POPULATION MENTAL HEALTH CONSORTIUM

SANDPIT APPENDICES

Appendix: intellectual property

The collaboration agreement for the Consortium states:

In this Agreement, "Intellectual Property" shall mean intellectual property of any description including but not limited to all inventions, designs, information, specifications, formulae, improvements, discoveries, know-how, data, processes, methods, techniques and the intellectual property rights therein, including but not limited to, patents, copyrights, database rights, design rights (registered and unregistered), trademarks, trade names and service marks, and applications for any of the above.

All Intellectual Property used in connection with the Project which has been generated prior to or outside the scope of the Project ("Background IP") shall remain the property of the Party contributing the same. Each Party acknowledges and confirms that nothing contained in this Agreement shall give it any right, title or interest in or to the Background IP of the other Party save as granted by this Agreement.

- *8.3 "Results" shall mean all information, know-how, results, inventions, software and other Intellectual Property arising in the course of the Project. The Lead shall own all the Results arising from the work conducted by the Collaborator under this Agreement.*
- *Each Party grants the other Party, subject to the restrictions in Clause 10, (i) a non-exclusive, non-transferable, non-sub-licensable, royalty-free license for the duration of the Project to use its Background IP solely to enable the other Party to carry out their respective part of the Project, and (ii) a non-exclusive, non-transferable, non-sub-licensable, royalty-free license to use its Results for academic and non-commercial research purposes, including research projects funded by third parties (including commercial entities) provided that those parties gain or claim no rights to such Results.*
- *If the Lead (the "Exercising Party") requires the use of Background IP of the Collaborator (the "Other Party") in order to exercise its rights in the Results then, provided the Collaborator is free to license the Background IP in question, the Collaborator will not unreasonably refuse to grant or delay granting a license to the Lead so that the Lead may use such Background IP for the purpose of exercising its rights in the Results.*

Appendix: Definition of Lived Experience

In this context, lived experience refers to:

- Having experienced mental distress or mental health issues, particularly;
  - in childhood or adolescence (Challenge 1);
  - including self-harm, suicidal ideation, or loss through suicide (Challenge 2);
  - and/or in conjunction with other long-term conditions, including physical health issues (Challenge 3)

- Having experienced structural disadvantage, discrimination, marginalisation, inequities, injustice, neglect, abuse, or violence of any kind (interpersonal and/or systemic), which either caused, worsened, were compounded by, or were connected is some way to the mental distress or mental health issues experienced.

- Having experienced race-based trauma, where racial discrimination, marginalisation, or systemic racism has directly or indirectly contributed to the mental distress or mental health issues experienced.

- Having experienced intersecting forms of discrimination or disadvantage based on protected characteristics[1] (such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation), which have compounded or exacerbated mental distress or mental health issues.

Perspectives drawn from lived experience provide retrospective insights not only on mental health struggles but also on risk, protective, and preventative factors; providing key insights on what should be considered for mental health prevention. To understand and address mental health issues and their bidirectional relationship with inequalities, we must understand these from the perspectives of those most affected and ensure that a diverse range of experiences are considered.

Appendix: Upstream Prevention

Introduction

The Population Mental Health Consortium aims to enhance mental health outcomes across the UK by leveraging large-scale datasets to create opportunities for population-level improvements, focusing on upstream prevention for children and young people, suicide and self-harm prevention, and multiple long-term conditions. As members, we are committed to addressing the societal conditions that create and reinforce mental health inequalities through prioritising research aligned with upstream prevention. The purpose of this paper is to explore our interpretation of upstream prevention in the context of the Consortium.

The case for upstream prevention

Upstream prevention refers to preventing poor health outcomes before they reach a critical point, often described as the 'downstream', by which time healthcare intervention is likely required (see Figure 1). In mental health, resources, energy, and attention are frequently directed towards downstream interventions, such as clinical care or psychiatric hospital funding. Upstream prevention emphasises the importance of proactive measures to avoid the need for later

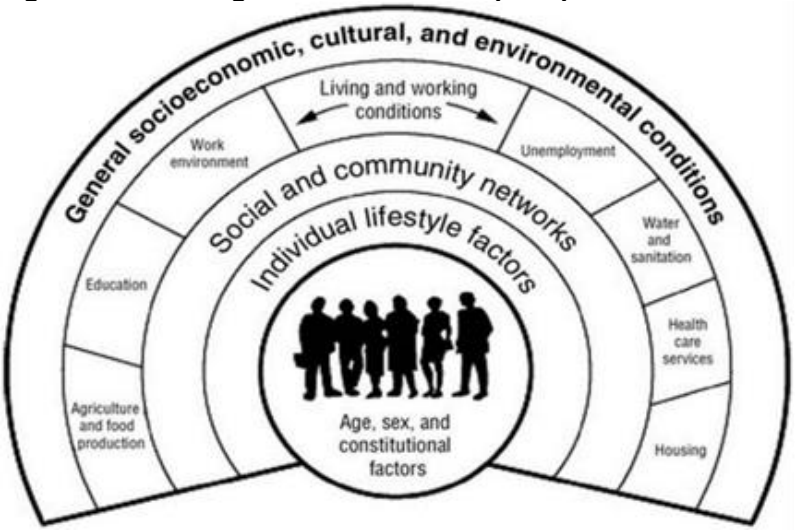
intervention, but in most nations less than 20% of mental health expenditure is spent on primary care, mental disorder prevention, or wellbeing promotion.[1] [2] Upstream determinants of health (see Figures 2 and 3) refer to the factors that comprise social structural influences on health and health systems, government policies, and the social, physical, economic and environmental factors that determine health.[3] The causal pathways linking these determinants with mental health are typically long and complex and often involve multiple intervening factors along the way.[4] This complexity makes it a challenge to study, and, ultimately, to address, the upstream causes of mental distress and ill health.

However, a focus on 'upstream' determinants of mental health is an opportunity to consider the vast, complex, and often overlooked experiences of social conditions which are distal to the onset of mental ill-health and distress, and importantly enables a shift in focus to population or policy-level factors and interventions. This approach challenges the historic rhetoric that mental health resides outside of public health,[5] and creates an opportunity to progress an underdeveloped evidence base, which can both inform and support evaluation of policy making for primary prevention.

Figure 1. The Cliff of Good Health applied to youth mental health, illustrating upstream population mental health solutions and downstream clinical responses (Oswald, 2022).

Figure 2. Social determinants of mental disorders and the Sustainable Development Goals: a conceptual framework by Lund et al. (Reference Lund, Brooke-Sumner, Baingana, Baron, Breuer, Chandra and Kieling2018).

Figure 3. The Dahlgren and Whitehead (1991) model of health determinants



What is in scope for upstream prevention

It is crucial to ensure that research proposals and activities shared by the Population Mental Health Consortium address and apply an understanding of upstream prevention. Some examples of research questions which explore upstream determinants in reference to the consortium cross-cutting platforms and challenge areas are given in Table 1. A summary of work which is in scope/not in scope for PHI-UK, stipulated by UKRI, is included in Table 2.

We must seek to explore and contextualise the social determinants of health and their relation to equity.[6] This requires us to shift our focus towards health equity, intersectionality, modifiable risk factors,[7] the social determinants of health, and a life course approach.[8] In these efforts we must avoid focusing on downstream factors, health service use, and 'lifestyle drift',[9] in which health policies that are intended to address upstream interventions eventually focus on 'lifestyle modification'[10] and individual behaviours, which potentially deepen health inequalities.

Table 1. Examples of upstream prevention research in population mental health

Study topics	Risk factors	Upstream examples
Narrowing inequalities - LGBTQ+ mental health inequities	Discrimination	Exploring mental health of LGBTQ+ people in the UK pre- to post-legalisation of same-sex marriage, using 'Understanding Society' cohort
Children & young people	Poverty	Will the introduction of free school meals reduce psychological distress in children and young people?
Suicide & self-harm	Social networks/isolation/digital harms	What effect did social restriction during the COVID-19 pandemic have on risk of suicide & self-harm?
Multiple long-term conditions	Unemployment Poverty	Does improving access to employment reduce rates of depression and anxiety in people with chronic physical health conditions?
Narrowing inequalities – housing conditions	Poverty Living conditions	If we prevented/addressed inadequate housing conditions, to what extent would this lead to reductions in psychological distress?

Table 2. Scope of the Population Health Improvement UK (PHI-UK; from UKRI)

In Scope	Not in scope
▪ Research focused on what actions can be taken early, and at the population level, to prevent later ill health ▪ Population-level interventions ▪ Research to inform policy development, for example involving local councils ▪ Evaluation of policy ▪ Natural experiments ▪ Methodology for evidence synthesis ▪ Novel data analysis methods (which may include artificial intelligence, machine learning and modelling) ▪ Interventions at scale that narrow inequalities ▪ Applications of digital health	▪ Underpinning research at the individual level ▪ Studies which solely describe current issues ▪ Individual-level interventions, except as part of a pre-defined subpopulation ▪ Policy development ▪ Interventions that aim to improve health service delivery ▪ Research that is not interdisciplinary