (2011)	Statement 2 Adults with a new episode of depression have a discussion with their healthcare professional about the full range of treatment options. **[new 2023]**
Eating disorders [QS175] (2018)	Statement 3 People with binge eating disorder participate in a guided self-help programme as first-line psychological treatment.
Learning disability: identifying and managing mental health problems [QS142] (2017)	Statement 4 People with learning and mental health problems who are receiving psychological interventions have them tailored to their preferences, level of understanding, and strengths and needs.
Psychosis and schizophrenia in adults [QS80] (2015)	Statement 8 Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

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