



Horticulture Sector Committee

Corrected oral evidence: The horticultural sector

Thursday 22 June 2023

11.35 am

Watch the meeting

Members present: Lord Redesdale (The Chair); Baroness Buscombe; Lord Carter of Coles; Lord Colgrain; Baroness Fookes; Baroness Jones of Whitchurch; Lord Sahota; Baroness Walmsley; Baroness Willis of Summertown.

Evidence Session No. 18

Heard in Public

Questions 211 - 217

Witnesses

[I](#): Annabelle Padwick, Founder, Life at No. 27; Dr David Rose, Independent Academic, and Visiting Fellow, Royal Agricultural University; Dave Solly, National Lead for Natural Environment, National Academy for Social Prescribing.

Examination of witnesses

Annabelle Padwick, Dr David Rose and Dave Solly.

Q211 **The Chair:** I welcome those giving evidence today. I will ask the first question. Could you say who you are and what are some of the issues you think are important in supporting mental health?

Dave Solly: Good morning. Thank you for the opportunity to join you this morning. I represent the National Academy for Social Prescribing, NASP for short. NASP is a national charity that was founded in October 2019, and we help people to live their best lives through social prescribing. We do that by championing social prescribing as an agenda and connecting people to the incredible work that is happening locally and globally. My ability and my background in doing that is from a basis of acting both locally and nationally, originally as a countryside ranger and a ranger in natural environment settings, and providing advice on how to manage natural areas to a range of organisations before coming to NASP.

Annabelle Padwick: I am the founder and director of Life at No. 27, which is a horticultural therapy and mental health counselling support charity based across Oxford, Northamptonshire and now south Wales. We set up the organisation in 2019. My way into the industry is very personal. The strongest evidence I can give you for horticulture supporting mental health is my own. That comes with a caveat on mental health support, which I will go into. That is my background and what I am here to represent.

Dr David Rose: Good morning, everyone. I am a visiting fellow at the Royal Agricultural University. I have done some research on the challenges facing agricultural and horticultural growers in the UK, particularly in mental health, looking at some of the drivers of poor mental health and some of the sources of support that they use for mental health. I have also done some research specifically in the commercial soft fruit sector, looking into the challenges it faces.

Q212 **Baroness Willis of Summertown:** Good morning, everyone. I declare an interest as I have funding from the Leverhulme Trust looking at the relationship between nature and mental health, and I am working with the Warneford team of psychiatrists. I just wanted to put that on the record, because I have not done so before.

Annabelle, my question is for you. This is from my own experience. I often feel that we are not properly joined up when it comes to funding of horticultural therapy, either funding from the Government or private providers, or even the Leverhulme Trust. Maybe that is wrong, but I would like to hear your views on it.

Annabelle Padwick: On funding, there is none. That is the straight point.

Baroness Willis of Summertown: Is that funding for delivery or

funding for research?

Annabelle Padwick: The funding is going into research when we need the funding going into delivery, and it is going into the wrong research. It is going into research, but it is going into very high-level generic research, of which we have enough. We know that going for a walk and looking at a tree will potentially enhance someone's well-being in that moment in time. It is not going to change someone's life. It is not going to help them deal with significant trauma. It is not going to take them past the moment they are in. There is not enough funding going into long-term research, and there is not enough funding going into the providers who are delivering the therapeutic work.

Baroness Willis of Summertown: Which providers should be supporting the therapeutic work?

Annabelle Padwick: It is a broad range. It is too easy to say the Government. That is automatic. We can all sit here and say that the Government should put more money into it. Do not get me wrong; I think that is true. You could say that the NHS needs to put more money into it. I also think there needs to be a big part from industry. We have heard in other conversations here that other parts of the industry are making a lot of profit. Other sectors like sport plough money into community projects to support mental health. This industry does not do it, or it does but it is very few and far between.

I have had numerous conversations over the last five or six years, before setting up and since running the organisation, trying to get industry to support and sponsor the organisation, and it is so tricky unless you can tell them that they are going to get a financial gain from it. The number of times we talk about them on social media, and then hopefully people click on their brand and buy their product, is what they gain and that is what they measure the sponsorship on.

There is money going in. In 2018 or 2019, £3.6 million went from the Government into social prescribing, and then another £4.5 million went into social prescribing. Not one penny of that, as far as I have seen from my experience and from the supporters I work with, has gone to the providers. It has gone into creating social prescriber GP roles. It has not gone to delivery.

Baroness Willis of Summertown: David, would you be able to respond to that? You are at the other side of it.

Dave Solly: Our perspective is from social prescribing and the growing of that concept. We recognise that there are challenges in the resourcing of activities. There is some resource that comes through to activity providers sometimes when the personal budgets can provide some support. There is strong potential for local community organisations to support social prescribing, and one of the things that we are very much trying to help bring together is the potential for all the activities that they can offer to contribute to social prescribing. We are aware of and hear

from those organisations about the challenges of funding and the short-term nature of it, and having to reach out for different funding pots on a regular basis.

One of the things that we and partners are thinking about is how sustainable resourcing can be approached. How can we do that, not just from the environment and health sector but the sectors that will benefit from it? Those are some of the questions for everybody to think about: how those who actually benefit can become part of the support, part of the conversation and help the delivery of the activities that will provide the benefits. We do not have the answers on the models yet, but it is an area that we in NASP are looking at with our partners and looking at options to try to find a way forward.

Baroness Willis of Summertown: Thank you.

Q213 **Baroness Walmsley:** My question is for you, Dave. Can you describe social prescribing for us? What range of people can benefit from it?

Dave Solly: Yes, thank you. Social prescribing is a practice whereby people in need of support are connected or referred to local agencies such as their local GP or local charities, social care and health workers, who can then refer them to a social prescribing link worker.

Baroness Walmsley: Who refers people in the first place? I thought it was GPs.

Dave Solly: It is fundamentally GPs. People with a need can go to GPs, but we recognise that people may seek support through community organisations. There are local community hubs and organisations that can signpost them to opportunities in social prescribing. It could be that they signpost them to a GP or can highlight activities that are available to help respond to their need.

Baroness Walmsley: The funding for the activity will only come if the referral has come from the GP. Am I right?

Dave Solly: If there is a personal pot for an individual to take part in activities, the funding will come through that route, but it is the activity providers who often have to look for funding to be able to deliver their activities on the ground. Currently, there is no further direct funding going with the referral.

Baroness Walmsley: A GP could refer somebody to somebody who delivers the activities, but there is no guarantee that the money is there to pay for it unless they can raise it from somewhere else. Is that correct?

Dave Solly: Unless they can raise it from somewhere else or have funding to be able to deliver the activities that communities need.

Baroness Walmsley: What is the range of people who can benefit?

Dave Solly: The range of people is anybody who is in need of support. We would consider social prescribing to be where there is a need, where someone requires support in some way with their mental ill health or potentially physical health issues. If somebody simply thinks that doing something different and going to an activity would help them to feel better, it would not necessarily fall under true social prescribing even though it can still be beneficial. Anybody who has a need for whatever reason can benefit from social prescribing.

Annabelle Padwick: From experience, most people come to us through referral. We have a social prescriber system set-up in our organisation as well as self-referrals. All self-referrals follow up with a GP referral, purely for safeguarding. The number of GPs who have questioned me on why I bother needing a referral is unbelievable. Safeguarding is paramount. Since setting up in 2019, only one person has come through our whole organisation who had a pot of money come with them, and that was £40 that we were given for a year-long, twice-a-week mental health support programme. On very few occasions, it is not the GP—I am not saying this just to be contradictory—it is the social prescriber.

Most GP practices are networked. There will be four or five GP practices in one network. Within that, the funding that I detailed, the £3.6 million and the £4.5 million, went into creating social prescriber roles, which is basically a person who has a job that sits across all the practices and signposts people to alternative therapies. Do not get me wrong: it is incredibly accessible, and it has enabled many people to curate their own recovery journey instead of just being offered tablets and group CBT.

They can come in and have a look at that, but it is down to the GP and the social prescriber and whether their interest lies with offering alternative stuff. I have spoken to many GPs to try to get them to refer in, and they say, "We will refer in, but only if the person says they are interested in gardening". I am sorry, but how many people go into a GP surgery explaining how they are feeling, when most of the time they are at breaking point before they go to a GP? It is not funny, but it is funny to the point where GPs are expecting them to say, "Oh, by the way, I like a bit of gardening". It is not going to happen. If the GP asks, "What do you like doing?", in that moment they are going to be like, "I don't know. Just help me". It should be down to GPs to offer all the options that empower people to have their own journey, backed up with the funding to enable us to do our work and support them for a year. Therapy is what we do.

Baroness Walmsley: Thank you. Dr Rose, have you anything further to add?

Dr David Rose: No, they are the experts in this area.

Dave Solly: The GP is the referral route, but the keystone in social prescribing is the social prescribing link worker, because they are the people who have the capacity and the time to spend with someone to understand and identify their needs, to start to think about what matters

to them, and to look at where the worker can then signpost them to support what really matters to them at local level.

Social prescribing is still relatively young in its connections with the health system. Yes, activities have been happening for many years in various forms and in isolated ways across the country, but we are in the very early days of connecting it with the health system, and there is still a lot of exploration about what is possible and a lot of building of the infrastructure going on. The number of link workers is growing—it is about 3,400 now—but it is still not necessarily at the levels that the NHS has set in its long-term plan. It is still working to grow that. A positive is that it is recognised in the health system as something that is of value to build and grow.

Baroness Jones of Whitchurch: There is a lot of money going into the NHS, and one of the arguments for that is that it would save money by not spending so much on traditional drugs. You would have thought that GPs would see the logic of the longer-term financial benefits to themselves and their budgets and so on of adopting a more proactive social prescribing model, but it sounds as if they have not quite got there yet. A lot more education needs to take place.

Annabelle Padwick: They are on the right track. If we can get the funding in, we will save a serious amount of money long term, because we can support people as early as possible and offer them therapies. The downside currently is the allocation of the funding. The allocation of funding is there, but my argument, as one organisation that delivers and creates it with many organisations and covers a lot of them, is that the funding is going into over 3,000 social prescriber roles, but that money needs to come to the providers. We need to divert it.

The GP can refer in. Then the money comes straight to us. We do not need the additional things. Maybe we do and there is something that I am missing, and I am open to that, but I think we are missing a trick by spending all that money on 3,000 roles that we do not need, as far as I can see from my experience of being a client struggling with mental health and the provider of a service now. We just need the money to come straight to the provider so that we can do our work and not have to fight to save people's lives, which is currently what we are doing.

Lord Carter of Coles: I am slightly confused. We have 3,500 link workers, but what are they meant to link? If, as you say, there was no money when the strategy was developed, what were they going to do about resources? What was the thinking? Which government department has financed the 3,500 so far? Where does responsibility sit?

Dave Solly: I am not in the department or the NHS, so I cannot comment on their thinking and the policy direction of that. The growth of the numbers of link workers is recognised in the NHS long-term plan, where it committed to build the infrastructure for social prescribing. The role of the link worker is a recognition that GPs have a lot to do in a very short time when they see individuals. They have a very short period with

individuals to respond to needs that are more psychosocial than medical. They are about people's situations and what is affecting their mental health—

Lord Carter of Coles: Forgive me, I think we understand that. The point is—

Dave Solly: They need time to work out with the individual what matters.

Lord Carter of Coles: If I have a pharmaceutical prescription and a GP writes it, it is filled. You are saying that if, as a result of a link worker seeing somebody, giving them a lot of time and a great service, it is determined that a prescription or however you deliver this is needed to go and work in the horticultural sector, it stops there because there is no money. Perhaps I have misunderstood.

Dave Solly: It may not be only a horticulture solution. Basically, this is about finding out what would make the difference for that individual.

Lord Carter of Coles: Forget the sector. Forgive me. Is there money to actually deliver something? Does the long-term plan for the NHS say that there is going to be money, or is it an aspirational concept?

Dave Solly: This is where we go back to what we said earlier. We all recognise that there are challenges about sustainable resource for the actual on-the-ground activities. There is a reliance on community groups being able to resource activities at the moment. We have to ask the policymakers where they think the money, the resource, can come from.

Baroness Willis of Summertown: My own examination situation—I would be interested to hear your views on this—is that one of the real problems with GPs right now is that they are stretched to the limit. With a drug, you know what the dosage should be, for how long and what the outcomes will be. Where I think there is a real gap in the science is the equivalence studies. There are a handful of studies right now that will say what the outcomes will be if you do CBT or you spend a year doing the two hours.

I come back to the question that I asked at the beginning. Do you think there is a lack of research in that area? Do you think that if we improve understanding of the efficacy and the dosage required it would then lead to the sorts of things that Annabelle is clearly delivering?

Dave Solly: The research is starting to grow and respond to some of the challenges. A pilot scheme for green social prescribing, connecting nature-based activities with social prescribing, has been working for the last two years to look at the system change that is needed, and that includes the evidence that the health system and GPs need to be able to see the change and the impact it can have on them and their systems. Although that pilot programme has concluded its pilot and delivery, the learning is still coming through and is yet to be published. Learning from that will be of value to this conversation, we hope.

There is a lot to do to demonstrate and to understand what the cost savings are between the different interventions, but it is starting to come through from the piloting work that we are seeing.

- Q214 **Baroness Fookes:** As an observation, it will not be the first time that a Government will the ends but not the means. Aside from that, I am still curious to know exactly how this process works. I was not really aware, I confess, of the work of the link people. Are they employed by the surgery as an addition to their staff? Is the position that a doctor who thinks this might be useful will, instead of prescribing tablets, refer the person to the link worker, who will then discuss in detail what form the social prescribing might take, which I presume could be green, as I hope it would be, but could be going to a gym or square dancing or whatever? Is that the system? How accessible is it currently, given that it is fairly new, in various parts of the country and particularly for people of different backgrounds? Do you have any information on that?

Dave Solly: Your description of the process is fairly close to the actual situation. The GP would signpost people to spend time with the link worker, who can be sitting in the GP surgery or in a community organisation that the GPs work with, depending on the situation that it has been decided locally works best for people. It is variable. It is the opportunity to shape things locally depending on local needs. The health system provides additional funding to enable some GPs to resource those roles.

The opportunities that link workers can signpost to can be in the natural environment. In the academy, I am the national lead for the natural environment. I have counterparts for arts and culture, heritage, and sport and physical activity, recognising that the whole mix of those sectors offers opportunities that could address people's individual needs. The signposting at link worker level can be to any opportunities that they are aware of. Part of the challenge of building the system is to find activities on the ground that are available, and signpost and connect them to the link workers, so that they have a range of understanding of what is available and the confidence that they can help and signpost to them.

Baroness Fookes: Annabelle, I think your view is that too much money has been spent on the link workers and not on those offering the service. Would that be a correct interpretation?

Annabelle Padwick: Absolutely. Accessibility is one thing. It is accessible as long as the GP is interested, as long as the link worker is interested and the person says they are interested in whatever they are being offered. Actually, everyone should just be offered everything, and they can pick and choose what they want to try and see what works. For me, what is more important than accessibility, because we have that as long as we can get the GPs on board, is sustainability. That is the big thing. I think I have made myself quite clear on that.

The other element is safety. I will get passionate about this, so apologies. We are looking at things that are designed to improve or change the lives

of people who are extremely vulnerable. It is not a game. Currently, it is being treated like it is a game. It is not. Our organisation has been checked through and through, and I am confident in it, but I know that there are many other organisations that currently take referrals that are not safe. There are no checks. No GP has ever asked me for any of our company's safeguarding policies or any of our information. I just say, "We do this", and they refer in. I know that we are safe because we have been checked through with other things, but I know of many other organisations, not just horticultural therapy but sport therapy, music therapy and art therapy, that have not been checked. They do not have safeguarding policies. If someone turned round to them and said, "I'm thinking of taking my own life", the person delivering that session would not know what to do in many situations.

Our organisation combines horticultural therapy with mental health counselling. It combines the two to make sure that I can support people and completely wrap around. They do not have to come to IAPT for six weeks of CBT and then come to me for horticultural therapy. We can do the whole thing for a year straightaway, but that is not the case in many organisations and they are not safe. Sustainability and safety are my key things, and are more paramount than accessibility at the minute.

It is such early days since 2019, and I respect that, but we need to get it right earlier, because we are playing with people's lives. It is not just the idea of going for a walk and looking at a tree. There is so much more damage to people's lives. If we say, "Oh, just look at a tree", it is taking the mick out of mental health, to a degree.

Baroness Fookes: When you talk about not being safe, are you referring perhaps to the inability of people to deal with complex situations, or is it something rather more sinister and an actual lack of safety through possible abuse of some kind?

Annabelle Padwick: No, it is more about safety if someone discloses something where people would not know what to do. In many cases, they would not know what to do. They are not trained or supported. They might rightly want to be there, but are they fundamentally educated and trained to be able to support a person correctly if they are at risk? In many cases, that is not the case. They are trying their hardest, and I see that. Nurses are trained and checked before they go into a hospital. It should be the same with mental health, or they should come with a caveat and a warning: "This is the limit of this session. Horticultural therapy has its limits. It can't help you with this and this. They're not trained for this". Does that make sense?

Baroness Fookes: Yes.

The Chair: Just before we go on to Baroness Buscombe, we have not received much evidence on that. If there was any opportunity to have short written evidence on it, it would be very helpful indeed.

Baroness Buscombe: I have just a couple of thoughts. I have not been

able to see my GP since before Covid. They do not want to see us at all where I live in Goring-on-Thames, and I think that is true across the country. Is that making life more difficult for you and indeed the social prescribers? I have noticed, just checking online, that we have 3,500 social prescribers with an average salary of £26,152, which is in stark contrast to your situation as a provider. I thought I would get that on the record. Would a solution be for you and all the other providers to have strong links with an organisation such as the Samaritans? I speak as a former chair of the advisory board of the Samaritans.

Annabelle Padwick: Correct me if I have interpreted your question wrongly. GPs are inundated; do not get me wrong. Most of our referrals come direct, through Facebook predominantly. We give people their own allotment as well as a counsellor for a year. All they have to do is message me or the organisation, "Can I have an allotment, please?" That is so much easier than trying to get a GP appointment and have the confidence to explain to the GP and go through all that process.

I get the GP referral afterwards. I say, "Yes, come and have a visit". I conduct the whole visit, and then I say, "We'll do the GP referral". They might say, "I don't trust going to a GP. I can't get to my GP". Not many organisations will do this, but I then ring the GP directly and say, "This person is one of your patients. They want to come here. If I forward you the form, can you sign it and send it back?" That is it. It can be made really simple if we do not add so many loopholes and processes. It comes down to the providers. It comes down to us to make it simpler. It comes down to the GPs. It comes down to everyone to simplify the process and fast-track it. It is just better for everyone. Does that answer the question?

Baroness Buscombe: Yes, that is helpful.

Annabelle Padwick: Thank you.

Q215 **Baroness Jones of Whitchurch:** I want to change emphasis a bit and move to you, David. You have been sitting there quite patiently for a while. I want to talk about the mental health of people working more professionally in the sector—farmers, growers and so on. We know that levels of suicide and poor mental health are very serious, certainly among the farming community. There is lots of isolation and extreme pressure on people, all the stuff that we can imagine. Can you give us a snapshot of that and what the measures ought to be to begin to address some of the very real problems that I know you will know the answer to?

Dr David Rose: I will try to be brief. I will start with growers and with a survey you might be aware of that RABI and the University of Exeter did in 2021. The Big Farming Survey spoke to 15,296 farmers and growers across England and Wales. The results for horticulture in particular suggested that perhaps 20% of growers were probably depressed and 13% were possibly depressed. That is a third of horticulture growers in England and Wales who were probably or possibly depressed. That is

quite stark. The committee will probably understand the broad challenges that growers are facing.

You have the fundamental challenges related to running a business: having to make sure that it is profitable, having a succession plan, and dealing with HR, changing regulations, and administration. You have all the challenges that are thrown at growers from weather, climate change, rural crime, accidents, crop diseases and pests. The worst of that has bitten after those stark statistics from RABI. The cost of production crisis and the labour crisis are all getting worse. You have the business factors. You have the social factors that we all face, whether it is bereavement, isolation, family breakdown or the caring responsibilities that many of us face. Then you have a huge amount of uncertainty for growers who are trying to understand what the policy landscape is: post-Brexit changes, what is happening with seasonal workers, and whether we are having a horticulture strategy or not. It is never just one thing. The different drivers all act on top of one another. Something very tiny that a grower would usually cope with can, in some cases, tip them towards crisis point in combination with those other factors.

I want to talk briefly about workers before we think of solutions. Not much research is done on workers. It is great that you spoke to some this morning, and that the projects that Roxana Barbulescu at the University of Leeds or Hannah Pitt at Cardiff University are doing are trying to shine a light on them. I am not saying that this is across the commercial horticulture sector. There are many growers who treat staff very well and staff want to return to those businesses, and I am sure you have spoken to them, but we know that there are too many instances of exploitation of labour, whether poor working conditions, long hours, surveillance of performance, poor pay or no career progression. Those workers face language barriers in getting support. All those things are bound to affect mental health and make it worse.

They are the challenges. Do you want me to continue broadly on solutions?

Baroness Jones of Whitchurch: Yes, we would like to know what the solution is.

Dr David Rose: It is hard. Part of our work has been to try to speak to the range of sources of support that growers and workers could access. You have people from the agriculture space such as the grower co-operatives and organisations, farming charities and peer groups. You have the pastoral care provided by primary healthcare, GPs and mental health specialists. You have mental health charities, including farming-specific mental health charities. You have agricultural chaplains and others, families, friends, informal support at horticulture shows, and local community support. There is a whole range of different sources of support.

What challenges are we finding? Some of the mental health charities face problems with funding, staffing, and the trauma of the situations they

deal with. I think they feel that they are having to plug the shortfall in state-funded provision of mental health care, which is not always accessible to people who need it. There are problems with stigma and stoicism. Growers feel that it is weak or not good to seek support. There is a lot of work that the horticulture sector could do in general to normalise speaking out and getting support for mental health.

There needs to be greater understanding of farming and growing from primary healthcare in particular. We had what I am sure is an isolated case of a GP who, when a farmer came in and said they were really struggling, replied, "Well, why don't you stop farming?", not quite understanding the generational investment the farming family had made. We have a problem, particularly in rural areas, of an erosion of community status. People are moving out of rural areas, spaces of the rural community such as churches, pubs and so on are shutting down, and there is a loss of the informal support that is provided.

Briefly, it is about increasing the accessibility of primary mental health care, trying to normalise conversations to break down stigma and stoicism, and investing in spaces of informal support in the community where people can just meet and talk to one another, not necessarily about mental health. The act of being with other people, and talking about how they are and sharing problems, can make a real difference to mental health.

Annabelle Padwick: When I was invited here, I wanted to make sure that I gave a really accurate representation of the industry. In some ways, gardening is seen as something that is helping to improve so many people's lives, and it is, but there are so many people—growers, farmers and professional gardeners—who are struggling with their mental health every day that it was important to me that I came here and gave you an accurate representation.

I reached out to Perennial, which is a charity that focuses on supporting professionals in the horticultural industry, who could be professional gardeners, people who work in a nursery or a garden centre, or self-employed gardeners. I reached out to it to get its study—I have a number of copies that I want to leave with you—because it did a massive research project. The mental well-being of 85% of the people it surveyed was poor or below average. The estimated average pay is £20,612. It is estimated that £19,200 is needed for a single person to keep their head above water, and that survey was done before the cost of living crisis.

I do not need to go into all the factors that lead to those struggles, because they have already been covered. The same applies to professional gardeners. Now they have the socially enforced message that gardening is great for their well-being. All that is doing is creating another consequential stigma, which means that they are not asking for help. The media say, "It's great for your well-being", so why would a gardener say, "I'm struggling with my mental health", when the isolation and everything else, as has already been explained, is leading them to have really poor mental health? I wanted to make sure that I gave that

fair and accurate representation. I will leave the report with you if you are interested.

Dr David Rose: I am sorry, but I think I missed the most important point. The greatest source of stress and anxiety for growers at the moment, as it has been for several years, is the labour shortages they are facing and the huge challenges with the cost of production, particularly energy, and the uncertainty of that. Frankly, short-term solutions leave growers not really understanding whether the worker shortage will be solved long term. Are we going to get more support with the cost of production, and are we getting a joined-up horticultural strategy or not? That is where the key intervention has to be made, so that growers understand that the Government have a joined up, long-term strategy to help them with their businesses. You can tinker with support and improve support for them, but if you do not address the core causes of poor mental health, which at the moment heavily affect the viability of the business in a very difficult environment, you are not really going to tackle what makes things challenging for growers.

Q216 **Lord Colgrain:** David, I will come straight back to you, if I may. You covered a lot of this question in your previous answers, but if there is anything else you would like to add, perhaps you could. Are farmers and growers effectively supported when they face mental health challenges?

Dr David Rose: Yes and no. It very much depends on the individual. Each individual likes to access support in different ways. Some will be very comfortable talking to family and friends, some will not be. Some will be very comfortable talking to GPs, some will not be. I always praise, and my heart goes out to, the mental health charities, agricultural chaplains and farming charities in particular that do an incredible amount of wonderful work, who are out there in the community manning helplines and are available to farmers and growers. Greater awareness that support is there is important. Largely, the third sector, particularly the charity sector, provides very good support.

I have two points. First, on the informal support, we know, and farmers and growers have spoken about this widely, that often the best form of support for their mental health is being with other people in their community, and with family and friends. The erosion of rural communities, whether through second home ownership, poor broadband or poor public transport, presents a threat to people socialising in those spaces. Secondly, I do not think that state-funded mental health care is accessible for people in rural communities. It is not there in the way it should be.

This is not a horticulture example, but a farmer in south Wales told us that they had been getting local state-funded support for their mental health. Through cuts, that was no longer available. The closest support through NHS referral they could find was in Brighton; the farmer was in south Wales. That is not an isolated story. There has to be better state-funded mental health care in rural areas, and the mental health care strategy of government needs to be rural-proofed.

Mental health care specialists need to understand, as far as possible, the particularities associated with farming and growing and what it means to live, work and farm in a rural community. The farm mental health charities are excellent for that—they might not always have professional mental health skills, although many of them do—but the professional mental health specialists are not accessible or, if they are, do not always have knowledge of farming. We need to marry the two.

We need to equip all the people who come into contact with growers, such as people who drive the lorry to go and pick things up, government inspectors, and other advisers. If we could improve mental health first aid training so that they could stop growers with signs of distress and know what to do about it, that would widen the safety net and take the pressure off many farming mental health charities and other mental health charities that are struggling to plug the shortfall in the support that ought to be there.

Lord Colgrain: Thank you. That is very interesting indeed. Annabelle.

Annabelle Padwick: I echo everything Dr Rose said. The DPJ Foundation, which is a farming counselling charity, is doing as much as it can. We are doing as much as we can, but we have limited resource. It comes down to sustainability. I always come back to that. It comes down to funding being put into the right places. If we as organisations have the funding, we can employ the right people, we can build and we can grow as organisations, whereas at the minute most charities are going month by month. I can pay my team for the next three months. After that, I have no idea. I will fight tooth and nail to do it and to deliver what we do, but it is not easy. There are loads of changes, but I will leave that for when that question comes up.

Lord Colgrain: Thank you.

Dave Solly: There is a lot to pick up there and a lot of great points made about the challenges for the sector. I cannot speak to the policy challenges or the broad range of support that I know is there for farmers already. All I can add is that the social prescribing system as envisaged has the potential to help with that in terms of connections. You mentioned the need to connect people who can support those in greatest need, and the ambition is for individual conversations to help to do that and to reduce the risk that they are sent to the wrong places or are not signposted to the support that will help them most.

The social prescribing system as it is growing now includes connections with the Money and Pensions Service, the arm's-length body of the Department for Work and Pensions, which can provide advice and support to help people in their individual situation. The ambition is to understand and grow the knowledge of those who are out there to support at community level and be able to equip the people doing the signposting to send people to the places that the individuals feel they most need.

Baroness Buscombe: David, you mentioned the closure of churches.

That is a huge problem, is it not, in rural areas? We used to be able to go to our local church. That is where we met people and where we shared our experiences on a regular basis. I want you to spend just one moment on that point, because we know that vicars now cover perhaps three or four, or sometimes five, different parishes. This in many ways is a role that vicars have been trying to fulfil.

Dr David Rose: Absolutely. I can speak from personal experience. My old family church, Oakthorpe Methodist Church, was shut down. A number of churches in the local area have shut down, reducing the number of ministers in the circuit who are taking on a huge amount of work. That really affects socialisation. People I know, who are probably vulnerable, went to that church, and now you never see them. You might make the effort to go and see them, but you very rarely see them. The same is true of all the spaces of socialisation in rural areas like post offices and pubs. We can all understand that if we are struggling, as we all do.

Just having a friendly smile or a friendly "Hello" in a post office or a church makes us feel better and makes us realise that there are probably other people going through similar challenges, or that there are other people we can speak to. Not having the spaces where we are forced together can cause some people to go into their shell and be ever more isolated and feel that there is no one out there to support them when there would have been. That is why I am always keen to stress that, when we are thinking about a mental health care strategy for farmers and growers, it is not just Defra and the Department of Health and Social Care that are involved. Of course it is about them, but it is also about the local community and local government, and making sure that you invest in rural areas. It needs a multi-department strategy to put the conditions in place where people can share problems and get support for problems when they need them.

Q217 The Chair: I get the final question, which is to all the panel members. If you had one recommendation to make to the Government, what would it be?

Dave Solly: David has just talked about it. The thing that we need going forward is sustained investment in the support available to people. Social prescribing can be part of it and can be a glue bringing it together. It is about building that in a way that is sustainable going forward. I do not just mean money. It is about people and policy areas that benefit having the willingness to become part of the conversation, to support it and to say, "This is something that your sector can be part of and make a contribution to by being part of the support locally". Real openness to work across policy areas is key.

The test and learn programme for green social prescribing has benefited from cross-departmental conversations between the Department of Health and Social Care and Defra, and connections with the Department for Levelling Up, Housing and Communities at points along the way. It is about how we build in different ways and at different scales sustainable

investment in the systems. At a small scale, can we make sure that the ask is there of GPs from the health system engaging, understanding and supporting social prescribing? There is support to help them do that. Can they be encouraged to engage with it? How do we build sustainability into the whole system from community support through to the signposting to it and those who help connect people to where the response to their need is?

Annabelle Padwick: I echo what Dave said. It is about sustaining, but it is also about regulating. We do not have any struggles as far as I am aware—correct me if I am wrong—in sustaining pharmaceutical industries. We can turn out tablets left, right and centre. Why can we not regulate this area of work? I have tried to shout this from the rooftops for the last five or six years. The only way it will be sustainable is if it is taken from the top and governed. I have always wanted Life at No. 27 to be a UK-wide organisation. It comes from the Government.

People would know that if you were looking for horticultural therapy you would refer to providers that cover the country and that is where they work. When they go to a GP, the GP knows the providers because they are the same across the country. With tablets, it is the same. They know how to get a drug. It is the same pharmaceutical companies across the country. They are all regulated and they are all checked. We need the exact same model applied across the rest of it, because that is the only way it will be sustainable, as far as I can see; every other way we have tried is not working.

At that point, we will get the proper research we need and not just the high-level research. We will get enough funding and enough recognition—at the minute, we are struggling to get that recognition—that it is as equal to, or better than, talking therapies and medication. Actually, people need access to medication, counselling and alternative therapies, whether that is gardening therapy or sport therapy. It is regulation across the board—regulation of messaging and marketing because that is doing way too much damage. It is being seen as a hashtag trend and clickbait for sales. Too many industries are using it and saying it is good for your well-being when, actually, it is people's lives we are talking about. It is not something we can get wrong or just use because it sounds good in the media.

Dr David Rose: Simply, growers need a horticulture strategy. The Government said that they want to increase self-sufficiency in fruit and veg. We want people to be eating more fruit and veg to stop diabetes and cancer crippling the health service. That requires a long-term vision. I am not saying that the Government are doing nothing. They are doing lots of things on technology and innovation. They have addressed seasonal worker permits year on year. There are other interventions going on, but they have given the impression for a number of years that these decisions are made year on year: "This is happening this year. We don't know what is happening next year". For a grower, that is not a sustainable course of action. They need to make long-term decisions to

understand where to invest, how to adapt and whether their business is viable. We need to see that joined-up vision.

I describe it like this: Defra regularly comes up with lots of different jigsaw pieces, and many of them are the right one, but what is missing is the picture on the box of the jigsaw. If you do not know what you are trying to get to, I do not understand how growers are supposed to understand what they are supposed to do. I would like to see a bit of a rethink and a rehash of the horticulture strategy. There must have been lots of work done on it because it was announced and worked on, I am sure, for some time, so it would be great to see that joined-up strategy.

The Chair: Thank you very much. That concludes all the questions in the evidence session. Thank you again for coming along and sharing with us today.