Towards mental health equality

The West Midlands Mental Health Commission

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4 Foreword

6 Executive summary

10 Introduction

12 Background

20 Children and young people

26 Mental health and the cost of living crisis

30 Tackling racial inequalities in mental health

36 Sport, exercise, physical activity and mental health

42 Thriving communities and the voluntary and community sector

52 Conclusion

54 References

Foreword

Foreword by Commission Chair Danielle Oum

It is with great pleasure and a sense of shared purpose that I present this report on behalf of the West Midlands Mental Health Commission. Our journey began with a clear understanding that mental health is the bedrock of overall wellbeing. Acknowledging the pivotal role mental health plays in shaping individuals, communities, and society, we set out to address the pressing challenges facing the West Midlands.

The emergence of the global Covid-19 pandemic underscored the importance of tackling physical health inequalities but mental health inequalities have been given less focus. In my substantive role as a Chair of one of the West Midlands Integrated Care Boards, I have seen first hand the lasting and devastating impact of the crisis heightened mental health struggles, and exacerbation of health inequalities amongst the most vulnerable groups.

To chart a path toward improving mental health and reducing inequalities in our region, this independent and representative Commission has worked over the course of nearly a year, with our diverse members considering a wealth of evidence, drawing upon the expertise of Centre for Mental Health and other national and local specialists in mental health and the related topic areas. Our goal was to identify evidence-based actions that could yield substantial and sustainable results in addressing mental health disparities.

This report stands as a culmination of our collective efforts, encapsulating the Commission's recommendations across key topics. Our vision for a mentally healthier West Midlands is rooted in comprehensive and integrated approaches that leave no one behind. Through a range of actions, we aim to nurture a transformative environment that supports the wellbeing of children and young people, dismantles racial mental health inequalities, promotes physical activity as a means to improved wellbeing, and empowers communities to thrive.

Education emerges as a powerful catalyst for change. Our recommendations call for the adoption of a 'whole school approach' to mental health, ensuring evidence-based learning and comprehensive support systems within schools and colleges, and aspiring to zero school exclusions. By prioritizing the mental well-being of our young generation, we equip them with the tools to navigate life's challenges successfully.

Recognising that inequalities in mental health manifest along economic lines, we advocate for the Living Wage Foundation accreditation for major employers, aspiring to become a Real Living Wage region. Anchoring institutions and public sector employers must lead the charge in fostering fair and equitable workplaces. Additionally, social value principles in procurement will channel resources back into the hands of local individuals and organizations, fostering economic empowerment.

Access to mental health support and resources should be universal and comprehensive. Our recommendations address the vital need for welfare advice, inclusive support hubs, and community-led organisations serving racialised communities. By working together, we can build a mental health workforce that is representative of our diverse population and acknowledge and address community and intergenerational trauma.

Physical activity, recognised as a powerful tool for mental wellbeing, must become an integrated element of mental health care pathways. We call for enhanced access to physical activity opportunities for individuals waiting for support or undergoing treatment. Simultaneously, we must actively reduce barriers to engagement in physical activities, including cost, cultural appropriateness, transportation, safety, and variety.

At the heart of our recommendations lies the recognition that mental health is made in communities. The voluntary and community sector, with its immense potential, requires sustained investment, support, and acknowledgment. Through strengthened collaboration, we can ensure that no one's needs are ignored or marginalised, creating an inclusive society that fosters the mental health and wellbeing of all.

As we conclude this report, we must acknowledge that our journey towards a mentally healthier West Midlands is just beginning. The challenges we face are formidable, but so too are the opportunities for transformation. It is only by uniting our efforts, sustaining action, and embracing long-term change that we can realise a region where mental health thrives, communities flourish, and services become more equitable.

Together, we have the power to build a more just and inclusive society, where mental health is a fundamental priority for all. Let this report serve as a guide and a call to action, inspiring us to forge ahead and create a West Midlands that embodies the principles of fairness, equality, and well-being.

It has been both a pleasurable and a sombre experience chairing this Commission. I want to thank all the Commissioners and the experts who have contributed their time, energy and expertise to the work of the Commission. A special thank you to the team at the Centre for Mental Health, Ed Davie and Andy Bell for their work and to the team at the West Midlands Combined Authority, Jed Francique and Jenny Drew, for their coordination and management throughout. Lastly, thank you to the Mayor of the West Midlands, Andy Street for supporting this work and for respecting its independence.

Danielle Oum, Chair
West Midlands Mental Health Commission

Executive summary

Executive summary

The West Midlands has led the way nationally in seeking to boost the public's mental health, including through its groundbreaking Thrive West Midlands report and action plan in 2017[1]. The report prompted action to address mental health inequalities and create fairer communities and healthier workplaces.

Since that time, the Covid-19 pandemic has drawn greater attention to mental health inequalities, both in the West Midlands and far beyond.
We all have mental health. But our chances of having good or poor mental health are far from equal. Inequalities in society – for example, in wealth, power, and the environments we live in – have a major part to play in determining our mental and physical health. Poverty and racial injustice are toxic to our mental health while living in strong communities and being physically active are known to boost our mental health.

To explore priority actions for improving mental health and reducing inequalities in the region, the West Midlands Combined Authority established an independent time-limited Commission of representative local people and services, which began work in April 2022. Over the course of almost a year, Commission members read and heard evidence collated by Centre for Mental Health and other national and local experts, including experts by experience. The Commission explored the cost-of-living crisis; racial inequality in mental health care; physical activity and sport; supporting thriving communities; and the role of the voluntary and community sector.

The Commission found that:

- Demand for children's mental health services in the combined authority area had increased significantly (by an average of over 50%) in recent years as child poverty, isolation and stress had worsened. Evidence shows measures to reduce child poverty, abuse and neglect are key, along with improving school experience and access to social activities and support.

- The cost-of-living crisis was causing and deepening poverty which is a major risk factor for mental ill health as it increases stress, reduces resources for healthy choices and worsens environmental threats. Evidence shows that regional and local measures to reduce costs and increase incomes of the poorest can have a significant benefit to people's mental health.

- Because of structural racism that exposes racialised communities to higher levels of poverty, stress and reduces their opportunities, Black, Asian and other racialised groups experience worse mental health outcomes than white British people. Evidence shows that pro-active measures are needed to ensure services are delivered and shaped by people from affected communities.

- Physical activity is a significant protective factor for mental health. One third of children and one in four adults in the West Midlands are doing less than the minimum amount of activity advised for good health. People from deprived and racialised communities are even less likely to get enough exericise. Structural barriers need to be reduced and removed to ensure more people from all parts of society can walk, cycle and take part in exercise and sport more frequently.

- Social connections between people are vital for mental health and a thriving voluntary and community sector can help make these links and provide support in a way that empowers people and communities. Austerity cuts and other funding challenges have weakened this sector and more works need to be done to ensure it is better resourced and supported.

Executive summary

No	Action	Rationale	Lead organisation/s
1	Schools and colleges should adopt a 'whole school approach' to mental health. This approach should include evidence-based learning about mental health within school curricula and access to counselling and other forms of support alongside the expansion of Mental Health Support Teams.	Mental health outcomes are most strongly influenceable in childhood, and evidence suggests 'whole school' approaches and early support are highly effective.	WMCA should convene a group of leading education actors, including local authorities, academy trusts and the Department for Education, to agree a joint approach. This plan could be piloted.
2	All schools and colleges should work towards zero exclusions. Support for this should include external advice and help for schools to improve behaviour and support children with complex needs including 'managed moves' to give students a fresh start.	Excluded children have much poorer mental health and other outcomes. Evidence is clear that supporting children to remain in their school is helpful.	See (1)
3	All parents/ carers should have access to and be encouraged to take up evidence-based parenting programmes.	Evidence-based parenting programmes highly effective in improving outcomes.	Local authority public health teams and education departments. WMCA could support a pilot.
4	Every West Midlands council area should have an early support hub drawing on the Youth Information, Advice and Counselling Services (YIACS) model or local equivalent.	These types of services are well evidenced to support better outcomes in children and young people.	Local authorities normally commission these types of service. A pilot scheme should be explored as part of implementing these recommendations
5	WMCA region should become a 'Living Wage Place' with every major public sector body achieving Living Wage Foundation Accredited by 2026 and a region-wide campaign run to get other major employers accredited	Poverty is the main driver of poor mental health. With 20% of West Midlands' workers paid below the poverty rate, this would make a big difference.	WMCA should lead on this but it will require action by local authorities, NHS trusts, universities, police and fire authorities and the private and voluntary and community sectors
6	Public sector organisations in the region should adopt social value principles in procurement, putting money in the pockets of local people and organisations.	'Preston Model' of buying more goods and services locally is associated with a 9% reduction in depression, among other evidence	WMCA should develop a Social Value Procurement Charter along the lines of the Greater Manchester version[2]
7	Welfare advice should be provided to anyone in the West Midlands using mental health services, including NHS Talking Therapies. This service should include support with personal finances, housing rights, legal issues and employment.	Adverse life circumstances, like poverty, worsen mental health outcomes. Addressing circumstances makes outcomes more likely to improve.	The Integrated Care Boards/Systems should lead on this work, supported, potentially, by a WMCA-led pilot scheme

Executive summary

No	Action	Rationale	Lead organisation/s
8	The three integrated care systems in the area should support and invest in community-led infrastructure so that they are able to deliver credible and safe mental health support for people from racialised communities in the region. These organisations should be supported to build capacity, form networks for support, and become more sustainable.	People from racialised communities experience much poorer mental health outcomes because of structural racism. Representative, community-led services can help address these problems.	The Integrated Care Boards/Systems should lead on this work, supported, potentially, by a WMCA-led pilot scheme
9	The NHS should seek to make the mental health workforce at every level and across all disciplines more representative of the communities it serves.	This would help address some of the structural problems that lead to worse mental health outcomes in racialised communities.	The Integrated Care Boards/Systems and NHS Trusts should lead on this work, supported, potentially, by a WMCA-led pilot scheme
10	Mental health services should provide ready access to physical activity opportunities for anyone who is waiting for support or currently receiving it. Physical activity should be built into treatment 'pathways' as a routine element of good mental health care.	Evidence shows that physical activity is good for mental health. People with a mental health diagnosis experience poorer physical health than the general population – exercise would help close this gap.	The Integrated Care Boards/Systems and NHS Trusts should lead on this work, supported, potentially, by a WMCA-led pilot scheme
11	ICS Partnerships and ICS Boards should invest in enabling the voice of marginalised communities to inform and be actively involved in decision making and this should explicitly include approaches to enable the voices of people living with mental health issues and with lived experience of these conditions.	Racialised, LGBT+ and deprived communities have worse mental health outcomes because of structural discrimination and disadvantage. Representation can be part of addressing this	The Integrated Care Boards/Systems and NHS Trusts should lead on this work, supported, potentially, by a WMCA-led pilot scheme
12	The WMCA and local authorities in the region should work systematically to reduce barriers that may prevent local people from engaging in physical activities – cost, lack of culturally appropriate options, transport including traffic, pollution and lack of active travel infrastructure, safety, and the range of activities on offer.	Physical activity is good for mental and physical health, but poorer communities struggle to access exercise because of structural barriers. Designing environments that privilege walking and cycling is the most effective way to do this	WMCA, including Transport for the West Midlands and local authorities
13	Integrated care systems should fund and commission voluntary and community sector partners to maximise their sustainability while retaining their independence, flexibility, and creativity. This may mean offering longer-term funding, encouraging provider alliance arrangements between voluntary and community sector organisations, and using grant programmes to support innovation.	There is good evidence that voluntary and community sector organisations can deliver better outcomes by tailoring support to diverse communities.	Integrated care systems/boards and their constituent NHS trusts and local authorities

Introduction

Introduction

Rationale

The Covid-19 pandemic and its aftermath have been accompanied by a sharp rise in demand for mental health services.

Across the UK between 2016-17 and 2021-22, the number of people in contact with NHS mental health services increased from 3.6 million to 4.5 million[3].

These rises were seen in the West Midlands Combined Authority Area, with the number of children in contact with mental health services in the Birmingham and Solihull integrated care service area increasing from 2,750 in April 2018 to 4,535 in May 2023, 64% higher than five years earlier. A similar (61%) rise was also seen in adult mental health service contact between April 2018 and February 2023 in Birmingham and Solihull and in the Black Country integrated care system area, where there has been a 57% rise in children in touch with mental health services between April 2021 and February 2023 and an 8% rise in adults over the same period[4].

Sadly, these rises are not surprising, as many of the risk factors for mental ill health, including bereavement, physical illness, loss of income, isolation and uncertainty, abuse and neglect are also features of the pandemic and the measures taken to control it. It is also likely that demand for mental health services was artificially suppressed in the earlier stages of the pandemic through lockdowns and school closures.

Even before the pandemic, mental ill health was one of the most prevalent forms of illness in the UK[5], with one in six people experiencing diagnosable symptoms at any time, at a cost of over £119 billion in England alone[6]. Modelling suggests the pandemic will see an additional 10 million people (8.5 million adults and 1.5 million children and young people) in England needing support for their mental health as a direct result of the pandemic up to the year 2027[7].

Threats to mental health do not fall evenly across the population, and people living in deprivation, disabled people, racialised and LGBT+ communities and different genders at different ages suffer much worse mental health outcomes at different ages[8]. With very high levels of deprivation and a wonderfully diverse population, these health inequalities are particularly relevant to the West Midlands Combined Authority area.

In order to tackle mental health inequalities across the region and support local efforts to improve mental health, the West Midlands Combined Authority convened, in April 2022, a new Mental Health Commission to look at the impact of the Covid-19 pandemic on the mental health and well-being of its citizens and to recommend actions that can be taken regionally with partners to respond.

The commission endeavoured to make this as inclusive a process as possible, starting with a community listening exercise that gathered the views of grassroots organisations who worked with people throughout the region before, during and after the acute phase of the pandemic. Commissioners were chosen to represent as broad a range of groups and services across the region. We drew evidence from a range of experts, including experts by experience.

Disempowered people, the poorest, most vulnerable and those that experience discrimination suffer the worst mental health outcomes because of a misuse of power.

Commissioners hope that their recommendations are taken forward in the same spirit of collaborative working, aiming to empower citizens and enable them to create solutions in their own communities.

Background

Background

About the Commission

The Commission includes leaders from essential sectors, including local government, health, social care, the voluntary and community sector, business, sports, and criminal justice, as well as those with experience of mental health difficulties.

Commission members

This group were chosen to represent the diversity of the population and the most relevant services in the West Midlands Combined Authority area.

They were assisted by Combined Authority officers and Centre for Mental Health, a national mental health research charity.

- Commission chair: Danielle Oum - Birmingham and Solihull Mental Health NHS Trust / Coventry and Warwickshire Integrated Care System
- Dr Lola Abudu - Office of Health Improvement and Disparities
- Dr Mubasshir Ajaz - West Midlands Combined Authority
- Lynne Bowers - West Midlands Association of Directors of Adult Social Services
- Louise Bown - Independent member
- Gavin Cartwright - Citizens UK
- David Harris - Transport for West Midlands, which is part of the West Midlands Combined Authority
- Ruth Jacobs - West Midlands Faith Strategic Partnership Faith and Mental Health Sub-Working Group
- Sheikh Nuru Mohammed - West Midlands Faith Strategic Partnership Faith and Mental Health Sub-Working Group
- Dr Helen Paterson - Northumberland County Council
- Dr Arun Saini - Black Country Integrated Care System
- Paul Sanderson - Office of Health Improvement and Disparities
- Fay Shanahan - Walsall Housing Group
- Jo Strong - Independent Member
- Tom McNeil – Office of the West Midlands Police and Crime Commissioner
- Giles Tinsley - NHS England and Improvement
- Russell Turner - Sport England
- Dr Justin Varney – West Midlands Association of Directors of Public Health
- Patrick Vernon - Birmingham and Solihull Integrated Care System

The Commission took a themed approach to working with different topics and communities over several sessions with support from Centre for Mental Health.

The World Health Organisation and other experts suggest that mental health outcomes are most strongly influenced by:

- Social determinants - poverty and discrimination, for example
- Individual factors, including diet, exercise and substance use
- The physical environment, such as access to green space and clean air
- Support – including social, educational and health services

The six themes chosen by the commission fall into these determinant areas, and if effective action follows, we would expect to see better mental health and less ill health result from this work.

The outline process for considering each topic area

For each topic, work was initially undertaken to capture research insights – predominantly through the work of Centre for Mental Health – and formed into an ‘evidence pack’ to inform a Commission discussion. Evidence was also drawn from other conversations and sources from the West Midlands area and an analysis of the seven boroughs’ most recently available Director of Public Health reports. This discussion then generated some initial findings and recommendations. These were captured in a draft ‘topic report’, which was then ‘stress tested’ through further stakeholder communication and engagement to arrive at finalised findings and recommendations.

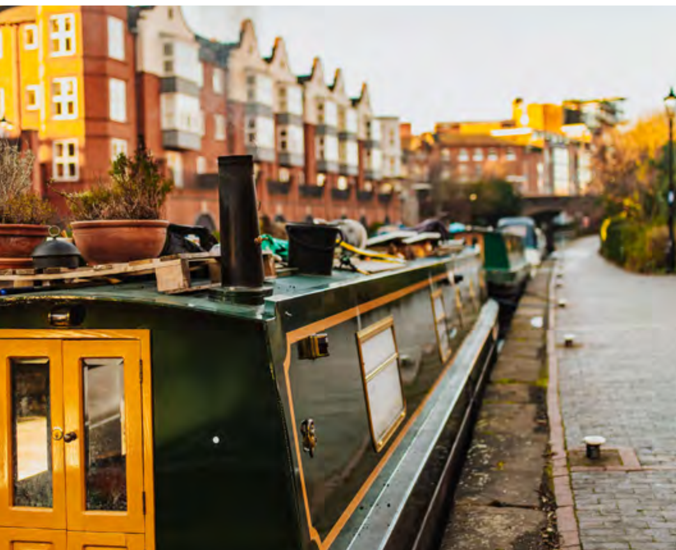
Background

The West Midlands Combined Authority area context

Baseline information on regional mental health

The information below is from the Office of Health Improvement and Disparities Fingertips tool. Each local authority Birmingham (Birm), Coventry (Cov), Dudley (Dud), Sandwell (San), Solihull (Sol), Walsall (Wal), Wolverhampton (Wol) and the West Midlands Combined Authority (WMCA) average are coloured red (if above the England average in right hand column), amber (same), green (if below). The most relevant and most recent data was chosen.

To summarise: apart from negligible differences in depression prevalence (1.6% below England average) and self-reported high anxiety (1% below England average), all other WMCA averages were higher than the England averages. That there are more mental health-related challenges in this area is to be expected, with deprivation considerably higher than England's average in all (with Solihull as a notable exception) WMCA local authorities.



Prevalence – estimates of the proportion of mental ill health and self reported wellbeing measures

Indicator	Birm	Cov	Dud	San	Sol	Wal	Wol	WMCA average	Eng
Depression % prevalence (2021/22)	11.4	11.9	15	12.7	11.6	14.4	12.8	11.1	12.7
Serious Mental Illness: % prevalence all ages (2021/22)	1.22	0.95	0.85	0.96	0.86	1.03	1.00	0.98	0.95
% people with self reported low life satisfaction (2021/22)	4	4.6	4.5	6.5	5.6	8.7	5.4	5.6	5
% people with self reported low worthwhile (2021/22)	2.4	3.3	4.8	5.8	5.3	5.1	5.1	4.5	4
% people with self reported low happiness (2021/22)	8.7	8.1	7.3	10.7	9.3	10.8	7.3	8.8	8.4
% people with self reported high anxiety (2021/22)	22.2	17.8	23.2	18.7	20.9	25.5	23.1	21.6	22.6

Risk and protective factors

Indicator	Birm	Cov	Dud	San	Sol	Wal	Wol	WMCA average	Eng
% Unemployment (2021)	8	5.5	4.1	5.8	4.3	6.5	6.5	5.8	4.5
Deprivation IMD (2019)	38.1	25.6	24.1	34.9	17.4	31.6	32.1	29.1	21.7
% children achieving good development age 2/2.5 (2021/22)	82.5	85.1	62.3	66.3	84.3	78.7	75.6	76.4	81.1
% physically active adults (2020/21)	58.3	58.6	58	59.9	68.8	52.8	60.1	59.5	65.9
Male healthy life expectancy at birth (2018/20)	59.2	61.1	62.9	61.6	67.4	59	60	61.6	63.1
Female healthy life expectancy at birth (2018/20)	60.2	64	62.7	60.5	65.7	58.4	59.3	61.5	63.9
Violent offences per 1,000 population (2021/22)	61.9	45.9	43.3	54.7	35.2	49.5	61.1	50.2	34.9
Air pollution – fine particulate matter (2020)	7.9	7.3	7.2	8.1	7.1	7.7	6.9	7.4	6.9
% of 16+ who felt they belonged to their neighbourhood (2017/18)	58.5	64.2	46.7	58	70.4	55.1	53.5	58	60.9

Background

Summary of relevant information from the local directors of public health and WMCA Health of the Region[9] reports

At the outset of the Commission's work, we reviewed the seven boroughs' director of public health reports. They provided insights into the priorities for the public's mental health at a time when each borough was in the early stages of recovering from the pandemic and addressing the heightened health needs and inequalities in its wake. This section summarises our review of those reports, combined with insights from WMCA's own Health of the Region report[10].

There is a broad consensus that the pandemic has undermined effect on mental health in the region and that this has been experienced unequally, with some groups experiencing bigger (negative) impacts than others. These include people from more deprived areas and on lower or more precarious incomes, people from racialised communities, children and young people, and people with pre-existing mental or physical health problems. Birmingham's report notes that more than half of the population (53%) in a local survey saw a deterioration in their mental health during the pandemic, and that for some it was a 'triggering' experience (for example, because of trauma, isolation or loss).

"...beyond the direct health impacts of the pandemic, there has been a series of crises that have affected every aspect of residents' lives, from daily mood to financial security to community spirit. Lockdowns and social isolation have caused a spike in mental health issues. Once again, though, the impact was uneven as women, older working-aged residents, and Black and Minority Ethnic residents reported higher levels of anxiety and loneliness. The restrictions on businesses have led to the highest level of unemployment in Birmingham for decades and a significant increase in youth unemployment, as the retail and hospitality sector was one of the largest employers of 18-24-year olds in the city." (Birmingham Director of public health report)

Solihull's report says that the longest-lasting mental health impacts are likely to be on children:

"The Covid-19 pandemic has caused unprecedented disruption in children's lives, potentially unsettling their emotional, cognitive and social development. Many known risk factors for child mental health disorders have intensified, such as socioeconomic disadvantage, social isolation and bereavement. Additionally, access to many sources of support, including friends, school and leisure activities, has been reduced. As a result, there is real concern that the pandemic may have long-lasting negative impacts on child mental health." (Solihull DPH report)

Some of the reports document actions taken during the pandemic to mitigate harms to mental health. These include community outreach programmes designed to boost mental health literacy and providing information on how to stay well. Wolverhampton's report also mentions specific efforts made to protect people with long-term mental health problems from the virus (for example, through vaccination), while Birmingham cites its use of the Government's Better Mental Health Fund to support wellbeing in the community.

The reports also look forward and how they want to boost mental health and wellbeing longer term. Walsall's report provides a detailed action plan with a range of priorities, including boosting mental health literacy within the population, addressing the economic and social determinants of mental health (e.g. tackling poor or overcrowded housing, unemployment and financial insecurity), improving connectedness in communities, and providing more bereavement support.

"Our ambition is to achieve optimal wellbeing for all Walsall residents and reduce mental wellbeing inequality. To achieve this ambition, we have committed to a shared understanding of population mental wellbeing, working together to increase opportunities for better mental wellbeing and enhancing the population's opportunity to self-care." (Walsall DPH report)

Background

Summary of relevant information from the local directors of public health and WMCA Health of the Region[ix] reports continued

Birmingham also sets out several actions towards its ambition of creating a 'Mentally Healthy City', including its 'Triple Zero' strategy to reduce suicide, drug and alcohol deaths, the importance of partnership with the voluntary and community sector, and the need to address racial inequality in mental health. It also commits to measuring progress towards reducing the prevalence of mental ill health and increasing wellbeing. It notes that:

"…by taking a public health approach to mental wellness and balance, we can support people to navigate these times successfully and continue a positive life journey… We are committed to creating a mentally healthy city where every citizen is supported to achieve good mental wellness and balance to navigate life's challenges." (Birmingham Health and Wellbeing Strategy)

All reports focus on the importance of community and overall wellbeing in the aftermath of the pandemic. Wolverhampton, for example, centres its plans around its 'Relighting Our City' programme, while Dudley's report includes actions aiming to reduce loneliness and isolation.

"What is critical is our response to addressing inequalities – either in access to services, support and care or in health outcomes. We have a deep commitment to addressing systematic, avoidable differences in outcomes, particularly by ethnicity and by deprivation. The way we want to do this is to build on the strengthened partnership working that came about from our collective efforts to address the pandemic. We want this to result in more co-productive, community led work to improve the health and wellbeing of our population." (Wolverhampton DPH report).

The Health of the Region report reflects the importance of addressing structural inequalities and the social and economic determinants of health. Its call for 'radical prevention' is described as:

"…taking action as a whole system to tackle the underlying causes of poor health and health inequalities (the 'causes of the causes') and shifting to more person and community-centred approaches to health and wellbeing. Early intervention and prevention in the early years can have lifelong impact, as well as yielding significant return on investment."

"Radical prevention also involves demanding more inclusive economic growth, which can reduce health inequalities. This can be done through improving access to employment, raising income, increasing community safety, improving housing quality and affordability, raising aspirations and improving educational outcomes, providing a high-quality local environment and green space, enhancing social relationships and connectedness, and increasing opportunities for participation."

Priority actions identified as being necessary to boost the region's health within that report included addressing health inequalities among racialised communities, tackling the social determinants of health, widening access to health and care services, and 'people-powered health' – for example, by promoting physical activity.

The Commission's work was undertaken within this context, and the rest of this report provides insights into how 'radical prevention' can be applied at scale to the public's mental health in the West Midlands. Our recommendations will give our residents the best chance of better and more equal mental health by addressing some of the biggest inequalities and supporting systemic change.

Background

Summary of community listening exercise

Ahead of the Commission being established, the West Midlands Combined Authority commissioned BVSC Research, the Institute for Community Research and Development at the University of Wolverhampton and the Centre for Trust, Peace and Social Relations at Coventry University to undertake a 'listening exercise' to understand more about the impact of Covid-19 on the mental health and wellbeing of communities across the region and to capture some initial community feedback on potential areas of focus for the commission. In this qualitative study, a total of 129 participants were engaged through a series of one-to-one interviews, focus groups, a survey and individual cohort case studies of "forgotten voices".

National and local research on the impact of Covid-19 highlights the following key drivers of worsening mental health:

- Fears of infection and of losing friends and families.
- Housing insecurity and poor quality housing.
- Employment and financial losses.
- The impact of children being at home.
- Increased isolation and loss of social contact.
- Loss of coping mechanisms, including exercise, work and access to green spaces.
- Reduced access to mental health services.

Local and regional research[11] suggests that some additional groups have been disproportionately impacted:

- Racialised communities
- People with pre-existing mental health difficulties.
- Adults with complex support needs.
- Populations that are marginalised.
- Disadvantaged or isolated people living in social housing.
- People living in poverty.
- Disabled people.

This research both reflects the national picture and adds further regional detail. The findings of the listening exercise suggest the most common reasons for deteriorating mental health were loneliness and isolation, increased anxiety due to the pandemic, increased family and relational tensions, and grief and loss. The prevalence of loneliness and isolation as a driver for worsening mental health was observed as having increased significantly across the whole population, with many 'new' presentations amongst individuals who had not previously contacted services for support.

Many of the people interviewed spoke of instances of behavioural changes in children alongside higher levels of anxiety. Children's education and the additional pressure of emergency home schooling was also a factor in increased anxiety levels, particularly among women who took responsibility for supporting home learning. Organisations working with families have seen a significant rise in domestic abuse driven, in part, by lockdowns.

Respondents also revealed the increased pressures on families, especially those trying to juggle family life under lockdown while working to support the mental health and wellbeing of others. People with caring responsibilities, and those working or volunteering in health and social care, were particularly affected by these pressures.

Grief and loss played a significant factor in people's deteriorating mental health. It was not simply that people had lost loved ones to Covid 19 (and other illnesses during the pandemic), but that people had not been able to grieve properly for their loss due to social distancing restrictions. The inability to be with loved ones in hospital, the disruption to normal funeral practices, and the inability to grieve as a collective with family and friends have inflicted a heavy toll on people's mental wellbeing.

All of these factors will have been borne more heavily by some groups of people and communities than others. For example, Black communities already faced higher levels of poverty than average and were affected more severely by Covid-19 and the measures taken to contain it.

Background

> *Children are also often overlooked when there are material comforts in the home. Whilst they are catered for materially, the emotional and mental impact of covid on their mental health and wellbeing can go unnoticed. Without the normal support services that can be accessed via school, children can become vulnerable to poor mental health.*

> *Online art therapy...it gives a break from the everyday stress. Helps with confidence and supports the development self-esteem. Online mindfulness course. Helps to give managing skills to people with PTSD.*

> Another factor is that round about May 2020, there were lots of media reports about black people being more likely to die. This has created a lot of anxiety. And this is on top of all of the existing inequalities that the black community already experience.

> *The pandemic has highlighted what the sector can do when organisations work together, and this highlights the need for reduced competition and short term funding opportunities that create silo working.*

> *Real strengths were shown by the third sector who provided impactful support at a local level. Hyper-local services that connected individuals to services provided support for those experiencing lower-level poor mental health. Access to services for higher level mental health concerns was less accessible, with access compromised by the pandemic.*

> *Being a new parent can be quite an anxious time, and this has been exacerbated by the effects of the pandemic. In particular, the general reduction in services, lack of ability to see medical professionals, worries about being permitted to take a birth partner into hospital, school closures for parents who have other children, disruptions to NHS services in general.*

> Mental health can still be quite taboo in the black community, and this is compounded by religious families and there are the other factors which mean some people do not want to come forward and this is primarily because of a fundamental distrust of agencies due to long term experiences of institutional racism. This is also now being seen around vaccine uptake amongst the community.

Valley

Children and young people

Children and young people

As the foundations of lifetime mental health are laid during people's childhood, it is vital to give children the best start in life well attached to at least one well-resourced and supported care-giver, in a stable, decent environment with good services and protected from abuse, neglect and other harms.

The impact of Covid-19

The Office for Health Improvement and Disparities (OHID) has produced a national overview of children's and young people's mental health and wellbeing in relation to the pandemic[12i]. It found that reductions in wellbeing were greatest during periods of school closure. While the majority of children's mental health improved after restrictions were reduced, some experienced longer term difficulties and continued anxiety. The biggest reductions in wellbeing were noted among children and young people with Special Educational Needs and Disabilities (SEND). Greater impacts were also noted overall among girls and among children from the most disadvantaged backgrounds.

OHID's national surveillance did not provide sufficient data about the mental health of children and young people from racialised communities or those who are LGBT+. Research by Centre for Mental Health with young Black men in Birmingham[13], however, provides evidence that the mental health impacts of Covid-19 were especially pronounced for this group as a result of higher levels of poverty, poor housing, higher risks to family members from the virus, over-policing of lockdown restrictions, and the stress resulting from the murder of George Floyd and subsequent Black Lives Matter protests.

Children and young people in the West Midlands

The number of children in contact with mental health services in the Birmingham and Solihull integrated care service area increased from 2,750 in April 2018 to 4,535 in May 2023, 64% higher than five years earlier. In the Black Country integrated care system area where there has been a 57% rise in children in touch with mental health services between April 2021 and February 2023, with a smaller but still significant rise in the third integrated care system, Coventry and Warwickshire[14].

A short survey was sent to members of the Transport for West Midlands research database. It received 160 responses from parents and carers who had at least one child in their household under the age of 25.

- 82% said the pandemic had had a negative impact on the mental wellbeing of the children/young people in their household.
- 73% included 'being away from school, college, university or workplace' among the factors that the children/young people in their household found most challenging.
- 21% included 'support provided by school, college, university or workplace' among the factors that the children/young people in their household found most supportive.
- 44% included 'better support for my children, e.g. Special Educational Needs and Disabilities support among the factors that would improve their mental wellbeing.

Children and young people

The West Midlands Young Combined Authority, a diverse board of young people who all live, learn and work across the West Midlands, were one of the many key stakeholders consulted for this part of the Commission.

Child poverty and mental health

Child poverty (children living in households with less than 60% of the average income after housing costs) increases the risk of experiencing multiple adverse childhood experiences (including neglect, abuse, bereavement, living with a parent/carer with substance misuse and/or serious mental illness), leading to increased risk of mental ill health. Rates of child abuse and neglect are five times higher for children in families with low socioeconomic status compared to those with higher socioeconomic status[15]. In a national sample of Scottish children, those living in households in the lowest quintile (20%) of household income were almost 12 times more likely to experience three or more adverse childhood events by age eight compared with those in the highest quintile[16]. Other research[17] finds that a 1% increase in child poverty in the UK was associated with an additional five children entering care, mainly due to abuse and neglect, per 100,000 children.

Researchers concluded that children's exposure to poverty creates and compounds adversity, driving poor health and social outcomes in later life. They recommend that national anti-poverty policies are key to reducing poor outcomes and improving wellbeing. It has also been found that children and young people living in the 20% least well-off households are four times more likely to experience severe mental health problems than those in the highest income households[18].

The relationship between poverty and experiencing adverse childhood events such as violence may be causal, as suggested by research that shows that cash transfers to households reduce intimate partner violence[19]. There is a great deal of high-quality scientific evidence demonstrating that adverse childhood events lead to a substantially higher risk of poor wellbeing, mental ill health, and other negative outcomes during the whole lifetime of the person affected[20]. For example, analysis shows that 46% of individuals with depression[21] and 57% of people diagnosed with bipolar disorder[22] report high levels of childhood maltreatment. Given the clear link between poverty, adverse childhood events, poor wellbeing and mental health outcomes, reducing child poverty and inequality should be the priority.

Evidence-based suggestions for reducing the adverse childhood events that heighten mental health risks include:

- Measuring and having strategies and targets to reduce child poverty as an explicit aim

Where there is a heightened risk of abuse, neglect and bullying, and therefore a higher risk of low wellbeing and poor mental health, there should be resources to intervene early and effectively. This means:

- Well-resourced maternity services, including perinatal mental health for expectant mothers, midwifery, health visiting, primary care, early years support including Sure Start Centres (and in future Family Hubs), particularly in areas of deprivation, nursery care, after school and holiday clubs.
- Every parent/carer should be offered and encouraged to take up evidence-based parenting interventions
- Provision and take up of high-quality child care for every child
- Children's social care should be properly invested in and supported to ensure the best quality interventions and placements for vulnerable children

Children and young people

Improving school experience, reducing bullying and stress for children and young people

Schools, youth clubs, colleges and other services that meet children and young people have a role in promoting their positive mental wellbeing and mental health literacy. Schools and other educational settings have a profound role in shaping a child or young person's mental health and wellbeing – positively or negatively. They also have an essential part to play in picking up issues early so that young people experiencing mental health problems can get the support they need as quickly as possible.
The Commission explored three key aspects of school experiences and their impacts on children and young people's mental health:

Transitions

Transitions in educational settings bring challenges. Children and young people must navigate new relationships, get used to new environments and cope with changing expectations in terms of work and behaviour.
Moreover, these transitions approximately coincide with developmental transitions. The change from primary school to secondary school happens at a time when many young people have started to leave their childhood behind and enter adolescence. And, towards the end of secondary school and/or further education, young people are becoming increasingly independent, taking on new responsibilities and making choices that will shape their adulthood.
Research has demonstrated that, for many children and young people, transitions are points of vulnerability for their mental health and wellbeing.

Special Educational Needs and Disabilities (SEND)

A wide range of children and young people are recognised as having special educational needs and disabilities in schools and colleges. These include learning difficulties and disabilities, autistic spectrum conditions, and other forms of neurodiversity. Children with SEND also have a broad range of experiences in the education system.

People with learning disabilities experience poorer health outcomes than the rest of the population, including with their mental health. Children and young people with learning disabilities are more than four times more likely to develop a mental health problem than those without. This means that 14%, or one in seven of all children and young people with mental health difficulties in the UK will also have a learning disabilit[23]. This is not inevitable and not the result of being disabled; poorer mental health is a function of structural discrimination and disadvantage faced by children with special educational needs and disabilities.

There is evidence that these children and young people face inequalities when it comes to their mental health and wellbeing. Sometimes this is because problems are misattributed to their learning disabilities, resulting in the underlying mental health problem going undetected. Other times, this is because mental health interventions fail to take the needs of children and young people with special educational needs and disabilities into account.

Exclusion

Persistent disruptive behaviour is the most common reason for exclusion from school, accounting for approximately one third of all permanent and fixed-term exclusions[24]. According to the Timpson Review of School Exclusion, the rate of both temporary and permanent exclusion is highest among Black Caribbean and Gypsy/Roma and Traveller pupils. It found that 78% of permanent exclusions issued during secondary school were to pupils who either had special educational needs, were classified as in need or were eligible for free school meals. 11% of permanent exclusions were to pupils who had all three characteristics.
There is a two-way relationship between psychological distress and exclusion: young people who have poor mental health are more likely to be excluded, and exclusion is associated with worsening mental health. Young people with conduct disorder and Attention Deficit and Hyperactivity Disorder are more likely to be excluded than young people with other types of mental health difficulties.

Evidence-based actions for education settings

Every school should be encouraged and supported to take a 'whole school approach' to mental health.

Children and young people

A whole school (or college, or university) approach

A 2021 Early Intervention Foundation systematic review[25] found that mental health programmes are more likely to be effective and result in enduring positive change when they are implemented as part of a multi-tiered whole-school approach to improving young people's mental health and behaviour. A mental health or behavioural intervention should not be a one-off event in the school's yearly calendar. Instead, schools need to be supported in the adoption of a whole-school approach which encompasses: (i) universal and targeted interventions; (ii) the embedding of this work within a supportive school environment which fosters positive relationships, a sense of belonging and purpose; and (iii) extending learning to the home environment and developing strong connections with mental health services to support the most vulnerable young people.

In other words, the hallmark of good support for mental health and wellbeing in educational settings is a whole school approach (or a whole college or whole university approach – but, for simplicity, unless otherwise stated, 'whole school approach' will be used to refer to all educational settings).

A whole school approach is one in which students, all school staff (not only wellbeing staff), parents, carers and the wider community work together. Mental health and wellbeing is not only explicitly addressed by dedicated services (e.g. student counselling) and lessons (e.g. in the personal, social, health and economic syllabus), but integral to the whole ethos and environment of the educational setting. Moreover, rather than being a 'checklist' intervention that is rolled out in the same way in every setting, a whole school approach seeks to identify and address challenges and concerns as they emerge, responding to the changing needs of the school, college or university, and of individual students.

A whole school approach should also include having a designated senior lead for mental health who can signpost students and parents to appropriate services and support colleagues to become more mental health-literate. It means taking action to prevent bullying and using evidence-informed classroom-based programmes to boost healthy behaviour and wellbeing and prevent exclusions. School counselling services can also provide an important opportunity for young people to be given psychological support. In taking this approach, the education system would be designed to maximise wellbeing and resilience and minimise risks.

Many schools in the West Midlands and elsewhere in the country have already adopted some of these provisions and practices. The introduction of Mental Health Support Teams in schools and colleges is likely to bring some benefit, but without adopting all aspects of the whole school approach, schools risk missing out on the benefits of each element.

The eight factors that characterise a whole school approach are summarised in the diagram below[26].

Key aspects of a whole school approach to support children and young people through transitions, to improve the experiences of those with SEND, and to prevent exclusions, include:

Trauma-informed responses to challenging behaviour

Trauma-informed responses seek to minimise the trauma-causing potential of the school environment. One aspect of this is using less emotionally harmful alternatives to restrictive interventions. The difference between a conventional response and a trauma-informed response has been summarised as the difference between asking "What's wrong with you?" and "What's happened to you?"

Social and emotional learning

Social and emotional learning (SEL) refers to interventions that actively set out to provide young people with the knowledge and skills they need to build positive relationships and look after their mental health. There is evidence that SEL interventions have:

- Positive effects on mental, emotional and social health and wellbeing in general
- Positive effects on social and emotional skills
- Positive effects on self-esteem and self-confidence

In Wolverhampton, secondary schools implemented the evidence-based Penn Resilience Programme as part of Headstart. This was developed by psychologists at the University of Pennsylvania to support students in developing skills and coping strategies which are designed to contribute towards a number of resilience competencies, such as emotional intelligence and flexible and accurate thinking. Participants also learn techniques for positive social behaviour, including assertiveness and negotiation. This version of the programme is delivered to primary school children. The programme is an 18-lesson curriculum that is aimed primarily at 11- to 13-year-olds. The programme enables young people to develop skills that empower them to be more resilient in dealing with situations both in and out of school.

Children and young people

Reliable and supportive adults

One of the strongest protective factors for children and young people's mental health is the presence of at least one reliable and supportive adult in their lives. Healthy attachments can buffer children and young people against adversity, and contribute to resilience. The most obvious source for this is the primary parent/carer and equipping these adults with the skills they need through evidence-based parenting programmes like Triple P[27] is vital.

There is evidence that not only parents and carers, but also teachers and other adults can play this role. Relationship-building is crucial. For children and young people from racialised communities, this can include having relatable role models from similar backgrounds to themselves, and staff members who have an understanding of racism and the significance of micro-aggressions on wellbeing (and who seek to prevent, reduce or mitigate these experiences).

The educational environment

The physical space, as well as the culture and ethos of the educational environment, have an impact on the mental health and wellbeing of students. There is a positive relationship between a supportive school environment and emotional and behavioural adjustment, especially in more vulnerable students.

The availability of creative and play spaces also plays a role in promoting mental wellbeing. And the visibility of messages about, and services for, mental health can play a powerful role in reducing stigma and 'normalising' help-seeking.

Mental health support in the wider community

Not all children and young people attend school, college or university, and many of those who do not attend miss out on the mental health support they may offer. Other young people may prefer to seek mental health support away from school or college.

Evidence[28] shows early support hubs using the Youth Information, Advice and Counselling Services (YIACS) approach can provide young people aged 11-25 with easy to reach help, without a referral or appointment, for their mental health as well as a range of other needs. Extending access to early support hubs to every young person in the intervene early and provide effective, holistic support.

Recommendations for children and young people's mental health

Action	Rationale	Lead organisation/s
Schools and colleges should adopt a 'whole school approach' to mental health. This should include evidence-based learning about mental health within school curricula and access to counselling and other forms of support alongside the expansion of Mental Health Support Teams.	Mental health outcomes are most strongly influenceable in childhood and evidence suggests 'whole school' approaches and early support are highly effective.	WMCA should convene group of leading education actors, including local authorities, academy trusts and the Department for Education to agree a joint approach. This could be piloted.
All schools and colleges should work towards zero exclusions. Support for this should include external advice and help for schools to improve behaviour and support children with complex needs including 'managed moves' to give students a fresh start.	Excluded children have much poorer mental health and other outcomes. Evidence is clear that supporting children to remain in their school is helpful.	See (1)
All parents/carers should have access to and be encouraged to take up evidence-based parenting programmes.	Evidence-based parenting programmes are highly effective in improving outcomes.	Local authority public health teams and education departments. WMCA could support the pilot.
Every West Midlands council area should have an early support hub drawing on the Youth Information, Advice and Counselling Services (YIACS) model or local equivalent.	These types of services are well evidenced to support better outcomes in children and young people.	Local authorities normally commission these types of service. A pilot scheme should be explored as part of implementing these recommendations

Mental health and the cost of living crisis

Mental health and the cost of living crisis

There is compelling evidence that financial wellbeing is a major determinant of mental health and the biggest single factor in explaining mental health inequalities[29].

Research has firmly established that poverty is associated with increased risk for at least 16 diseases, including psychiatric disorders, that form a 'cascade' of interrelated health conditions, including later heart disease, lung cancer and dementia[30]. Poverty is a key social determinant of health and illness and is responsible for a large proportion of ill health, early deaths and costly health and care services.

In 2020 researchers from the Massachusetts Institute of Technology (MIT) and Harvard University brought together the evidence linking poverty to mental ill health[31]. They found multiple studies showing that job loss leads to reduced income and precedes episodes of mental illness[32]. Evidence from natural experiments confirms that this relationship is causal[33].

The most compelling causal evidence that poverty causes mental illness comes from randomised-controlled trials that evaluate anti-poverty programmes. The MIT/Harvard researchers cite several studies evaluating cash transfer and broader anti-poverty programmes, which have found significant positive impacts on mental health, including over long term horizons after the effects of any initial celebratory reactions among recipients have worn off. Across a wide range of populations and study designs, positive economic 'shocks' to individuals are shown to improve mental health, whereas negative economic shocks undermine mental health.

Intersectional inequalities

People from some racialised communities in the UK experience much poorer mental health outcomes than white British people, and this intersects with levels of poverty. It is important to note that racism, in itself and independently of poverty, causes and worsens mental ill health[34]. Poverty rates vary significantly by ethnicity, but all racialised groups are more likely to be living in poverty. For Indian people, the rate is 22%; for Chinese people, 29%; for Bangladeshi people, the rate of poverty is 45%; and for Pakistani people, it is 46%. This is due to lower wages, higher unemployment rates, higher rates of part-time working, higher housing costs in England's large cities (especially London), and slightly larger household sizes. Around 18% of Bangladeshi workers, 11% of Pakistani and Chinese workers, and 5% of Black African and Indian workers are paid below the National Minimum Wage, compared to 3% of white workers.

Poverty and financial inequality also intersect with gender, disability, data published by the Office of National Statistics[35], for example, shows that the disability pay gap in the UK workforce is around 14%, with the biggest gap in earnings facing autistic people[36].

Mental health and the cost of living crisis

Potential solutions

Action can be taken both short- and long-term, regionally, locally and nationally, to tackle the impact of the cost of living crisis on people's mental health and address the structural issues that make people vulnerable to poverty and mental ill health. We know that local authorities across the WMCA area are already taking steps to protect their residents from the effects of the cost-of-living crisis and acknowledge the importance of these measures to support mental health, as well as people's overall wellbeing.

Maximise people's incomes

- Ensure that all NHS organisations and local councils in the region get Living Wage Foundation accredited and use their economic power to encourage similar commitments from suppliers and partner organisations (for example by including this in contracts for public service providers).
- Social Value procurement can also direct investment into the area and boost businesses, charities and social enterprises that create local jobs at a fair wage. This approach draws on the methods outlined in Rose et al.'s 2023 study published in the Lancet[37]. The so-called "Preston model" of community wealth building encourages local organisations, such as the council, to invest in the local economy. This means developing local supply chains; supporting the development of local enterprise; investing local wealth (such as local government pension funds) in the local area; ensuring participating local organisations pay living wages and model good employment practices; and maximising socially productive use of land and property owned by anchor institutions. The subsequent stimulation of the local economy and improvement of local working conditions was shown to improve local mental health outcomes. For example, the rates of depression in the study area were reduced by 9%.
- Address the growing gap between benefit payments and living costs. Reducing benefit payments is associated with a significant increase in mental ill health while increasing entitlements and access to social security brings about improvements[38].

Reduce people's costs and precarity

- Use Council Tax relief schemes to ensure people facing the biggest threats to their finances are not at risk from non-payment.
- Offer Healthy Start Vouchers and other means to support young families to get access to early years education. Evidence-based early years interventions may mitigate the effects of poverty by supporting better mental health among young children and their parents, increasing the likelihood of later success in education and employment
- Provide help for people to insulate their homes, reducing the costs of heating to those with the lowest incomes: there is evidence that having a warm home has a direct and causal positive impact on mental health, with knock-on benefits to physical health. An evaluation of the Warm Front scheme (a UK Government initiative to enable vulnerable people to keep their homes warmer from 2000 to 2005) found that reducing fuel poverty and cold brought about a 40% reduction in psychological distress[39].

Provide advice and support

- Ensure sufficient supply of money, debt and housing advice services, with a particular focus on the most deprived areas/communities and people seeking support for their mental health. Co-locating expert advice services in easily accessible community spaces, in general practice, psychological therapy and secondary mental health services can ensure help is offered proactively to people with mental health difficulties.

Improve services for the most deprived areas and communities

- Locate mental health services in areas with the highest levels of deprivation, working arm-in-arm with trusted organisations that support communities with the poorest access to effective support.

Mental health and the cost of living crisis

Current initiatives in the West Midlands

- Gaining Living Wage Foundation accreditation: which currently includes the West Midlands Combined Authority, Birmingham City Council and Aston University and is being taken forward by Coventry City and Dudley Councils;
- Work to drive social value in procurement includes the Office of the Police and Crime Commissioner, West Midlands Combined Authority and metropolitan local authorities in some form;
- West Midlands Combined Authority-led retrofit projects to support energy efficient housing;
- Work to enable community advice services – Coventry has 4/5 Community Empowerment Hubs being set up; Sandwell has a Voluntary and Community Sector development reserve, and Birmingham has funded community advice and supported training programmes for community partners on benefits.

Case Studies

Managing rent arrears

Walsall Housing Group (WHG) worked with the National Housing Federation (2022) to explore ways social housing providers changed their rent arrears management processes during the Covid-19 lockdowns. WHG employs a money advice team that helps people maximise their incomes as well as deal with problems in paying rent, with additional support for residents with vulnerabilities to enable them to sustain their tenancies.

Recommendations to address the cost-of-living crisis

Action	Rationale	Lead organisation/s
WMCA region should become a 'Living Wage Place' with every major public sector body achieving Living Wage Foundation Accredited by 2026 and a region-wide campaign run to get other major employers accredited	Poverty is the main driver of poor mental health. With 20% of West Midlands' workers paid below the poverty rate, this would make a big difference.	WMCA should lead on this, but it will require action by local authorities, NHS trusts, universities, police and fire authorities and the private and voluntary and community sectors
Public sector organisations in the region should adopt social value principles in procurement, putting money in the pockets of local people and organisations.	'Preston Model' of buying more goods and services locally is associated with a 9% reduction in depression, among other evidence	WMCA should develop a Social Value Procurement Charter along the lines of the Greater Manchester version[40]
Welfare advice should be provided to anyone in the West Midlands using mental health services, including NHS Talking Therapies. This should include support with personal finances, housing rights, legal issues and employment.	Adverse life circumstances, like poverty, worsen mental health outcomes. Addressing circumstances makes outcomes more likely to improve.	The Integrated Care Boards/Systems should lead on this work supported, potentially, by a WMCA-led pilot scheme

Tackling racial inequalities in mental health

Tackling racial inequalities in mental health

There are stark inequalities in mental health outcomes and mental health care between ethnic groups in the UK.

Disparities point to both the direct and indirect impacts of structural racism across our society, with Black communities most affected. Addressing these disparities is particularly urgent within the West Midlands region, where 1.3 million people living across the metropolitan area do not identify as being from a White British background (UK Census 2021). This means that any intervention which does not deliberately recognise and address race inequality will have a limited impact for our population.

Population surveys and research indicate that rates of some mental health conditions are substantially higher than average among some racialised communities in the UK. Among Black communities, there is evidence of higher rates of psychosis (including schizophrenia), post-traumatic stress disorder, and suicide risk. These higher rates are not evident in Black-majority countries, suggesting that disproportionately poor mental health outcomes for racialised groups in white-majority countries are caused by systemic racism as opposed to a genetic or cultural difference within different ethnically minoritised communities.

Higher rates of mental ill health (particularly serious mental illness) are mirrored in the greater use of coercion in mental health services. Experiences of racism in society are too often reflected in the ways people are treated within mental health services[41].

This perpetuates the 'circles of fear' that exist between mental health services and Black communities in the UK[42].

In England and Wales, people from Black communities are 4.5 times more likely to be sectioned under the Mental Health Act than white people (a disparity that has been growing in recent years, despite growing awareness of the problem). Black people are also eleven times more likely to be given a community treatment order when they are discharged from hospital[43].

Data from NHS Benchmarking shows that Black people in the UK represent:

- 3% of the adult population
- 5% of the caseload of community mental health services for adults
- 8% of hospital admissions
- 12% of people who are sectioned at admission to hospital
- 19% of people in medium secure mental health wards.

Racial disparities in mental health care also affect other racialised communities. Significantly higher rates of Mental Health Act use are evident among Bangladeshi and Pakistani communities and among those classified by NHS Digital as 'other' white communities (that is not British or Irish).

The overall picture is one of stark inequity. While higher rates of service use would be expected if the prevalence of mental illness is also higher among many racialised communities, the routes by which people come into the system and the outcomes that result would not.

Evidence suggests that Black people (including children) are far more likely to enter mental health services via the police or criminal justice system. And Black people are more likely to have multiple compulsory hospital admissions than their white counterparts – suggesting that their experiences and outcomes were poorer.

Racial inequalities in mental health also intersect with other inequalities and protected characteristics. For example, communities with the lowest incomes and least resources tend to have higher rates of poor mental health and disproportionately coercive treatment from mental health services. It is important to note that racialised communities are often disproportionately exposed to these wider inequalities, such as poverty, due to longstanding and structural race inequality.

It is also important to note that our understanding of disparities is hampered by a paucity of good quality data . Categories used by researchers and official bodies to describe people's ethnicity are often highly aggregated (for example, where people are grouped into artificially homogeneous categories such as 'BAME'), and this does not allow for detailed analysis of people's experiences or for evidence about what works for specific groups that people identify with to be articulated44. This lack of granularity also makes it more difficult to explore intersectionality . Other issues include relying on surveys with small sample sizes and an overall gap in data relating to children and young people[44].

Centre for Mental Health has produced a factsheet summarising racial inequalities among young people's mental health[45].

The West Midlands Race Equality Taskforce were part of a joint session for this section of the Commission

Tackling racial inequalities in mental health

The impacts of the pandemic

It has been widely recognised that the pandemic has affected racialised communities in the UK disproportionately. That includes higher rates of death and hospitalisation from the virus, as well as greater indirect risks, for example, to people's livelihoods. These greater risks are recognised in the directors of public health reports of the local authorities in the West Midlands, several of which went on to note the consequences of this inequality for mental health.

The longer term impacts of the pandemic on the mental health of people from racialised communities are likely to be greater still. The Centre's forecasts identify groups facing higher risks of poor mental health stemming from trauma, loss and burnout. These groups include people who experienced severe illness, the family members of those who died during the pandemic (and especially during lockdown periods), and people working in high-risk occupations (especially in health and care)[46]. All these risks will fall more heavily on racialised communities. The cost of living crisis and recession are highly likely to exacerbate these risks further.

The Centre worked with young Black men in Birmingham throughout the pandemic as part of our evaluation of the Shifting the Dial programme[47]. This gave us insights into their experiences, gathered through peer research. We found major concerns relating to:

- Negative experiences at school, for example, being given lower teacher-assessed grades at GCSE or A-Level, and the introduction of more punitive behaviour policies (which disproportionately affect Black pupils).
- Policing of lockdown restrictions, with young Black men more likely to be sanctioned: as one participant told us: *"Being in lockdown has felt like being a Category D prisoner."*
- Misinformation about Covid and the vaccination programme.
- Bereavement and loss.

These experiences were heightened in the aftermath of the murder of George Floyd and the Black Lives Matter movement, which for many young Black men crystallised the impact of systemic racism and discrimination in their lives[48].

Potential solutions

Tackling structural racism and racial inequality in mental health means working systemically to address the determinants of mental health and to ensure support is provided equitably. Equity in mental health support means more than not being discriminatory. This evidence paper focuses on the provision of support rather than the determinants of mental health inequalities.

We start with two major national developments that provide important context for the Commission's work, both resulting from the Independent Review of the Mental Health Act.

Ensure compliance with Section 149 of the Equalities Act 2010

Despite having 13 years to implement changes many public bodies are in breach of the legal duty, under Section 149 of the Equalities Act 2010, to:

(a) eliminate discrimination, harassment, victimisation
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

In addition the NHS, councils and other public bodies have legal duties under this Section to 'advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

(a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
(b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
(c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

There is also a duty to tackle prejudice, and promote understanding.

Tackling racial inequalities in mental health

Patient and Carer Race Equality Framework

The NHS in England has adopted a major change programme, the Patient and Carer Race Equality Framework (PCREF), as part of its Advancing Mental Health Equalities (AMHE) strategy (NHS England, 2020). Together, they aim to bring about systemic change in NHS mental health services by:

- Supporting local services to provide more equitable care to racialised communities
- Using data to assess progress, raise accountability and stimulate improvement
- Developing a more diverse, representative, and culturally competent mental health workforce

The Patient and Carer Race Equality Framework and Advancing Mental Health Equalities strategy are still in their early days: as previous efforts to address racial inequity in mental health care have demonstrated, major change programmes of this type take time to make a sustained impact on people's experiences. For example, addressing the lack of diversity in the mental health professions means improving access to education and training (including structural barriers such as cost), creating fair working conditions and career opportunities (free from harassment and discrimination), and tackling cultures and processes that prevent some groups of people from reaching more senior positions.

Mental Health Act reform

The PCREF was initiated as part of the Independent Review of the Mental Health Act[49]. It was a key recommendation regarding reducing the disproportionate use of coercion among racialised communities. Other recommendations were also set out in the review, including:

- Sufficient provision of culturally competent Independent Mental Health Advocacy (IMHA) services,and the extension of these services to informal patients in mental health hospitals
- Reforming the criteria for the use of the Act to limit the subjectivity of decision-making by clinicians
- Tightening the regulations around the use of community treatment orders
- Extending people's rights to produce advance choice documents and for these to be considered when they lack capacity to make decisions.

Implementing and spreading the Birmingham and Lewisham Caribbean and African Health Inequalities Review[50]

In 2022 Birmingham and Lewisham Councils published the outcomes of a review they had jointly commissioned to improve the health of Black African and Black Caribbean people in those communities by listening to them, recognising their priorities, discussing, and reflecting on findings and coproducing recommended solutions for their Health and Wellbeing Boards and NHS Integrated Care Systems to consider and respond to. These findings need to be fully implemented, and the learning from the report need to be considered by other areas in the WMCA.

Community-led and coproduced services

The NHS and local government cannot address racial inequity in mental health services alone. Tackling the 'circles of fear' that exist between racialised communities and mental health services means making fundamental changes to the kind of services that are on offer. Statutory services that are not trusted by racialised communities need to 'earn' trust by working arm-in-arm with those communities. This means shifting the balance of power in systems so that community organisations have a bigger role in service provision and greater influence over how they are organised. Organisations like the Black, African and Asian Therapy Network (www.baatn.org.uk) promote and list organisations and people that take this approach.

Some approaches that have been evaluated include:

Skill-sharing: mental health professionals providing training and support to faith leaders, barbers and other members of communities to deliver mental health support and address myths or stigma about mental health. This brings new people into the wider mental health workforce and takes skills into communities, which makes it possible for more people to get support[51].

Meeting people 'where they're at': providing mental health support in spaces people feel comfortable, for example youth clubs, community centres, places of worship, or online. The Centre recently evaluated Project Future's scheme locating clinical psychologists in a youth club in Haringey, which found that working alongside trusted youth workers made discussions about mental health more acceptable and brought about improvements in wellbeing[52].

Collective impact: working at a community level to generate system change and shift the power balance between organisations and the people they serve[53]. For some community organisations, this is their core purpose (e.g. Black Thrive), while for others, it is additional to direct support for individuals and groups (e.g. Project Future). The aim of such projects is to bring about social change, for example, by influencing local or national policies, practices or resource allocations.

Tackling racial inequalities in mental health

Case Studies

Pattigift is a Birmingham-based community interest company that seeks to embed African centred psychological thinking to promote self-knowledge and the potential in people, so helping to build healthier communities.

It delivers holistic, culturally congruent psychological and physical therapies for underserved communities and develops an educational centre for the delivery of African centred psychological approaches to health and wellbeing.

Black Thrive is a Lambeth-based community organisation that was set up following an inquiry by Lambeth Borough Council into the mental health inequalities faced by the borough's Black African and Caribbean communities. Black Thrive takes a 'collective impact' approach to using its resources to maximise its influence on local systems. This approach was developed in the United States, and it seeks to generate large-scale social change by bringing organisations together with *"a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants"*[54].

Peer support: community led initiatives create spaces where peer support and mutual aid can flourish, often without formal structures or referral systems. Online peer support can bring together people without geographical limitations, which allows for groups to form that reflect intersectionality in experience and identity (e.g. Taraki and The Motherhood Group).

Tackling racial inequalities in mental health

Case Studies

Taraki (https://www.taraki.co.uk/) is a movement working with Punjabi communities to reshape approaches to mental health. Taraki was founded by Shuranjeet Singh after his experiences with mental health challenges and focuses on four key areas: awareness, education, social support and research. The organisation began with awareness work focused on social media and in faith centres but has extended to providing social support for Punjabi men, Punjabi women and Punjabi LGBTQ+ people through open groups or forums, to foster social connection. These groups aim to facilitate open and inclusive spaces where members feel comfortable and able to discuss mental health, resilience and vulnerability, share coping strategies and challenge stigma.

The Motherhood Group (www.motherhoodgroup.com) is a support platform for Black women experiencing difficulties during and after pregnancy which includes poor mental health. The group's founder, Sandra Igwe, established the group four years ago after encountering stereotyping and unconscious bias from maternity services and finding that mother and baby groups did not create space for Black women to discuss their experiences. She found that Black mothers preferred to suffer with significant mental or physical health problems than to seek help from statutory services. The Motherhood Group raises money to link Black women with birthing partners, psychotherapists, counsellors and perinatal mental health practitioners and to connect Black mothers to each other to reduce isolation and enable peer-to-peer support.

They also run events, workshops and peer-to-peer sessions to connect mothers and equip them with tools to thrive in all aspects of their parenting. The Group is raising funds to train health care practitioners and the community to better identify the specific needs of Black women and to help Black mothers have the knowledge, awareness and confidence to recognise perinatal mental health problems and seek adequate support.

Celebrating Black identity and culture:

Community-led approaches can help to combat racism by drawing on Black culture to create positive narratives and role models (e.g. Shifting the Dial). By celebrating the resilience and struggles of communities to overcome racial injustice, they can counter dominant narratives and build a more positive sense of belonging and possibility. It was only after many years of work by Black civil rights campaigners that Black History Month was first established in 1987 and Windrush Day in 2019.

Until 2021 there was only one statue of a named Black woman in the UK, the statue of Mary Seacole outside St Thomas's Hospital, London. This statue has now been joined by statues of Henrietta Lacks in Bristol and Betty Campbell in Cardiff, both erected in 2021 after campaigns about statues and racism in the UK. This campaign further demonstrates the struggle it has taken to get achievements of racialised people recognised and the toll this takes on people and their mental health.

Recommendations for racial equity in mental health services

Action	Rationale	Lead organisation/s
The three integrated care systems in should support and invest in community-led infrastructure so that they are able to deliver credible and safe mental health support for people from racialised communities in the region. These organisations should be supported to build capacity, form networks for support and become more sustainable.	People from racialised communities experience much poorer mental health outcomes because of structural racism. Representative, community-led services can help address these problems.	The Integrated Care Boards/Systems should lead on this work supported, potentially, by a WMCA-led pilot scheme
The NHS should seek to make the mental health workforce at every level and across all disciplines more representative of the communities it serves.	This would help address some of the structural problems that lead to worse mental health outcomes in racialised communities.	The Integrated Care Boards/Systems and NHS Trusts should lead on this work supported, potentially, by a WMCA-led pilot scheme

Sport, exercise, physical activity and mental health

Sport, exercise, physical activity and mental health

Physical activity can help prevent and manage mental health problems and promote mental wellbeing It does this through several pathways:

- Neurobiological, for example, the release of brain chemicals
- Psychosocial, increasing social connectedness through group activity
- Behavioural, promoting self-efficacy
- Environmental, increasing the amount of time spent outdoors in green spaces
- Physical, preventing or improving physical health conditions that are associated with poorer mental health outcomes

Physical activity can be used in treatment for depression and was included in the recently updated National Institute for Health Care and Excellence (NICE) guidance for the management and treatment of depression in adults.

Although there are more gaps in the literature, there is also good evidence that physical activity can be beneficial in addressing anxiety disorders.

And there is evidence that, for people with a diagnosis of severe mental illness, physical activity can help with mental health symptoms and quality of life. It can also help with physical health problems and weight gain, which people with a diagnosis of severe mental illness experience at disproportionately high rates, and which can have a negative impact on mental wellbeing.

Finally, physical activity is beneficial for people with neurodegenerative conditions such as dementia. It is both protective against dementia and, for people who are already living with the condition, it can slow further decline in functioning and improve quality of life.

The current context

Covid-19

When the pandemic was at its peak and restrictions were in place, activity levels were down in the UK, especially among people from racialised communities, people who were unemployed, and the oldest and the youngest age groups. Participation in team sports was down, but activity outdoors was up.
Data from the later part of the pandemic, roughly covering 2021, showed similar trends, with widening inequalities and drops in volunteering numbers. For example, Activity Alliance's Annual Disability and Activity Survey found that fewer than one in three people living with a disability felt encouraged to return to physical activity after the pandemic, and the support they needed to be active was less available.

West Midlands

As highlighted in West Midlands on the Move data from Sport England shows that one third of children (32.2%) of children in the West Midlands do less than 30 minutes of physical activity a day, and OHID data shows that 40.5% of adults do less than 30 minutes physical activity a week.

Recent research by Transport for West Midlands paints a mixed picture of the impact of Covid-19 on activity levels. There have been changes to how and whether, people commute to work, and to their gym attendance. However, the effect of these changes on overall activity levels remains unclear, andmore research will be needed.
There are several initiatives in place to support people in the West Midlands to become more active and to reduce the inequalities in activity levels, and careful thought is being given to the legacy of the 2022 Commonwealth Games.

Sport, exercise, physical activity and mental health

Diversity, equity and inclusion

There is evidence that, with the right activity and the right support, the mental health and wellbeing of people of all ages and abilities stands to benefit from physical activity. Within this overarching positive message, there are considerations of diversity, equity and inclusion.

Barriers to access
Some groups face more barriers to being physically active than others. These groups might be locked out of the benefits of physical activity unless careful thought is given to their inclusion.

These barriers can take different forms. For example, they may be psychological (e.g. fear of failure); linked to the social environment (e.g. racial harassment or violence against women); or linked to the physical environment (e.g. lack of wheelchair access). The harder it is for someone to take part in physical activity, the less likely they are to be active.

Sport England 2022 findings

- Adults from mixed or multiple ethnic backgrounds are most likely to be active, and least likely to be inactive. In contrast, adults from Pakistani, Bangladeshi, and Arab backgrounds are the least likely to be active, and most likely to be inactive. And the inequalities in the physical activity levels of adults of different ethnic backgrounds are also observed in children and young people.
- People from racialised communities are seven times more likely to live in an urban area than someone from a white ethnic background. These geographical factors can contribute to, and perpetuate, some of the socioeconomic, social cohesion and social mobility issues that influence a person's ability to engage in sport and physical activity.
- There is a gender gap observed in physical activity levels across nearly all ethnic groups, such that women are less likely to be active than men; and, for Asian and Black African women the gap is even more pronounced.
- Adults from a low socioeconomic classification are twice as likely to be inactive compared to a person from a high socioeconomic classification, and people from the Bangladeshi, Pakistani and Black communities are disproportionately likely to have a low socioeconomic classification.
- Unemployed adults are 59% more likely to be inactive compared to a person who is working full- or part-time. Around one in ten adults from Pakistani, Bangladeshi, Black or Mixed ethnic backgrounds are unemployed, compared to one in twenty-five white British adults.
- Adults from the most deprived quartile of neighbourhoods are 45% more likely to be inactive compared to a person from the least deprived quartile of neighbourhoods. People from Black (20%) and Asian (17%) ethnic groups are the most likely to live in the most deprived 10% of neighbourhoods. Within those groups, Pakistani (31%) and Bangladeshi (28%) adults are the most likely to live in the most deprived 10% of neighbourhoods.
- Children and young people with low family affluence are 55% more likely to be less active compared to a child or young person with high family affluence. People living in a household headed by someone from a racialised background are more likely to be on a relatively low income. This is particularly the case for households headed by someone of Bangladeshi, Chinese, Pakistani, or Black ethnicity, with 51%, 49%, 46%, and 41%, respectively on a relatively low income. This compares to only 19% of White households on low income.
- The patterns observed in adults when looking at the influence of ethnicity, gender, and socioeconomic status on participation are also observed in children and young people.
- Children and young people with a disability or long term health condition are an average of 4% (between years 1-11) more likely to be less active than those without.

Sport, exercise, physical activity and mental health

Ensuring everyone can access the benefits of being physically active that are most important to their needs

As discussed above, 'physical activity' and 'benefits to mental health and wellbeing' are broad concepts. They make it possible to talk in general terms, brushing over some of the complexity they contain. For example, this section started by saying, *"The mental health and wellbeing of people of all ages and abilities stands to benefit from physical activity."* But different people have different mental health and wellbeing needs, and different ways of being physically active bring different benefits.

This leads to the question: what can we do to make sure these different benefits reach the people who need them the most? This might mean, for example, making sure that physical activities intended for older adults are ones that are particularly good at fostering social connectedness; or, for people living in built-up urban environments, providing more opportunities to be active in green spaces.

Reaching those who are underserved by other forms of support for mental health and wellbeing

The most common forms of mental health treatment in the UK are talking therapies and medication. For some groups of people these work well; these groups view the treatments and the institutions that provide them as designed for 'people like them'. As a result, many people in these groups have a range of options that they would consider, and would find helpful, in terms of supporting their mental health and wellbeing. For them, physical activity is one alternative among many.

Other groups, however, face more barriers to accessing and engaging with common forms of mental health treatment. For example, Black people are disproportionately likely to be detained under the Mental Health Act; there is evidence that this has eroded levels of trust in statutory services. For those who are underserved by common forms of support and treatment, the availability of acceptable alternatives is crucial: it may make the difference between something and nothing.

For some in these groups, physical activity may be one of the few activities with mental health benefits that they feel positively about; and, as a result, for them physical activity will be especially important, compared to those who have a range of other options.

Sport, exercise, physical activity and mental health

Case Studies

- The WMCA is running a campaign, 'Include Me', to make the city region the best place for disabled people to access sports and other activities with funding and awareness raising
- Solihull Commonwealth Active Communities' programme of work to, amongst other things, seek to reduce inactivity, improve mental health, encourage the use of parks, canals, cycle paths, streets and pitches, encourage pride in local areas, plus a wellness marketing and communication strategy;
- Sport England work with Rethink to embed physical activities within severe mental health community systems and pathways;
- Birmingham and Solihull Mental Health Foundation Trust work to trial 24-week sessions of local community based physical activities for users of adult community mental health teams.
- Freewheelin Dance (Birmingham) – aims to promote wheelchair dancing as a sport and a leisure activity. It is inclusive, working in association with Para Dance UK, and is open to any age, ability or experience. Many of the members are wheelchair users.

Recommendations for improving access to physical activity

Action	Rationale	Lead organisation/s
Mental health services should provide ready access to physical activity opportunities for anyone who is waiting for support or currently receiving it. Physical activity should be built into treatment 'pathways' as a routine element of good mental health care.	Evidence shows that physical activity is good for mental health. People with a mental health diagnosis experience poorer physical health than the general population – exercise would help close this gap.	The Integrated Care Boards/Systems and NHS Trusts should lead on this work supported, potentially, by a WMCA-led pilot scheme
The WMCA and local authorities in the region should work systematically to reduce barriers that may prevent local people from engaging in physical activities – cost, lack of culturally appropriate options, transport including traffic, pollution and lack of active travel infrastructure, safety, the range of activities on offer.	Physical activity is good for mental and physical health but poorer communities struggle to access exercise because of structural barriers. Designing environments that privilege walking and cycling is most effective way to do this	WMCA including Transport for the West Midlands and local authorities

West
Midlands
Cycle Hire
265

Thriving communities and the voluntary and community sector

Thriving communities and the voluntary and community sector

Community wellbeing is more than the sum of people's individual wellbeing. Communities with good mental wellbeing have:

- Strong social networks
- Trust and reciprocity
- Power and control

Community wellbeing is defined as 'the combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfil their potential.'[55]

Key components of community wellbeing have been described as: 'social capital, social cohesion, social inclusion, community resilience, as well as measures of individual wellbeing and social determinants of health and wellbeing such as local economic outcomes (e.g. employment and volunteering.'[56]

Three pillars that facilitate and support community wellbeing are:

1. Connectedness. This is supported by a community's social networks that:

- Empower members to participate in community and democracy
- Enhance social trust
- Offer social support
- Support members living harmoniously together
- Promote civic engagement

The Danish word for community, fællesskab, literally means the 'common cupboard' or 'shared resources'[57]. By sharing resources like time, money, space and knowledge, we help each other survive the lows and reach greater heights. Places where people have a greater number of links with each other, meet regularly, and have networks that overlap with each other have higher overall wellbeing and are more likely to take responsibility for what happens in their area.

2. Liveability. A liveable community has an infrastructure that provides sufficient and high quality.

Planning and licensing powers can be used to improve or worsen mental and physical health by influencing the environment in which residents live.

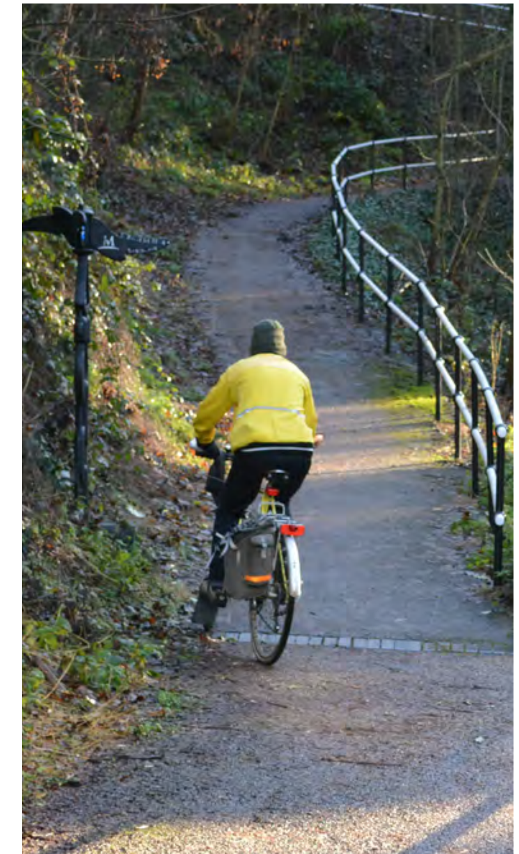
The ideal mentally healthy environment is one where everyone has a decent home with easy access, via tree-lined, safe, walking, cycling and electric public transport routes, to:

- high-quality employment and training opportunities
- parks and waterways
- free/affordable 'pro-social' space including libraries, leisure and community centres
- decent childcare and schools
- healthy, affordable food
- arts, culture and sports

It also limits:
- crime and anti-social behaviour
- air pollution
- access to cheap alcohol
- harmful gambling
- poor quality food.

3. Equity. An equitable community is underpinned by values of social justice, empowerment and diversity where:

- Community members are treated with fairness and justice
- Basic needs are met
- There is equal opportunity to get education, learn and meet
- People feel safe going about their daily lives, for example without fearing racial harassment, gender based violence or homophobic abuse.



Thriving communities and the voluntary and community sector

The pandemic and community

The Covid-19 pandemic has put more people at risk of mental ill health and we are likely to see higher rates of distress because of trauma, loss, bereavement and burnout in individuals, families and communities[58].

But at the same time, and especially during 2020, civic participation and social cohesion increased. Thousands of new volunteer groups were established[59]. For those who volunteered a third say they will 'definitely' and almost half will 'probably' continue to volunteer[60].

Office for National Statistics weekly research into the social impacts[61] found:

- 64% said other local community members would support them if they needed help during the pandemic
- 78% thought people are doing more to help others since the pandemic
- 63% had checked in on neighbours who might need help at least once in the last seven days
- 38% had gone shopping or done other tasks for neighbours.

While this level of participation is unlikely to have been sustained, Director of Public Health reports from local authorities across the West Midlands demonstrates the value of health 'champion' schemes, for example, to increase vaccination uptake and dispel myths as a means of reducing structural inequalities in access to the programme.

For example, Wolverhampton's most recent director of public health report states that: 'Covid-19 has brought into sharp relief and exacerbated inequalities that were already well established... What is critical is our response to addressing inequalities – either in access to services, support and care or in health outcomes. We have a deep commitment to addressing systematic, avoidable differences in outcomes, particularly by ethnicity and deprivation. The way we want to do this is to build on the strengthened partnership working that came about from our collective efforts to address the pandemic. We want this to result in more co-productive, community led work to improve the health and wellbeing of our population.'

Boroughs that have benefited from the Better Mental Health Fund have also invested in projects that have sought to boost social capital (among other priorities). The Better Mental Health Fund was a government-funded initiative supporting pandemic recovery by supporting mental health improvement projects in 40 of the most deprived local authority areas in England in 2021/22. Funding was given to the local councils to spend on evidence-based initiatives to address mental health inequalities and improve wellbeing in their communities. Many of the local authorities invested in community and voluntary organisations to deliver interventions to boost mental health literacy and build connections through activities, often using creative arts or physical activity as routes to engagement.

Case Studies

Sandwell has worked with 30 local organisations since October 2021 with projects including a community hub for new parents in the borough's libraries, a football-based programme through the local club, and a project offering befriending within racialised communities through gardening.[62]

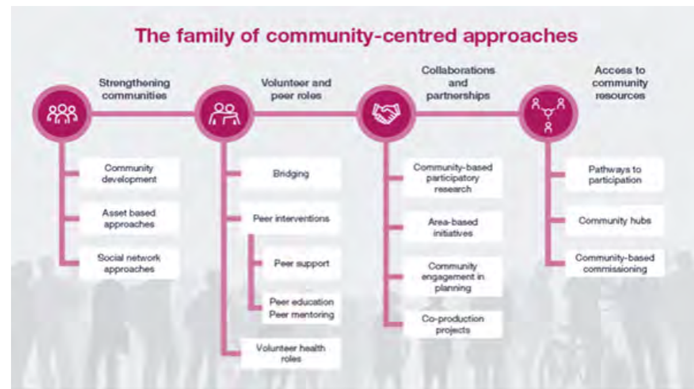
Birmingham funded 11 projects reaching more than 24,000 people through organisations such as The Delicate Mind, which works with Muslim communities in the city to run workshops for men and women and bring about wider social change drawing on people's experiences and challenging structural inequalities[63].

These investments have clearly demonstrated the value of investing locally in communities and peer-led groups, using relatively small sums of money to enable them to run activities at the grassroots level and on their own terms (Centre for Mental Health Better Mental Health Evaluation – publication pending at time of writing).

Thriving communities and the voluntary and community sector

Effective and promising approaches

Community-centred approaches that underpin and facilitate social capital have four key domains: strengthening communities; volunteer and peer roles; collaboration and partnerships; and access to community resources (illustrated in the figure below, taken from GMICP, 2021[64]).



Strengthening communities

Policies and interventions which promote social connections have been found to improve physical health and mental wellbeing.

Many local authorities have adopted community asset-based approaches to improve wellbeing. These involve mapping and supporting local community assets (from large-scale voluntary sector, faith group or civil society organisations to informal groups and societies) and connecting people to resources[65]. This can include initiatives such as 'Men's Sheds', that seek specifically to promote mental wellbeing, as well as a wider range of networks and groups that promote inclusion and belonging through creative, sporting or social activities. In some areas, social prescribing and link-worker schemes have been set up to ensure people are directed and, where necessary, supported to get access to relevant community assets and resources.

Volunteer and peer roles

Volunteering has a significant positive impact on physical and mental wellbeing[66]. Volunteering can reduce exclusion, social isolation and loneliness[67]. Formal volunteering as part of a group improves wellbeing significantly more than informal, irregular volunteering. It also gives a sense of identity and purpose, and it helps people to build their social relationships and continue to volunteer in their communities.

Collaboration and partnership

Sharing decision-making and co-production with communities can help to build social networks and improve social cohesion. Projects such as Shifting the Dial in Birmingham[68] have demonstrated the value of co-production in the development of resilience-building activities and of including social action as a means of bringing about wider change.

This is often a feature of early support hubs using the Youth Information, Advice and Counselling (YIACS) model, such as YPAS in Liverpool and MAP in Norwich. They combine personalised advice and psychological support for young people (11-25) with group activities and campaigns led by young people to bring about change in their local areas.

Centre for Mental Health is currently working alongside the Diana Award and UK Youth to deliver a major programme of Young Changemakers which supports young Black people to lead social action projects to address the causes of mental health inequalities in their communities.

Social prescribing

Social prescriptions link patients in primary care with non-medical support in the community. They have been found to improve mental health outcomes, improve community wellbeing, and lower social exclusion[69]. Interventions including presecriptions for exercise, learning and the arts have been used to increase vulnerable people's self-esteem, self-efficacy, mood, and social contact[70]. A review of social prescribing schemes in the UK[71] showed the schemes had several positive outcomes including increases in self-esteem and confidence; improvements in mental wellbeing and positive mood; and reductions in anxiety, depression and negative mood.

Social housing providers

Many social housing providers are part of the voluntary and community sector and have considerable potential to boost community wellbeing and offer earlier intervention for people's mental health. General needs housing providers can engage with the communities they serve to build on assets in the community, for example through social prescribing, as well as providing proactive support to individuals and families who are struggling with their mental health at an early stage.

Case Studies

Walsall Housing Group

Walsall Housing Group (WHG) produced a Health and Wellbeing Strategy for 2021-2024, whose aims included reducing loneliness and isolation and using social prescribing and health coaching techniques to improve the health of those with the poorest outcomes. It built a network of Community Champions and its social prescribing service, The H Factor, was evaluated by the Housing Association Charitable Trust (HACT) and found to have improved the mental health of 90% of participants, the majority of whom had low wellbeing scores when they contacted the service. The service linked people with a range of resources, including debt counselling, food banks, training opportunities, bereavement services, and befriending groups. The benefits included greater financial security, employment and volunteering opportunities, and increased confidence.

Thriving communities and the voluntary and community sector

Time banking

Time banking is an initiative where people undertake supportive activities for their community and then bank the time they spend doing this. They can spend the time they have banked by receiving equivalent support from others. Timebanks hosted by public and community bodies have also been found to be effective. Time banking can increase levels of engagement, reduce social problems, and break cycles of dependency and inactivity.

Community-based arts projects

Community-based arts projects empower communities, improve people's confidence, give a sense of self determination, as well as creating social cohesion and enhancing people's perceptions of their local area[72]. Arts projects with a cultural wellbeing, self-expression and creativity focus have helped improve neighbourhoods[73]. Projects using creative arts approaches can also generate opportunities within socially and economically excluded communities and reach groups of people who find traditional approaches to mental health promotion inaccessible or unhelpful. As stated previously, projects using sports and physical activity may have similar benefits to those based on arts and cultural activities in supporting community wellbeing.

Boosting the voluntary, community, faith and social enterprise sector's role in supporting mental health

Boosting mental health in communities will require sustained investment in the organisations of all types and sizes that come from and support those communities.

The VCS has strengths that are different from and complementary to those of statutory services. Research identifies three broad areas of skills and expertise that often characterise VCS organisations:

- Address the social determinants of mental health, and work across traditional clinical and disciplinary boundaries
- Advancing equality, diversity and inclusion
- Offering choice, consulting with service users and adapting to changes.

In comparison to statutory services, VCS organisations often:

- Provide a broader range of services under one roof (e.g. social and practical support, as well as clinical support)
- Provide more holistic services to help people maintain or improve their mental wellbeing in a variety of ways (e.g. art groups and cooking classes)
- Have a focus on the wellbeing of communities, as well as individuals
- Have a deep understanding of the issues affecting the communities they support
- Have fewer barriers to admission (e.g. services that can be accessed by self-referral or on a drop-in basis).

People who are poorly served by statutory services or find them unhelpful or oppressive may benefit especially from support from VCS organisations. VCS organisations are often particularly successful at:

- Building trusting, respectful relationships with service users
- Offering flexible services that wrap around the needs of the people they are intended for
- Empowering service users to take active roles within the organisation (e.g. as peer supporters or as members of an interview panel)
- Taking a strengths-based approach
- Working in ways that are appropriate to a person's cultural background.

Thriving communities and the voluntary and community sector

Voluntary and community sector organisations during the pandemic

The Covid-19 pandemic has been a time of considerable challenge and innovation in the VCS. Organisations, from large charities to small unconstituted groups, have stepped up to meet needs that statutory bodies could not, especially during lockdowns. Many had to adapt quickly to new ways of working and pivot their offer to new or emerging needs resulting from the pandemic.

During the earlier stages of the pandemic, VCS organisations saw a rise in demand for their mental health services and people presenting with more complex mental health needs. As well as creating and exacerbating mental health needs, the pandemic highlighted the inequalities that divide our society.

The sector played a critical role in supporting mental health within communities and lessening the strain on the NHS. It did this not only by providing extra capacity, but also by providing skills and expertise that were complementary to and distinct from those of statutory services.

These included:

- The ability to form trusting and equitable relationships with their service users
- The ability to quickly and creatively adapt to changing circumstances in consultation with their service users
- Experience addressing the social determinants of mental health (e.g. job insecurity, poverty and isolation)
- Experience working with marginalised communities who are often underserved by statutory services[74]

Two important ways in which the pressures on VCS organisations were eased during the pandemic were emergency funding and changes in relationships with key stakeholders. Positive changes included more dialogue, more trust and more flexibility. Many VCS organisations spoke about a more equitable and supportive dynamic that enabled them to focus on delivering services and responding to the needs of their community.

Many funders had taken a more flexible, pragmatic and supportive approach, providing extra funds, loosening targets and extending contracts. Several organisations had also been able to access emergency funding made available by the Government. This eased the financial pressures on some VCSE organisations during the early stages of the pandemic, allowing them to focus on delivering services. But it is not being sustained.

Some VCS services have seen the extra support they received during the pandemic start to recede. Emergency funding is being phased out, and, in some places, there has been a return to shorter-term contracts and more competitive bidding processes. At the same time, demand for services is rising, and the energy and morale of many staff are flagging. The sector will also be affected by changes in the wider system, as mental health services transition to Integrated Care Systems and work to deliver the Community Mental Health Transformation programme within a tight timeline.

If these trends continue, the distinctive skills and expertise of the VCS sector, which have made its mental health services a lifeline for many over the last three years, are likely to be compromised.

Local government funding has been particularly stretched over recent years. This has led many VCS organisations to seek more funding from the NHS or charitable and philanthropic sources. A number of VCS organisations have noted the practice of ‘more for less’ contracting from statutory bodies, where they are expected to deliver the same or more than previously but with lower budgets (Allwood and Bell, 2019).

It has also been observed that when funds are tight in statutory services, the VCS is seen as an optional extra and statutory providers “eat up” all the contracts:

“There is […] a sense that resources are being spread very thin and that often the [VCS] is seen as an afterthought or receives only the ‘crumbs’.”[75]

Thriving communities and the voluntary and community sector

Short-termism

For many VCS organisations, funding is limited by short-term contracts. These do not allow for the development of infrastructure or capacity. Even when short-term contracts are renewed yearly, delays to decision-making often mean that staff have to be put on risk of redundancy notices[76]. The recent Better Mental Health Fund was also limited by the time-limited nature of funding, which undermined relationships between councils and VCS providers (Woodhead et al, publication pending).

By contrast, smaller VCS bodies can struggle with bidding for long term contracts, as they may not be able to demonstrate the long-term need for the specific services they provide. This can exclude them from arrangements that could sustain them for longer[77].

Staff and volunteer health and wellbeing

Adapting to new ways of working while navigating the challenges of the pandemic hasn't been easy. One source of stress – enforced home-working – has ended for many. But another – heavy caseloads and high demand for services – continues. Coping with the pandemic has taken a toll on the VCS sector, as it has on others, and there are warnings of burnout if staff are expected to continue working at the same pace without additional resources or financial security[78]. This will be compounded for many by the cost of living crisis.

Inequities between larger and smaller organisations

Newbigging and colleagues[79] found that the likelihood of a VCS organisation obtaining grants goes up as the size of the organisation increases. Smaller organisations do not have specialist bid-writing teams and other infrastructure to compete equally with larger bodies. This leads to concerns that the creation of integrated care systems has further disadvantaged smaller organisations working in local areas or with specific groups within these large geographical areas with populations of well over a million[80].

Power imbalances

While more VCS organisations are being brought into statutory services, there remains a strong "payer-provider mentality," where statutory bodies continue to hold the power and VCS partners have a subservient role, dependent on the goodwill of their funders. This both reduces the ability of VCS organisations to influence the wider system (offering a complementary approach on a small scale, but not changing the overall picture) and risks undermining their vital advocacy work if they have neither the resources nor the freedom to speak out.

Acknowledging the impact of austerity

Many VCS organisations have traditionally been funded by public health grants and wider local authority sources. Since 2013 the public health grant, moved from the NHS to local authorities, has been cut by 24% and wider council spending power has fallen by a third. This central government imposed austerity has had a knock-on effect on resources available for the VCS. Local government and NHS commissioners are also under pressure to ensure value for money by being able to evidence outcomes from spending public money. Commissioners would often want to support the VCS with the skills and tools to provide evidence of positive outcomes but can lack the resource to do so.

Measuring what works

Conventional measures of value for money can be challenging for VCS organisations:

- They may require substantial infrastructure to collect data, e.g. on throughput
- Outcome measures may be simplistic or unrealistic (e.g. to evidence changes in wellbeing scores following brief interventions) or impossible to collect without adaptations to their context[81]
- Metrics and measures that are not relevant to a VCS organisation's work can distort activity in order to meet a commissioner's expectations (but in so doing, falling short of their potential)[82]

Thriving communities and the voluntary and community sector

Ways forward

Boosting the VCS's contribution to mental health support means addressing the 'class system' in both statutory and charitable funding that limits the potential of groups and organisations[83]. Whilst acknowledging that central government bbears ultimate responsibility for providing sustainable funding models rather than limited non-recurrent funds that organisations must bid for, there are steps that can be taken to strengthen the sector, iincluding:

Sustainable funding and investment

For many VCS organisations, the struggle for survival year to year limits their ability to focus on meeting people's needs. Regarding funding in the sector as a form of investment, and providing 'core' funding rather than limiting it to specific projects or contracts may enable more organisations to thrive, innovate and advocate freely.

Small grants

For smaller organisations and unconstituted groups, grant funding can make a big difference. Even in small amounts, grant funding enables groups to build their capacity and try new approaches without being tied to service specifications and contracts.

Fair contracting arrangements

There is no single model of contracting that works for VCS organisations of all kinds in all instances. More systems are now adopting 'alliance' contracting models with consortia of VCS organisations, often with a 'lead provider' that subcontracts for specific activities with smaller organisations[84]. This may provide a helpful framework for involving a range of providers within a system, but it requires a strong commitment to partnership working, shared decision-making, and supporting the entire workforce across the different sectors to collaborate on an equal basis.

Social value procurement

Public bodies can use their 'anchor institution' role in communities as a means of boosting VCS organisations in their localities. This can include buying goods and services from community-led organisations or local charities or social businesses:

"By supporting local businesses and other organisations to bid for and supply more of those goods and services, an integrated care system can support more local residents into decent employment and out of poverty. In doing so, the risk of them and their families becoming mentally and physically unwell reduces, and pressure on services falls as well.

Social value procurement, where the awarding of contracts is influenced by outcomes other than just quality and price, can also be used to support specific groups of people at higher risk. Some NHS mental health trusts have supported service users to establish social enterprises where they provide gardening, decorating, and cleaning services commissioned by local councils and other local anchor institutions. This fosters peer support, meaningful therapeutic activity and decently paid employment for people who may otherwise struggle in the job market.

Tenders for contracts should contain social value scoring to support local providers and those employing vulnerable members of the community. Very large tenders can often be impossible for local organisations to bid for, so it is also important to examine how contracts could be broken up into more manageable pieces and how local organisations could be supported to work together to supply them." [85]

Thriving communities and the voluntary and community sector

Evaluation

For many VCS organisations, it may be more helpful to use evaluation approaches rather than performance measures to understand the value they bring to a system. Where quantitative data is used within an alliance contract, it may be helpful to apply it to the whole partnership rather than the individual organisations[86]. For some VCS organisations working with specific communities or groups, culturally relevant outcome measures can be helpful[87].

Workforce development & wellbeing

Support for the skills, knowledge and wellbeing VCS workforce needs to be as robust as that for statutory sector workers[88]. Burnout is as great a risk in VCS organisations following the pandemic, as it is in the NHS or local government. Statutory bodies working with VCS partners may be able to offer support as part of their funding or contracting arrangements.

Recommendations for thriving communities and the voluntary and communities sector

Action	Rationale	Lead organisation/s
Integrated care systems should fund and commission voluntary and community sector partners to maximise their sustainability while retaining their independence, flexibility, and creativity. This may mean offering longer-term funding, encouraging provider alliance arrangements between voluntary and community sector organisations, and using grant programmes to support innovation.	There is good evidence that voluntary and community sector organisations can deliver better outcomes by tailoring support to diverse communities.	Integrated care systems/boards and their constituent NHS trusts and local authorities

Conclusion

Conclusion

The region's mental health has suffered during the Covid-19 pandemic and its aftermath, as it has across the UK and internationally. The job of this Commission was to try and understand why this is the case, why its effects have been so unequal, and what can be done about it. This report sets out to answer those questions and provide a way forward to boost the region's mental health and close some of the biggest gaps in wellbeing and outcomes.

Our mental wellbeing is determined by the places we live in, the experiences we have from early life onwards, and our chances in life. Our chances of having good or poor mental health are starkly unequal. So, improving mental health and wellbeing means addressing the economic and social inequalities that put some people at a higher risk than others, and means that very often, those with the poorest mental health get the least effective help.

We believe that it's vital to give every child a mentally healthy start in life. There are opportunities from conception into early adulthood to boost children and young people's mental health. Tackling child poverty would help to protect families and children from one of the biggest risk factors for poor mental health. And supporting schools and colleges to adopt 'whole school approaches' to mental health will create a stronger scaffolding of support around children and young people to protect their wellbeing while also boosting their attainment and learning.

We know that the cost-of-living crisis has put more people's mental health at risk. Therefore, taking action to protect people's incomes and prevent people falling into poverty will help to reduce the risk of mental health difficulties both now and later. From paying real living wages to helping people get payments they're entitled to, public bodies and employers can make a big difference, especially at this crucial time.

We see that racial injustice is toxic to mental health, and too often, the support available for mental health difficulties isn't good enough for people from racialised communities. Health and care services are not trusted by many communities to provide safe and effective support. This has to change. Working arm in arm with communities to deliver services that meet people's needs and are trustworthy must be the aim across our region.

Last year, the Commonwealth Games highlighted the value of physical activity for our mental as well as physical health. Now we have to grasp the opportunity to make physical activity more accessible to more people, especially those getting help for their mental health. This means creating safe and friendly environments for everyone and breaking down the barriers to a healthier way of life.

We are clear that mental health is made in communities. Thriving, inclusive and caring communities can nurture good mental health and wellbeing. Voluntary, community and faith organisations often have the knowledge and skill to promote good mental health, but seldom have the resources to fulfil their potential: they are too often short-changed with short-term contracts and insecure funding. We must boost the voluntary and community sector's voice and strength across the region so that no one's needs are ignored or sidelined.

Our recommendations offer a way forward for better mental health for all in the West Midlands. They won't bring about change overnight. They are long-term recommendations that will build a mentally healthier region: with mentally healthier schools and colleges, thriving communities, and more equitable services. By coming together and sustaining action to build a mentally healthier region, we will give more people a better chance in life and create a more just and equitable society for everyone.

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