

Centre for
Mental Health
Commission for Equality



Commission for Equality in Mental Health

Mental health for all?

The final report of the Commission for Equality
in Mental Health

Centre for Mental Health, November 2020

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FOREWORD

Inequalities in health, including mental health, have been highlighted in national reports for at least 40 years, from the publication of the Black Report in 1981 to the more recent Marmot reports (in 2010 and 2020).

Despite a panoply of policies and programmes that have sought to improve health, expand and reform health services and reduce health inequalities, these inequalities persist. And mental health inequalities have been some of the most entrenched.

Our call for evidence unearthed a wealth of examples of people trying to change this picture: from grassroots community-led work successfully engaging people who don't trust services, to systemic partnerships between civil society and statutory agencies to shift the way services are planned and delivered. But many of these approaches are isolated, often small scale and short-term.

Our diverse set of Commissioners was determined to set an agenda to generate change that is sustainable over time, and can operate at scale. That is why we have made practical recommendations for local action – that could be pursued now, in the context of Covid recovery planning and new networked systems in health and care – and for government, to support the initiatives and commitments that have the power to change lives within communities nationwide.

People directly affected by inequalities have spoken powerfully within and with our Commission. Their voices, views and activism are essential to guide developments, locally and nationally. One of the impacts of inequality is powerlessness and we want to replace that powerlessness with strong leadership of lived experience, and with accountability that puts organisations at the service of communities.

Inequality is not simply a fact of life. It damages people's wellbeing and causes harm that can last a lifetime. It doesn't have to be this way. Through concerted action, it can be changed.

Liz Sayce

Chair, Commission for Equality in Mental Health and Senior Visiting Fellow,
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SUMMARY

The Commission for Equality in Mental Health was set up in 2018 to explore what causes mental health inequalities, what perpetuates them, and what might help to break the cycle. This is the Commission's final report, drawing on evidence we have received during the last two years.

Our vision is of a society where everyone's mental health is valued throughout life. We believe it is possible to create better mental health in society through actions informed by evidence. We believe that a mental health system where inequalities are addressed and redressed is achievable.

Today, some groups of people have far poorer mental health than others, often reflecting social disadvantage. In many cases, those same groups of people have less access to effective and relevant support for their mental health. And when they do get support, their experiences and outcomes are often poorer, in some circumstances causing harm. This 'triple barrier' of mental health inequality affects large numbers of people from different sections of the population.

Mental health inequalities cause harm to individuals, families, communities and society as a whole. From rising antidepressant prescriptions to the growing use of the Mental Health Act, inequalities carry a heavy cost. Reducing mental health inequalities will have multiple benefits: better lives, a fairer society, and a stronger economy.

While mental health has become a bigger and higher profile policy imperative in the last two decades, the deep inequalities that cause mental health difficulties, and the stark inequalities in people's access to and experiences of mental health services, have been hidden in plain sight.

The Covid-19 pandemic has brought these injustices to the surface in the most tragic ways. But it also creates a unique window of opportunity for a new start. Social innovation has frequently followed national and international traumas: from World Wars to natural disasters. We must grasp this opportunity to think and act differently.

Mental health inequalities are economic and social inequalities. Inequalities in wealth, power, voice and autonomy weigh down on groups and communities that end up with the poorest mental health. Racism, misogyny, homophobia and other forms of oppression, discrimination and injustice heap layer after layer of pressure on communities and individuals, causing long-term harm.

Mental health inequalities are deeply rooted in society. But it does not mean they are inevitable. And they can no longer be ignored.

The Commission has explored a wide range of ideas to boost mental health equality. There are no simple solutions or overnight remedies for entrenched injustices. But we have found that effective action is possible. We need to scale up the best approaches, and for those with resources and power to invest differently. And we need communities, local organisations and national government to work together to generate change at scale.

Mental health is created in **communities**. It is not just the business of government or public services. It is a collective good and a collective responsibility. Businesses, charities, faith groups and others in **civil society** all have an impact on our wellbeing. Community initiatives provide opportunities for mutual aid, collective action and a positive identity for groups that have been poorly supported, unheard and dismissed.

Local authorities, city regions and devolved administrations across the country can take action to pursue mental health equality in their communities. By viewing the public's mental health as everyone's business and taking a holistic view, they can be a catalyst for system change, the redistribution of public resources and wider investment for mental health equality. This includes supporting inclusive education in local schools and colleges, improving digital connectivity where it is poorest, protecting low income areas at risk from flooding, and investing in safe, warm homes.

Public services need to change dramatically to better address mental health inequalities. Mental health support must be provided by services that are comprehensive, engaging, tailored to people's needs, holistic in their approaches, responsive to people's wishes, and accountable for achieving change. They can also reach out to communities more proactively, creating employment opportunities and skill-sharing with the people they serve. The Advancing Mental Health Equalities programme, instigated by NHS England, sets out a clear and comprehensive agenda for practical change in mental health services. The Commission hopes that this programme will receive the resources it requires to make a difference nationwide, and will continue to receive support from leaders nationally and locally for as long as it is needed.

National leadership is vital to back action to achieve mental health equality. While mental health equality begins in communities, backed up by local systems and services, national action and leadership is the keystone to enable change to happen. The UK Government has pledged to take action to prevent ill health, reduce health inequality, fund and reform social care, and 'level up' between communities across the country. Taking action to enable mental health equality will help it to achieve all of these ends. And in the aftermath of Covid-19, there is now a unique opportunity to 'reset' and 'build back better' as a result of the needs that have emerged and the endemic inequalities that have become so apparent during 2020.

In a system designed for equality, action would happen at each of these levels, for example to:

- Tackle poverty and financial inequality: for example through a Living Wage, workplace justice and a fairer benefits system
- Secure housing for all: including action to prevent homelessness, improve housing conditions and protect against climate emergencies
- Tackle racism and discrimination: for example addressing hate crime and ending 'hostile environment' policies
- Invest in early years: including a national programme to support positive parenting
- Support inclusive education: creating places where everyone can flourish and prevent discrimination.

Our recommendations identify some of the large scale changes that are necessary to make a system designed for mental health equality possible. They are not exhaustive, and they will not achieve results overnight. But taken together, they will reset the mental health system towards greater equality and help to break the triple barrier of unequal determinants, access and outcomes. They are:

1. Communities can lead the way in pursuing mental health equality: Communities can make a vital contribution by taking action to tackle inequalities and promote mental health and wellbeing inclusively. But they need investment from public bodies, charitable funders and civil society organisations to lead change. This should include sustainable funding for user and community-led organisations and robust partnerships, so that successful approaches can be scaled up and influence the whole system of services locally.

This is essential to address the determinants of mental health: community leadership and engagement could help improve people's lives, transform access by offering support people value, and change outcomes – all three elements of the 'triple barrier'. Community and user-led organisations would have the resources to enable people facing inequalities to have greater voice and power, to support people 'where they are', with help tailored to physical, cultural and social needs, and to influence public services through partnerships and learning.

2. Local authorities need an urgent funding boost to coordinate action to pursue mental health equality: Close working with partners in voluntary and community organisations, the NHS and other public services should include robust assessments of mental health inequalities locally, combined with action plans to close the gaps.

Local authorities have shown that they can build partnerships to help them to understand needs and assets in communities, identify gaps and inequalities in existing support available, and help develop practical solutions. But to fulfil their potential, local authorities urgently need funding to build their capacity to work in a collaborative way with communities.

3. Statutory bodies should maximise their role as anchor institutions in their local economies:

This should include applying inclusive economy principles to create employment opportunities, to boost community infrastructure, and make use of their assets. Local and combined authorities and devolved administrations can use their powers and responsibilities to boost inclusive economies.

Creating more inclusive economies will give local people more opportunities to participate in activities that improve their wellbeing, prosperity and life chances, and have greater influence over their environment. Inclusive employment opportunities will also help to develop a more diverse public service workforce, which better represents the communities which experience mental health inequalities and which offers decent employment conditions including a living wage.

4. Mental health services must implement the *Advancing Mental Health Equalities* strategy in full:

The strategy must be given the necessary resources, senior leadership commitment and time to make a difference. Crucial action to support system change and build a more diverse and capable workforce to challenge mental health inequalities will require consistent and persistent leadership. It must not be a short-term or marginal activity that gets abandoned if it does not generate immediate results.

Fully implemented, the strategy will facilitate urgently needed improvements in mental health support: improving access, experience and outcomes for groups that currently miss out. It will increase transparency about how well NHS organisations are addressing mental health inequalities, which will enable greater accountability.

5. Mental health services should provide a genuinely ‘whole population’ offer:

No one must be left behind or left out. New organisational networks – like Primary Care Networks and Integrated Care Systems - should collectively rethink the whole system of services and change the way they are designed so that they specifically redress inequalities and provide holistic support, including with work, housing and money advice. This would help build trust with different local communities and communities of interest.

A whole system approach to mental health services should mean no one is left out because of gaps between different services – so people are offered support quickly and not made to ‘battle’ for help. It should mean working in partnership with local and specific communities to ensure services meet the greatest local needs and redress inequalities in access, experience and outcomes.

6. Mental health services should be accountable for reducing inequalities in access, experience and outcomes:

This should include accounting to local communities for the steps they have taken and progress they have made towards closing gaps; and transparent publication of progress with benchmarking against other services.

Increasing accountability can lead to improvements in service delivery, produce more learning about what works in addressing inequalities, and foster more trust between communities and statutory services.

7. The Government must tackle poverty and commit to reduce income and wealth inequality:

This should include learning from academic work on the best economic and regulatory approaches; taking steps to institute a Living Wage and Living Hours nationwide; a reset of the social security system to provide security, reduce poverty and promote social solidarity; and the adoption of effective employment programmes such as Individual Placement and Support.

Reducing inequality of wealth and income would reduce the number of people who experience poor mental health and also offer people who experience mental health challenges greater security and better opportunities to lead fulfilling and valued lives.

8. The Government must commit to tackling all forms of racism, discrimination and exclusion:

This should include action to address injustices in public life and public services (in education, criminal justice, housing and employment, for example) and a commitment to end ‘hostile environment’ policies.

Addressing these injustices will help break the cycles of discrimination which lead to mistrust, trauma, and fractured relationships between those who experience the poorest mental health and the services that should keep them safe and healthy. This needs leadership from national government, but it can also be led by combined and local authorities, NHS organisations, police services and other public sector bodies.

9. The Government should set a clear ambition and roadmap for achieving mental health equality:

This should include both immediate and long-term actions to be taken in all departments to enable action towards mental health equality. It should also include an agreed set of measures to assess progress towards this ambition, including public health metrics for local authorities.

Embedding accountability and establishing clear actions across government will drive an immediate response to the inequalities illuminated and exacerbated by the pandemic and create a legacy that tackles mental health inequalities and enables the population to thrive longer term.

10. The Government should refresh and update the Public Sector Equality Duty: It should strengthen the positive requirement for public sector organisations to take steps towards equality in all aspects of their work: including in the development, commissioning and design of services, not just in the ways they are provided to individuals. This should apply to all of the existing ‘protected characteristics’ of the Equality Act and to inequalities in wealth, by commencing and fully implementing the ‘socio-economic duty’ in England, as it is in Scotland and Wales.

This enabling measure would create a bedrock for mental health equality by deepening the duties on public bodies to pursue equality and ensuring that wealth and income inequalities are given the same status in the implementation of the law as the other nine protected characteristics. It would also extend accountability by placing greater expectations on organisations to demonstrate to their public how they are addressing inequalities and what progress they are making to close gaps.

Key contributors to mental health equality



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On behalf of the Centre and the Commission, we want to thank all of the individuals and organisations who have given us their time, their experience and their evidence. It is their insights that have enabled us to build up an understanding of what mental health inequalities feel like, how they are perpetuated, and what might be done to break the cycle.

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1. INTRODUCTION: WHY DESIGN FOR EQUALITY?

What mental health inequality feels like

“Everyone has their stereotypes and their little prejudices in their own head... But...the problem [is]...the media perpetuates it and even those guys who are not naturally outgoing racists, they see you, you fit the description...and they make those assumptions...I know it’s the truth anyway ’cos even with us we do it, if we see a man dressed exactly the same as us from a different postcode then we automatically assume that he’s a gang member as well...you get me – ’cos you’re receiving the same images.” (Khan et al., 2017)

“It’s psychologically damaging to think, at that young age, that you’re different, that you can’t do anything and that your life is almost over before it begins. So when you’re almost mentally segregated and pushed away, well - it’s going to cause immense mental problems.” (Khan et al., 2017)

“My daughter went through CAMHS at around 14 with severe anxiety in at school. We were told there would be no treatment, because ‘autistic people ARE anxious’.” (Harper et al., 2019b)

“Growing up gay under Section 28 was incredibly difficult and isolating – I felt like there was no one else out there like me. Even though I had loving parents who made it clear that I would be accepted, not hearing this message from outside of the home led me to believe that I wasn’t ‘normal’ and there was something inherently wrong with me. The shame I experienced during this time has left a lasting impact, and I have spent a long time trying to overcome the effects of this.” (LGBT Foundation, 2020)

“Once you’re a kidney patient, you are a kidney patient for life... Every time you are admitted or have a procedure you go into that carrying all the trauma from previous procedures. Trauma that has had time to grow and solidify in your head. Then you are made to feel like you are overreacting. This often leads to you feeling even worse. Shame, self-doubt and criticism all mix in with the trauma

and make de-escalating your reaction harder and harder... I think all too often the medical professionals hugely underestimate the burden that we carry and minimise the psychological effects of this burden.” (Centre for Mental Health and Kidney Research UK, 2020)

“I have a severe anxiety disorder and therefore I rarely leave my house except for going to work. I’m fairly certain the reason I rarely experience harassment anymore, and haven’t in the last year, is simply because I go to great lengths to hide from it, not because there has been any great change. I experienced harassment and violence because I was/am known to be trans in my small town on a daily basis for many, many years. I have been hit, kicked, tripped, spat at, cornered, I was even whipped across the face with a skipping rope once in the street. I’ve been called just about every vile name under the sun.” (Bachmann and Gooch, 2018)

“I was assessed for NHS treatment – therapy – and the doctor who saw me asked if I felt it was worth my while looking for treatment, now that I was on the run down to the end of my life!” (Seaman et al., 2020)

Our ambition

“I can find my people... You can take your armour off. You don’t have to explain.”

Our ambition is to stimulate action that will achieve a sustained reduction in mental health inequality, and as a result create a fairer and healthier society for all.

We want to spark a seismic shift in the way mental health inequalities are addressed at different levels: from communities in every corner of the country to national policies and strategies.

Our vision is of a society where everyone’s mental health is valued. We believe it is possible to create better mental health in society through actions informed by evidence. We believe we can create a mental health system where inequalities are addressed and redressed.

“They don’t ask your history, or what you look like, or how you dress, they came with open arms and gave you a fresh start. They put people first and they always stand for us, even though we cause headaches.”

Mental health inequality is a stain on our society. That poor children are four times as likely to have a mental health problem before they leave primary school than their wealthy peers is unacceptable. That Black people are three times as likely to be sectioned under the Mental Health Act is a scandal. And that older people get so little help for their mental health is intolerable in a society that believes in fairness and social justice. We have known this for decades and accepted it as the norm for too long.

Mental health inequality has been ignored for too long. While mental health has become a bigger and higher profile policy imperative in the last two decades, the inequalities that cause mental health issues, and the inequality in accessing and experiencing mental health services, have been hidden in plain sight. And while the Equality Act 2010 placed a duty on all public services to promote equality, implementation of that duty has been patchy.

The Covid-19 pandemic has shone a light on structural inequalities at the heart of our society. Higher mortality rates among some groups of people, and evidence of the unequal mental health impacts of the virus have made this more urgent than ever. However, if we only respond to the pandemic we are at risk of missing the point. For too long we have normalised that people are low-paid, that they live in over-crowded housing, that they live in food and fuel poverty and that they have poor mental health. The unimaginable events surrounding the death of George Floyd, events that have resonance for many people living in the UK, mean that we cannot ignore that much of this is driven by structural and institutional racism at the heart of our society.

The crisis does, however, create a unique window of opportunity for a new start. Social innovation has frequently followed national and international traumas: from World Wars to natural disasters. We must grasp this opportunity to think and act differently.

“...if you are in debt and depressed, get debt advice not anti-depressants; if you are depressed because you are experiencing racism, work with others to stand up against racism...”

We make practical recommendations for local and national action that could start to create a fairer and healthier society for us all to live in. We know that mental health equality cannot be achieved overnight: it is too entrenched and has been sidelined for too long. But with a concerted effort, we know that change is possible.

Our approach

The Commission was set up in 2018 to explore what causes mental health inequalities, what perpetuates them, and what might help to break the cycle. There have been multiple reports, investigations and inquiries into a wide range of mental health inequalities. Many have made far-reaching and sensible recommendations. Yet little has changed. The gaps remain, and lives are damaged and even lost as a result.

Our aim is to go beyond the statistics to understand what drives mental health inequalities and why they are so stubbornly entrenched in our society. We wanted to explore the interlocking nature of mental health inequalities: not just to look at a single dimension or a single part of the system.

Commission members were recruited through open advertisement in 2018 and selected for their personal and professional knowledge and experience of mental health inequalities. We also brought together an advisory group of people with expertise in specific areas of mental health inequality to help us to build a rounded picture.

We issued an open call for evidence for the Commission in late 2018 which remained open for six months. In that time, we received more than 100 items of evidence from individuals, organisations and groups. We also explored recently published evidence on mental health inequalities and reviewed national mental health policies, data and intelligence.

We also undertook a number of visits, interviews, evidence sessions and focus groups, including in London, Great Yarmouth, Manchester and Oldham. We especially sought evidence from organisations working in communities whose voices are rarely heard nationally, but whose insights have given us a fuller picture of how mental health inequalities manifest and what can be done to address them.

The Commission's primary focus is on England, though we have reviewed evidence and intelligence from across the UK. Our recommendations focus on England as the policy environment and institutional arrangements differ across the 4 nations of the UK. Nonetheless, all of our recommendations could be applied in any part of the UK or beyond.

Throughout the Commission's investigations, we sought evidence at a number of different levels. We wanted to know about the determinants of mental health inequality as well as what stops people with the poorest mental health from getting access to support, and why the same people have poorer experiences and outcomes from services. We also sought evidence about what could change this at multiple levels, including within communities and civil society, in local and regional systems, and in national policies.

During this investigation, a lot has changed. Mental health inequality has started to get some more attention nationally in England. The Advancing Mental Health Equalities strategy in particular has committed NHS organisations to take significant steps towards some of the changes we know are necessary to reduce inequalities in mental health care, for example through the Patient and Carer Race Equality Framework. We have also this year seen a change in the level and intensity of debate about racial injustice through the growth of the Black Lives Matter movement. This has special resonance in mental health services and in Black people's experiences of systemic racism.

Throughout our work, we have incorporated knowledge and understanding from these developments. Our recommendations are designed to stimulate action to build on the steps that have been made so far, to extend our shared ambitions and expectations for mental health equality, and to complement the work of the many others who are actively pursuing it.

Our main findings from the evidence gathered for the Commission have been published in a series of briefings. They explored the causes of mental health inequalities and what might help to address them.

The conclusions of this report reflect the consensus achieved between Commission members and do not necessarily represent the views of any individual member.

In this report, we set out the actions we believe are necessary to create a system designed for mental health equality. Our recommendations focus on the major system changes that are needed to address mental health inequalities. They begin at the community level, where mental health can be both sustained or damaged, before exploring the roles of civil society, local systems, public services and finally national policies. We have taken this broad approach because it is clear that systemic change that makes a difference must come from action at every level that adds up to something bigger and greater still.

First, we have drawn together the main insights drawn from the evidence.

2. MENTAL HEALTH INEQUALITIES

Some groups of people have far poorer mental health than others. In many cases, those same groups of people have less access to effective and relevant support for their mental health. And when they do get support, their experiences and outcomes are often poorer, in some circumstances causing harm. This ‘triple barrier’ on mental health inequality affects large numbers of people from different sections of the population .

- Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20% (Morrison Gutman *et al.*, 2015)
- Children and young people with a learning disability are three times more likely than average to have a mental health problem (Lavis *et al.*, 2019)
- Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk, and are more likely to be diagnosed with schizophrenia (Khan *et al.*, 2017)
- 70% of children with autism (Simonoff *et al.*, 2008) and 80% of adults with autism (Lever and Geurts, 2016) have at least one mental health condition (Autistica evidence to the Commission)
- Women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives: of those who have, 36% have attempted suicide, 22% have self-harmed and 21% have been homeless (Scott and McManus, 2016)
- Deaf people are twice as likely to experience mental health difficulties (All Wales Deaf Mental Health and Well-Being evidence to the Commission)
- People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people, and the gap is greater for older adults (over 55 years) and those under 35 (Semlyen *et al.*, 2016)
- Half of LGBT people (52%) said they have experienced depression in the last year. One in eight LGBT people aged 18-24 (13%) said they’ve attempted to take their own life in the last year. Almost half of trans people (46%) have thought about taking their own life in the last year, 31% per cent of LGB people who aren’t trans said the same (Bachmann and Gooch, 2018).
- Older adults (over the age of 65) account for only 7% of people who use NHS Improving Access to Psychological Therapies (IAPT) services (NHS England, 2017)
- People living in more deprived areas of England are more likely to be referred to an IAPT service by their GP but are substantially less likely to receive a complete course of treatment (Hodgson, 2019) or to make a successful recovery (Baker, 2020).
- Recovery rates in IAPT services are lower for bisexual people (43%) and lesbian and gay people (49%) than for those identifying as heterosexual (53%) (NHS England, 2020).
- Almost one in four LGBT people (23%) have witnessed discriminatory or negative remarks against LGBT people by health care staff, and 14% of LGBT people have avoided health treatment because of worries about discrimination.
- Black people are three times more likely than white people in England to be sectioned under the Mental Health Act, and they are eight times more likely to be given a Community Treatment Order that limits their freedoms when they leave hospital (NHS Digital, 2019).

These inequalities do not happen in isolation from each other. For many people, they are interlocking. For example Black people in the UK are more likely to be on lower incomes and live in more deprived neighbourhoods. And within Black communities, women and girls’ experiences will be different to those of men and boys, and those identifying as LGBT+ may face bullying or hate crime that additionally impact on their mental health.

The ‘triple barrier’ bears down more heavily on communities and individuals facing the most and biggest risks to their mental health and the least protection for it.

Mental health inequalities cause harm to individuals, families, communities and society as a whole. From rising antidepressant prescriptions to the growing use of the Mental Health Act, inequalities carry a heavy cost. School exclusion, homelessness and imprisonment are too often the results of unresolved mental health inequalities. Tragically, suicide is also linked to inequality: lives lost from which we must learn to save others (Samaritans, 2017).

The causes of mental health inequalities

Anyone can have a mental health problem – and most people do at some point in their lives – but our chances of having good or poor mental health are far from equal.

The risk and protective factors for mental health are the things in our lives that either harm or help our mental health. The determinants of mental health relate to the balance of these factors in our lives. Understanding these determinants is essential to inform any action to address mental health inequalities.

Despite this, explanations for mental health inequality have tended to focus on the innate qualities of those affected by them: for example

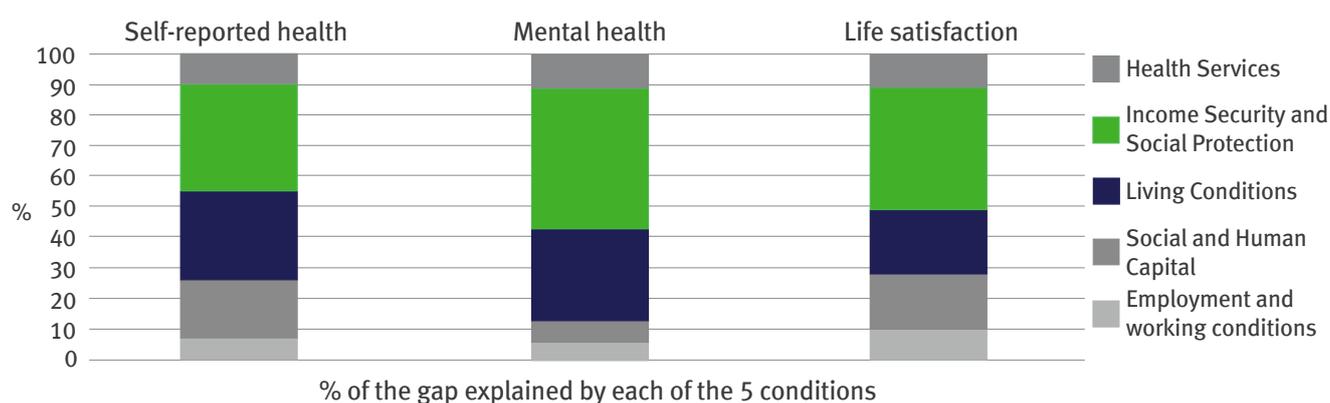
in seeking genetic or cultural explanations for variations in mental health or ‘resilience’ between ethnic groups, or looking for personal traits, or ‘character’, that increase an individual’s risk. Some attempts to explain mental health inequalities have homogenised diverse experiences into generalisations and stereotypes (Barnett *et al.*, 2019). Few have explored the interlocking nature of inequalities across multiple dimensions (for example how a person’s gender or age might affect inequalities relating to race or wealth). Even fewer have sought to understand mental health inequalities from the perspectives of those who live with them every day.

Throughout the Commission’s work, it has been clear that mental health inequalities are economic and social inequalities. Inequalities in wealth, power, voice and autonomy weigh down on groups and communities that end up with the poorest mental health. Racism, misogyny, homophobia and other forms of oppression, discrimination and injustice heap layer after layer of this ‘allostatic load’ (Kelly-Irving, 2019) on the same shoulders. And this, over time, erodes wellbeing at both an individual and collective level.

Wealth

Financial inequality and material deprivation are major drivers of mental health inequality. According to the World Health Organisation (2019), 76% of mental health inequality is a consequence of economic inequalities (in income, housing and financial security, see Figure 1).

Figure 1. The five conditions’ contributions to inequities in self-reported health, mental health and life satisfaction (EU countries)



Adapted from World Health Organisation (2019)

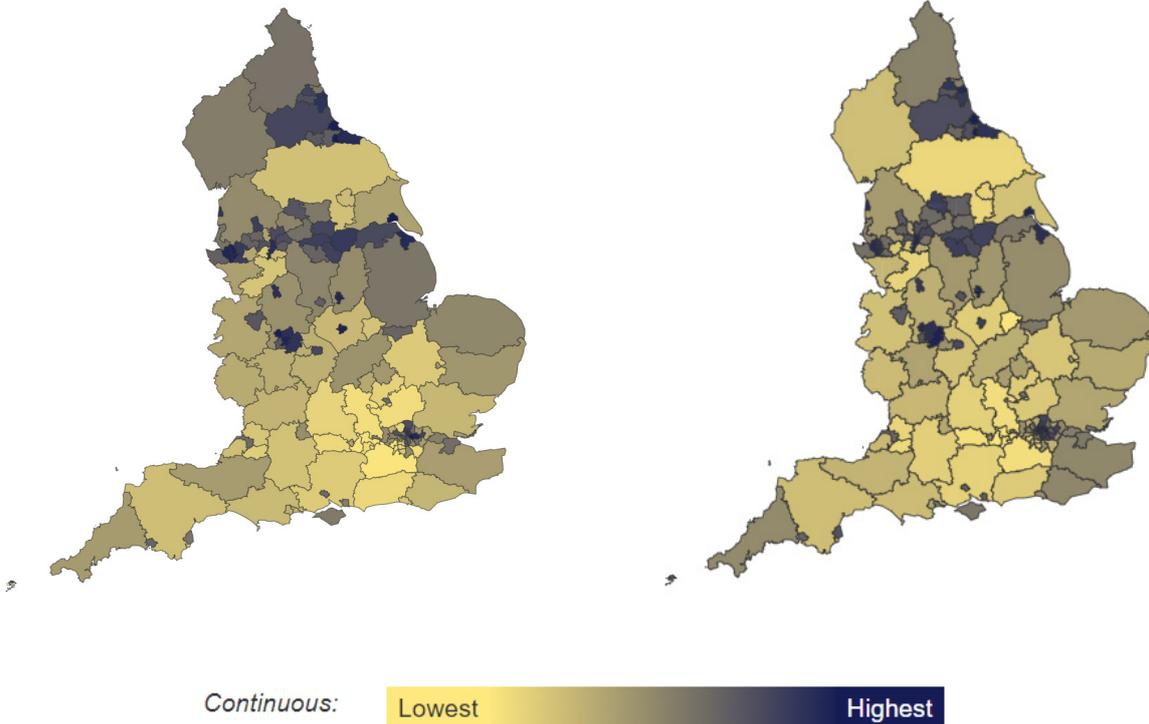
International evidence points to two important conclusions:

First, it is clear that poverty is toxic to mental health. Being poor, in both absolute and relative terms, harms mental health and increases likelihood of mental ill health. Child poverty in particular is not just a short-term risk to mental health: it has an effect throughout life. For

example, children with poor mental health – which is strongly associated with family poverty and disadvantage (see Figures 2 and 3) – go on to experience multiple disadvantages throughout their lives. And economic ‘shocks’, such as job losses or reductions in income, can have a major effect, with some evidence that there may be a bigger effect for women than for men (Ridley *et al.*, 2020).

Figure 2: Map of County & UA (pre 4/19)s in England for Estimated prevalence of emotional disorders: % population aged 5-16 (Proportion - % 2015)

Figure 3: Map of County & UA (pre 4/19)s in England for Children in low income families (under 16s) (Proportion - % 2016)



Used with permission from Public Health England

Second, economic inequality affects mental health collectively. More unequal societies have higher levels of mental ill health, and when societies become more unequal, rates of mental ill health go up too (Patel *et al.*, 2018). The UK has had a high level of inequality for several decades and has greater inequality of income than most comparable countries (Sowels, 2018).

On top of this, there is evidence that the effects of poverty on mental health are not the end of the story. Poor mental health that arises as a consequence of poverty translates into later physical health problems (Kivimaki *et al.*, 2020). Mental health inequality is the ‘missing link’ between poverty, physical ill health and shorter life expectancy.

Linked to financial inequality, housing inequality is another major risk factor for poor mental health. Homelessness, housing insecurity and poor quality housing all affect mental health. Becoming homeless has been described to the Commission as a ‘trauma’ in people’s lives, frequently following on from other traumatic events such as a severe financial loss, abuse and violence. Poor housing conditions, such as damp, leaks and cold, affect mental as well as physical health, and the longer people are in poor quality accommodation the greater and more persistent the impact (Pevalin *et al.*, 2017). This is a major concern for growing numbers of people with a mental illness living in private rented accommodation (Brown, 2019b).

Likewise, unemployment is a major risk factor for poor mental health. Long-term unemployment,

especially in areas where this is widespread, has been linked to a higher risk of depression and higher rates of antidepressant prescribing (Thomas *et al.*, 2018). Higher unemployment does not just affect the mental health of people who are out of work: it can also drive insecurity and lower pay for those in work, which are also major risk factors for mental ill health.

Figures 4 and 5 compare levels of deprivation with rates of common mental health problems among adults in England. Youth unemployment has also been identified as a major long-term risk to mental health, with a ‘scarring’ effect that lasts long into adult life (Bell & Blancheflower, 2011). This will be an especial risk in the near future, with rising levels of unemployment among young people following the pandemic.

Figure 4: Map of County & UA (pre 4/19)s in England for Estimated prevalence of common mental disorders: % population aged 16 & over (Percentage point - per 100 2017)

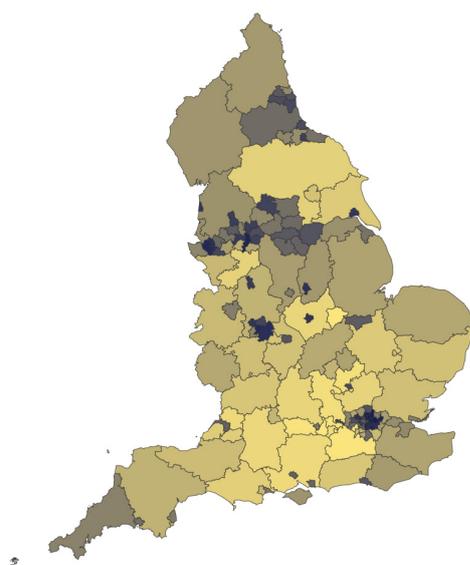
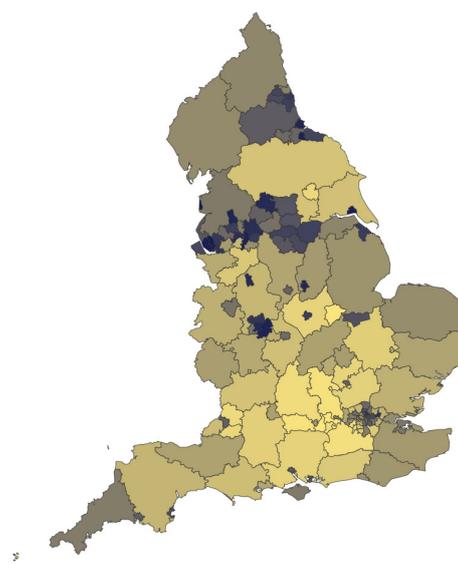


Figure 5: Map of County & UA (pre 4/19)s in England for Deprivation score (IMD 2015) (Score - 2015)



Continuous: Lowest Highest

Used with permission from Public Health England

Explaining how income and wealth inequalities may harm mental health, Wilkinson and Pickett (2018) argue that more unequal societies create stronger narratives about ‘superiority and inferiority’ which increase stress levels in individuals. People who lack money and status may feel social anxiety and shame, which feed into instincts for withdrawal and subordination, increasing vulnerability to mental ill health. Even

those with relative financial power are affected, as inequality can make them fear losing their position when there is ‘further to fall’ in an unequal society. Other explanations centre on the fact that poverty generates greater exposure to adversity – for example to violent crime – and the stress of the struggle to survive day to day with minimal resources (Ridley *et al.*, 2020).

Power

Inequalities in income and wealth do not act alone in creating mental health inequalities. Power inequalities have a profound impact on our mental health, too. Having a voice (and being heard), being able to make decisions in life and being treated justly are all essential ingredients for good mental health. For groups of people experiencing the highest levels of mental health difficulty and the lowest wellbeing, these basic needs are often a constant struggle.

Inequalities in power reach into every aspect of society. In schools, for example, they can have visible manifestations, in homophobic bullying or in the higher use of restrictive interventions and exclusions on Black or disabled children (EHRC, 2018). But they can also occur under the surface in the education system's "hidden curriculum... which perpetuates disadvantage in education along class lines" such as streaming, school trips, sports and assemblies as well as the broader social 'segregation' between schools (Morris *et al.*, 2019).

In adult life, power inequalities can emerge strongly in workplaces, where bullying, unfair treatment, unrealistic expectations and a lack of control over the work environment are major risk factors for poor mental health (Harvey *et al.*, 2017). Again, this can occur at the individual level but it can also apply across an organisation – where experiences or perceptions of procedural injustice may increase risks to mental health for everyone.

Inequalities in power and privilege frequently intersect with 'protected characteristics' such as race, religion, disability, sexuality, gender and gender identity; and also with social class. Experiences of interpersonal violence are especially significant for women's mental health, with clear evidence that violence and abuse is connected to mental ill health, and that the severity and duration of abuse is a major determinant of later distress (Scott & McManus, 2016). Hate crime is also a major risk factor for poor mental health: research has shown that both physical and mental health harm is greater and more prolonged where someone is a crime victim because of their race, religion, gender, sexuality or disability (Diverse Minds, 2018).

Once again this can happen at the individual and collective level. For an individual, being subject to racist abuse or discrimination is a traumatic and harmful experience. But for a community, exposure to others' experiences and the fear of abuse can have a collective impact on mental health. Seeing people who are Black or Muslim or trans or disabled repeatedly being treated unjustly, either in person or on television or social media, can have a profound cumulative impact.

Worryingly, many of these experiences are repeated in people's attempts to get support for their mental health. For some communities, mental health services are not seen as safe or trustworthy. For example, many women experiencing perinatal mental health difficulties, and especially those from marginalised communities, express fear that if they disclose and seek help they will be treated punitively and risk losing their baby (Khan, 2015). And young people from marginalised communities describe how previous experiences of discrimination from statutory services undermined their trust in the whole system:

"Once you've been failed in one part of the system...forget about it... They don't care about me. If I don't feel safe, I'm not going there."
(Evidence from young person to the Commission, February 2020)

For people who do get help for their mental health, experiences of compulsory and coercive treatment can similarly mirror and thus reinforce the traumatic experiences that caused their distress in the first place. This is a particular risk for women and girls, both in formal mental health services and in other public services they encounter (Bear *et al.*, 2019).

The clearest expression of this phenomenon remains the 'circles of fear' between Black communities and mental health services in the UK, described by Keating and colleagues nearly twenty years ago (2002). Sadly there is no evidence that this relationship has changed markedly in the two decades that followed their landmark report; instead it reinforces itself in the many interactions between Black communities and public services.

Recent research from the Synergi Collaborative has sought to understand how Black people’s experiences of racism prior to making contact with mental health services get repeated or reinforced. They note that while there is little evidence of explicit discrimination within mental health services, microaggressions, “behaviours and communications [that] can signal prejudicial attitudes, a lack of trust, fear or avoidance” (and the denial of them) have a cumulative impact on mental health and on people’s trust in and sense of safety within mental health services. “Structural and organisational racism,” they note, “reflect broader conditions in which all varieties of racism thrive” (Bhui *et al.*, 2018). It has also been noted that the mental health services workforce is not representative of the communities it serves (Dyer, 2020), especially in more senior roles.

What perpetuates mental health inequalities?

Mental health inequalities have been reported for decades. They are widely known and frequently described. Yet they have persisted, even as political interest in mental health has grown. Understanding why little has changed is critical to breaking the barriers.

An individualised approach to public mental health

As public awareness and understanding of mental health have grown in the last two decades, the dominant narrative has focused on mental health as something we experience alone. We are impelled to ‘look after ourselves’, to be more ‘resilient’ and, if we’re having problems, we are told to ‘just talk’. While these narratives are helpful for some, and have helped to demystify and to an extent destigmatise mental ill health, they miss the point for many. This reflects a phenomenon in the wider public health field known as ‘lifestyle drift’ (Popay *et al.*, 2010). While it is well known that the determinants of health are structural and collective, investment and resource allocation in public mental health tend towards interventions targeting individual ‘behaviour’ (Williams & Fullagar, 2018). And this is surrounded by a continued belief that our mental health is determined by our ‘character’ or our personal ‘resilience’.

This approach is often mirrored in people’s experiences of mental health services, too. While there is a growing movement to adopt a ‘social model’ of mental health, the balance within services is often still skewed towards a more ‘clinical’ approach that places people in isolation from their communities – sometimes literally where people are placed in units far from home for long periods of time (CQC, 2019b); and sometimes simply by treating the individual’s symptoms without support to address the life challenges that are the context of distress.

Discriminatory narratives

There is also evidence that the way mental health is understood remains unequal, with discriminatory narratives applied to some social groups. A recent exploration of this phenomenon, in relation to systemic racism in medicine in the US, noted that:

“...the history of medicine and public health in the United States reveals a pattern of medicalizing the suffering of White communities while ignoring or criminalizing the similar suffering of minority communities, especially Black communities. This dichotomy is particularly stark with regard to issues at the intersection of health, politics, and law. That our collective awareness comes only in the wake of a global protest movement for racial justice highlights the pervasiveness of our collective biases and wilful ignorance” (Paul *et al.*, 2020).

This dichotomy reflects many of the key themes in the Commission’s investigations. The predominance of the ‘medical model’ in mental health services has been extensively challenged in recent years, led by campaign groups from the mental health service user and survivor movement. Their voices have helped to shift the focus of mental health services slowly towards a more ‘social’ model which appreciates that people often need their social and economic environment to change, rather than just be supported to ‘fit in’ to the environment as it is. But this has not been the case for everyone. And for African and Caribbean communities in particular, from childhood onwards responses to distress are more likely to be punitive – including the use of restrictive interventions in school, the involvement of the police in admission to hospital and the use of physical restraint in mental health services.

National policies and strategies

National policies, strategies and approaches to mental health in England have, with some notable exceptions, given limited attention to equalities. The leading imperative for most national policies since the 1999 National Service Framework for adult mental health services has been to increase the supply of mental health care in response to growing demand for support. Political and public pressure to expand provision, to speed up access to treatment and to improve crisis care (all quite reasonable ambitions) has left relatively little room for innovation or for a focus on groups of people who do not find existing service models helpful (Bell, 2016). Approaches to recovery and inclusion have however grown. The best mental health support is focused on people's assets and hopes, including in relation to removing barriers of inequality, and offering properly supported peer support opportunities – but these approaches are not yet the norm across all services.

Often, equality has been an afterthought in these strategies, with little clear direction or resource given to it. Separate strategies to address specific inequalities have been produced at times: including the 2002 *Women's Mental Health: into the Mainstream* policy and the 2005 *Delivering Race Equality* strategy, which began a five-year work programme that included training, data collection and appointing 'community development workers' (Wilson, 2009). While this enabled some valued work to take place, it was discontinued in 2010 and has had little long-term impact on Black communities' experiences of mental health care. Both policies sought to shift long-term, systemic inequalities, abuses and injustices, but within very short timescales. More recently, the Women's Mental Health Taskforce report set out a range of actions required to address gender inequalities in mental health care, though with little clear evidence of follow-up action or additional resources (DHSC, 2018).

Within social care services, there has been a recent emphasis on human rights and strength-based services that is replacing the original 'care management' approach. This approach emphasises ensuring that people can access their rights under the Care Act, based on equality. It uses a personalised approach and recognises people's strengths within their communities. However, the impact of this has been reduced by the budget cuts to local councils over recent years and delivering this policy has been challenging for local councils.

Most mental health strategies have focused predominantly on statutory mental health services, with little influence on policies outside health and care. This has intensified since 2015, when the locus of mental health strategy development shifted from the Government to its Arm's Length Bodies. It is harder for an executive agency overseeing, for instance, the NHS to have major impact on government policies in critical areas such as housing or education. They can offer advice to government and other public bodies, but little more. Yet without making these changes to wider systems and services, we risk continuing a cycle of expanding mental health services without taking steps to reduce the need for them.

In October 2020, a more promising development occurred when NHS England published the *Advancing Mental Health Equalities* strategy (NHS England, 2020). The strategy sets out plans to address inequalities in mental health services through support for local systems, improved data collection and use, and steps to build a more diverse workforce with the skills to bring about change (Dyer, 2020).

Austerity

The Commission has also received evidence about the impact of austerity on mental health inequalities across a range of domains. International evidence identifies austerity policies, which have been predominant since the 2008 recession, as a major threat to health, and especially mental health (Stuckler and Basu, 2013). Austerity affects mental health in multiple ways: for example by reducing the value of social security benefits and reducing the provision of services that promote mental health in communities, such as early years, youth work and social care services for adults and children (IFS, 2019). While austerity measures have had a widespread effect across society, Toyne and Walker (2020) note that some of the biggest cumulative effects are felt by children and young people, resulting from disinvestment in early years services, arts-based activities in schools, libraries, youth services and benefits payments for families.

Perversely, austerity policies tend to direct public spending to high-cost crisis services by reducing spending on services that prevent problems or intervene earlier (O’Shea, 2019a).

Successive changes to social security policies in Britain appear to have had a significant cumulative impact on mental health. Research has identified that policies that have restricted access to benefits (for example by limiting eligibility or changing assessments), reduced their real terms value (for instance, through the benefit freeze) and made the system more demanding of individuals (for example by introducing conditions and sanctions) have each increased the risk of poor mental health among some of those relying on them. The introduction of Universal Credit has been found in one study to have worsened mental health among unemployed people who moved to the new benefit between 2013 and 2018 (Wickham *et al.*, 2020). Other studies have found that reductions in Housing Benefit for private renters in 2011 increased the prevalence of depression among this group (Reeves *et al.*, 2016) and that the Work Capability Assessment is associated with increased mental health problems and antidepressant prescriptions (Barr *et al.*, 2016).

Adding these individual system changes together in the context of high economic inequality, the cumulative impact on mental health is likely to be substantial.

There may – despite the huge economic challenges attendant on the Covid pandemic – be opportunities for government to reset social security policies in the light of: its commitment to ‘levelling up’; its learning from temporary Covid-related changes to social security; the national and international shifts away from policies of austerity; and the growing international concern about the impacts of economic inequality on health (and especially susceptibility to the virus).

Invisibility

The Commission has found that data and intelligence about inequalities within mental health services has been scant. For example, we have data on the dramatic inequalities between ethnic groups in the use of the Mental Health Act, but we do not know about how this overlaps with gender or age. The experiences of disabled people, of LGBT+ communities or of older citizens of mental health support are invisible in routine data. This lack of transparency undermines accountability: how can we hold systems to account if we do not know what or how they are doing?

One element of the mental health system, Improving Access to Psychological Therapies (IAPT), offers a partial exception. Here, we can see that with each decile (10% of the population) of deprivation, people are more likely to be referred to IAPT services – reflecting the higher risk of depression or anxiety. But at each stage of the IAPT system the graph goes into reverse. People from more deprived neighbourhoods are less likely to begin treatment, less likely to complete treatment, and less likely again to recover or see an improvement in their mental health (Baker, 2000; Hodgson, 2019). Incrementally, poorer people are getting a poorer experience of the system. A system designed to be fair and equal – like all parts of the NHS – is quietly producing poorer outcomes piece by piece.

Under the Care Act, everyone has the right to an assessment of need, as do their carers. However there is concern that people with mental health issues do not always get access to their rights under the Care Act either due to a lack of coordination across health and social care services, or the effects of austerity on councils.

For some groups of people, invisibility leads to major gaps in support despite higher levels of need. Autistic people, for example, describe finding mental health services poorly adapted to their needs or that they are “routinely denied access to mental health support for arbitrary reasons” (Harper *et al.*, 2019). Likewise, research with young people with learning disabilities has identified a culture of ‘diagnostic overshadowing’, in which their mental health difficulties were overlooked because of their disability (Lavis *et al.*, 2019). And similar situations have been described by people living with long-term physical conditions.

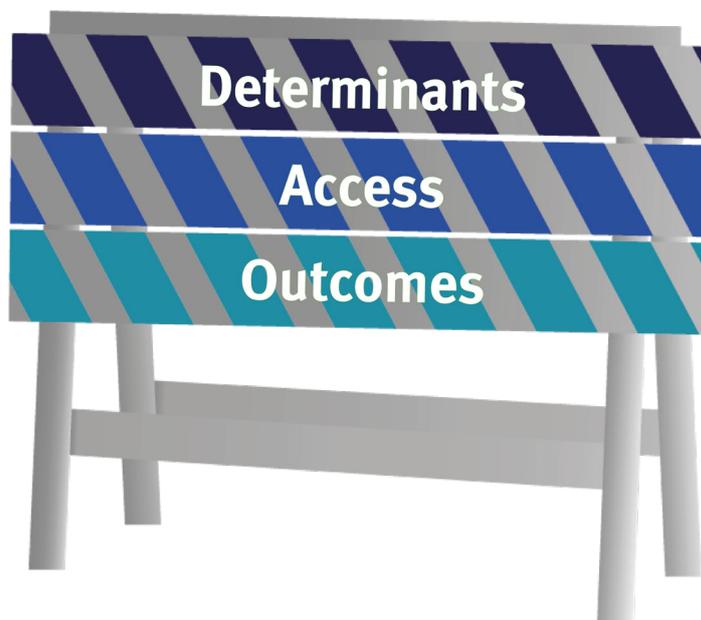
Covid-19

The Covid-19 pandemic broke out early in 2020 as the Commission’s research was concluding. It has highlighted stark health inequalities that were already there in plain sight. While the virus

may not discriminate, groups of people who face a higher risk of getting the virus, of becoming seriously unwell, and of losing their lives are often the same as those with a higher risk of mental ill health (PHE, 2020). Many of the reasons for this inequality are shockingly similar: insecure livelihoods, unsafe workplaces, inadequate housing. And as a consequence of this greater exposure to the virus and its after-effects, it is highly likely that mental health inequalities will grow in the months and years to come unless concerted action is taken (Allwood and Bell, 2020).

The mental health impacts of the pandemic are only now starting to be understood and quantified (e.g. O’Shea, 2020). Research is beginning to expose the significant harm both the virus and the measures taken to control it are having on mental health across societies, and the extent to which the ill effects are concentrated among the most marginalised, disempowered and disadvantaged (Allwood and Bell, 2020). Some of these impacts are immediate – for example the effects of quarantine conditions on children, of exposure to domestic violence and abuse, or of isolation among older people and anxiety among those shielding from the virus. Others will take longer to develop: for example the long-term impacts of youth unemployment and the traumas of complex grief.

The 'triple barrier' of mental health inequality



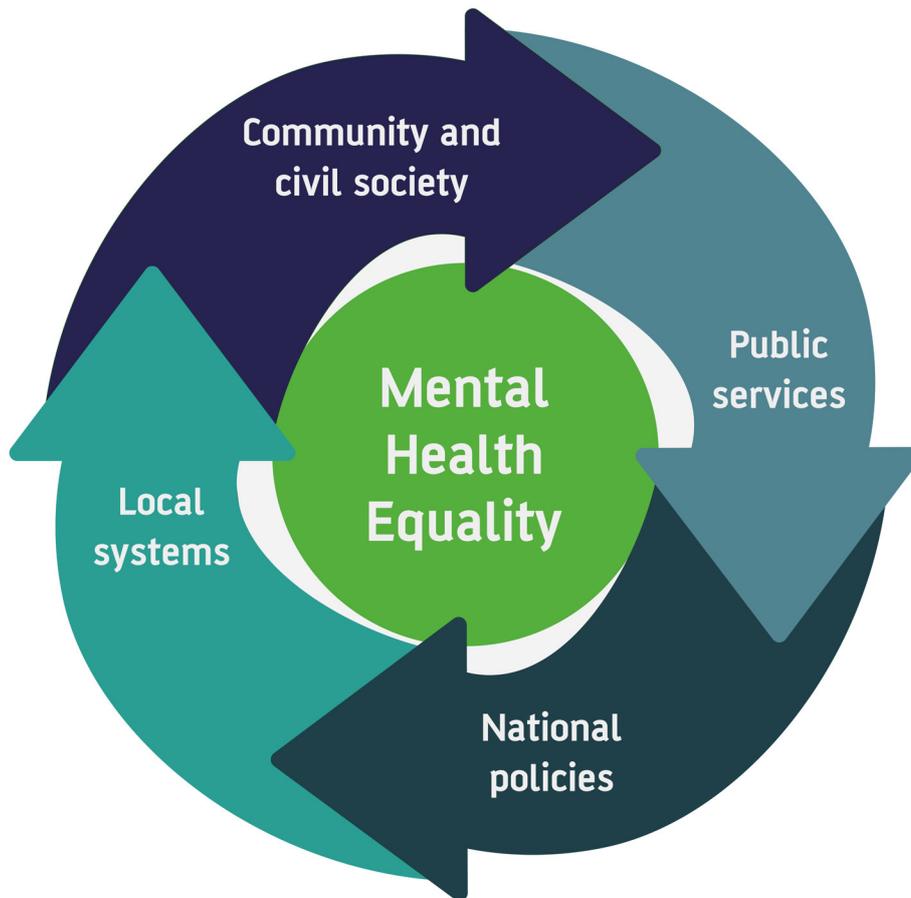
© Centre for Mental Health, 2020

3. A SYSTEM DESIGNED FOR EQUALITY

Mental health inequalities are deeply rooted in society. But it does not mean they are inevitable. And they can no longer be ignored.

The Commission has explored a wide range of proposals and ideas to boost mental health equality. There are no simple solutions or

overnight remedies for entrenched injustices. But we have found that effective action is possible. We need to scale up the best approaches, and for those with resources and power to invest differently. And we need communities, local organisations and national government to work together to generate change at scale.



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4. COMMUNITIES AND CIVIL SOCIETY: CREATING MENTAL HEALTH EQUALITY

Mental health is created in communities. It is not just the business of government or public services. It is a collective good and a collective responsibility. Businesses, charities, faith groups and others in civil society all have an impact on our wellbeing. They can either reduce or exacerbate inequalities. By seeking to create mental health equality, they can be active participants in addressing the unequal determinants of mental health.

Communities – geographical, demographic or cultural – can nurture members’ mental health, but they can also do harm. They can create powerful feelings of identity and belonging, and they can exclude or oppress. For people experiencing some of the biggest mental health inequalities, community is an essential resource that can act as a buffer against the stresses of the world outside.

The Commission has seen numerous examples of community-led initiatives in localities and among communities of identity that have addressed mental health inequalities creatively. Many bear the hallmarks described above: leadership by people with lived experience, prioritising

engagement, supporting basic needs first and creating a sense of safety and belonging. Some have been actively supported and nurtured by local councils or NHS organisations, working in partnership with community organisations. But with a few exceptions they are small-scale, insecurely and often inadequately funded, and short-lived. Few are robustly evaluated, either because they are not resourced to assess their impact or because they do not last long enough to demonstrate ‘hard’ outcomes. Among the key elements of community-led approaches the Commission has seen are:

Mutual aid

Many of the groups that emerge from communities begin life offering informal mutual help where there is a need – and often a gap in mainstream services. They provide accessible, acceptable and relevant help and support to members of the community, often seeking to build bridges with statutory agencies that feel remote or forbidding to members. Such groups often branch out into research and campaigning for wider system change.

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.

The group recently led a national campaign drawing attention to the specific challenges faced by Black mothers and the lack of effective support from mainstream services: Black Maternal Mental Health Week.

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 of 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. Shuranjeet describes these groups as “therapeutic, not necessarily therapy”. They may discuss mental health directly or indirectly by sharing common experiences, for example of racism or exclusion.

Taraki moved its groups online during the lockdown and carried out research into the impacts of the pandemic on the mental health of Punjabi communities in the UK (Singh, 2020).

Opening Doors London (ODL) is the biggest charity providing information and support services specifically for Lesbian, Gay, Bisexual and Trans (LGBT+) people over 50 in the UK.

It is a membership organisation providing regular social opportunities across London to help develop networks and communities for LGBT+ people, aged over 50.

It also offers specialist training and consultancy for statutory and voluntary organisations, such as care homes, housing associations and hospitals, to help them understand the needs of older LGBT+ people.

A recent review of ‘community wealth’ by the Young Foundation (Tauschinski *et al.*, 2019) noted that strong communities, with high levels of mutuality, exist across the country, in rural and some urban areas, in both highly deprived and more wealthy areas of England. The review found

that both state and charitable funding levels had little correlation with community strength, but identified a number of areas, in the North West, the Midlands and East Coast, that combined low funding and low affluence with low levels of mutuality.

Collective impact

Community organisations do not only seek to support individual members; many also aim to bring about wider social change. As well as offering alternatives or complements to mainstream public services, they seek to change what the mainstream looks like and advocate for

the community in local and national systems. By taking a ‘collective impact’ approach, community groups have demonstrated that system change is possible and that larger organisations (including health care providers and commissioners, local councils and charitable funders) can benefit from the challenges and insights that this brings.

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” (Kania and Kramer, 2011).

Black Thrive’s director, Natalie Creary, describes the group’s role in generating system change: ranging from school exclusions to dementia and isolation among older people in the borough. It makes institutional racism ‘part of the conversation’ with statutory organisations and seeks to be involved when decisions are made. This includes working with the local authority in its youth violence reduction strategy to bring an anti-racist approach, and with mental health services to review how they measure outcomes. Black Thrive partners with other groups to ensure the needs of LGBT+ and disabled members of the Black community are heard. Black Thrive is not creating add-ons or alternative services to larger public services; it is using anchor institutions and networks to change the mainstream services themselves, fuelled by community leadership.

Mamas Health and Poverty Partnership brings together 12 organisations working across Greater Manchester which are run for, and by, black women and girls.

Between them, the partners offer a range of culturally appropriate mental health support, including outreach, counselling, psychotherapy, dance therapy and advocacy. They also offer holistic support around the determinants of poor mental health and disadvantage: life coaching, social inclusion activities, sexual health advice, solicitor signposting, immigration advice, housing support, access to basic provisions like food and donated white goods, as well as specialist support around harmful traditional practices. Mamas provides culturally appropriate advice and information to minimise negative impacts of health inequalities and poverty.

Mamas provides a collective voice for black women who provide and who use support. Through the partnership, these organisations advocate for mainstream services and strategies to respond to their needs and experiences, and to involve black women in policy, service design and decision making.

The Support and Action Women's Network (SAWN) promotes the welfare of Black African women in Oldham and Greater Manchester. The organisation provides opportunities and events to make women independent, self-sustaining and more empowered to influence the issues which affect them. SAWN works in partnership with other statutory and voluntary agencies, including as a member of Mamas Health and Poverty Partnership, and reaches out to marginalised communities through working closely with faith and community leaders.

To support women and their families, SAWN provides holistic health and wellbeing service where sessions can cover mental health, domestic violence, parenting and racism. An additional drop-in service specifically supports women and their families to adjust to life in the UK, offering advice on housing, education, immigration, work readiness and benefits. SAWN operates a low cost furniture bank and access to basic financial advice to further support women with practical matters. The organisation also runs an awareness and support group for women who have been affected by or are at risk of Female Genital Mutilation.

Additionally, SAWN delivers a 'prisoner project' offering support and guidance for prisoners, ex-offenders, detainees and families. This includes language and interpretation advice, immigration advice, befriending in prisons, supporting community connections, advice on prison regimes, mental health signposting, 'through the gate' support and community resettlement.

Positive identity

Community-led initiatives can help to confront the negative stereotypes and discriminatory narratives that undermine the wellbeing of people from marginalised and oppressed communities.

Celebrating a community's culture and building a positive identity can help both to challenge oppressive ideologies and reframe mental health as something that can be created collectively.

The British Muslim Heritage Centre (BMHC) is a community space in Manchester with the aspiration to celebrate Islam's heritage and inspire all communities to embrace diversity. It offers numerous opportunities for members of Manchester's Muslim community to explore their heritage and engage with one another. It is also open for people from other communities to learn about Islamic history and culture.

The BMHC is in a unique position where onsite facilities and a prominent position in the lives of community members facilitates bringing people together. This has been a key asset opening up conversations around mental and physical health in a space where people feel comfortable and welcome, and where local faith and community leaders can have an active role in encouraging people to learn about mental health and look after their own wellbeing.

The BMHC is also developing relationships with the local authority, NHS and other mainstream services. By doing this, it aims to bridge the Muslim communities of Manchester with mainstream health services in culturally appropriate ways that address inequalities, particularly around mental health, diabetes, dementia and cardiovascular disease.

Rainbow Noir is a volunteer-led social, peer support and community action group, which celebrates and platforms people of colour who identify as Lesbian, Gay, Bisexual, Trans, Queer and/or Intersex (LGBTQI).

Regular group meetings, both online and in person, create spaces for people who have not felt included within either the local LGBT scene or their own cultural communities. In these spaces, LGBTQI people of colour are able to feel safe, meet others with similar experiences, form friendships and socialise, find community, and heal.

The organisation also strives to provide a voice for LGBTQI people of colour in Greater Manchester and the North West. Volunteers from Rainbow Noir have attended strategic partnership meetings locally, talked on academic, health and artistic panels, and been featured in local and national magazines and online platforms.

“I can find my people... You can take your armour off. You don’t have to explain.”

(Participant, Manchester focus group, 2020)

Allyship

Communities can provide mutual support, create a positive identity and seek to change wider systems in ways that overcome mental health inequalities. But they cannot do this in isolation. Few have the resources, the power or the influence over wider systems to tackle the determinants of mental health inequality alone. For that they need allies. In later sections, we will explore the key roles of allies in the public sector: including local system leaders, public services and national government. But first we look at the roles of civil society organisations, and in particular businesses, charities and charitable funders, in supporting communities and building a society that supports mental health equality at every level.

Business

Businesses have an important part to play in securing Mental Health Equality. As discussed above, work gives people a means to earn a living as well as being a part of our identity and creating a community. Good working conditions, fair and equal pay, just policies and practices, and freedom from bullying are all critical elements of a healthy workplace (Harvey *et al.*, 2017). This has multiple benefits. Not only does it support mental health among working people and their families, it has

been shown to be good for employers’ financial position (by boosting productivity and loyalty) (Centre for Mental Health, 2017).

Businesses are increasingly being judged on their achievements and responsibilities beyond the bottom line. Companies are required to report on how they contribute to wider society, how they support their workforce and on their performance with regards to pay gaps. All of these have an impact on mental health inequalities. Businesses that support corporate social responsibility (CSR) activity or encourage charitable giving can look at how their resources are deployed to address inequalities in their communities – although the most effective businesses make equality core to their business model rather than relying only on donations or one-off CSR activities.

Charity and philanthropy

Charities and philanthropy have a critical and often overlooked role to play in challenging mental health inequalities. Charitable activity very often seeks to reduce inequalities by focusing resources on projects or interventions that support people with the least resources and greatest difficulties in life. Charitable funders frequently state an ambition to fund activity outside the remit of public services, to avoid duplicating effort.

But the Commission has observed that charitable and philanthropic funding continues to be held back by a ‘class system’ that can exclude smaller organisations and community groups from the majority of available resources. Public charitable giving and philanthropic activity is skewed towards larger organisations (for example that have fundraising infrastructure and social ‘connections’ to make successful appeals), to ‘innovation’ (making it difficult to sustain promising new approaches beyond their ‘pilot’ stage) and to approaches that do not challenge existing structures of power or privilege. This has been pronounced during the pandemic: faced with serious financial pressures throughout the charitable sector, many funders have prioritised ‘front line’ activity to meet immediate needs in the midst of the crisis.

Some charitable funders and philanthropic bodies have sought to work differently. This may include supporting community organisations to adapt and evolve, providing core funding rather than just limiting themselves to paying for projects, and prioritising funding for coproduced activity. During the pandemic, for example, while the majority of government emergency funding for mental health charities went to larger organisations, the National Survivor User Network distributed smaller sums to user-led and unincorporated organisations such as Taraki to enable them to adapt to the lockdown or carry out specific projects in response to the crisis.

Up My Street was a series of community projects working with young Black men in Birmingham to support resilience through the use of creative arts. It was funded by Mind and led by local organisations in the city, including Birmingham Repertory Theatre and First Class Legacy. Up My Street’s evaluation report by Centre for Mental Health, funded by Comic Relief, found that the projects successfully challenged racist stereotypes that affected the young men’s wellbeing – for example by celebrating Black culture and providing positive adult role models. The evaluation was conducted by peer researchers – young men from the Black community – who produced a video about the project and presented the results in the Houses of Parliament, as well as producing a written report (Khan *et al.*, 2017).

Following the evaluation, the National Lottery Community Fund encouraged and supported the project’s partners to develop a new, larger scale project to build on Up My Street’s work and bring about system change. The result, **Shifting the Dial**, seeks to boost young men’s resilience and life chances, including by creating platforms for them to influence how public services such as education, public health and policing in the city affect their wellbeing in their policies and practices. This has already resulted in citywide events focusing on schooling, public health and youth violence, and the development of a resource for schools (Harris and Whittle, 2019).

“It’s made me feel more comfortable within society, and that there’s other males going through the same situations as me, and...other males looking for the same kind of guidance and that there are role models to talk to out there. Something that lifts up your spirit and your vibe to be a better person.”

(Khan *et al.*, 2017)

DRILL (Disability Research on Independent Living and Learning) is a five-year UK wide programme led by disabled people, for disabled people and funded by the National Lottery Community Fund.

DRILL promotes coproduction and collaboration between disabled people and their organisations, academia, research bodies and policy makers. Disabled people are empowered to have direct influence on decisions that impact on their independent living, particularly in relation to policies, legislation and services.

The programme has funded 32 coproduced research and pilot projects across the UK. The purpose of the projects is to find solutions about how disabled people can live as full citizens and take part socially, economically and politically.

Some charitable funders are taking steps to embed these considerations in their routine grant making activity: for example requiring organisations they fund to employ people from the communities they serve and to include leadership of people with lived experience. This can, over time, create a significant shift.

5. LOCAL LEADERSHIP: PLANNING FOR MENTAL HEALTH EQUALITY

Local authorities, city regions and devolved administrations across the country can take action to pursue mental health equality in their communities. Local councils have already demonstrated the ability to apply a new kind of leadership for better public mental health and many have had a clear focus on reducing inequalities. By viewing the public's mental health as everyone's business, in all aspects of a local authority's duties, and taking a holistic view, they can be a catalyst for system change, the redistribution of public resources and wider investment for mental health equality (Allwood, 2020). This can be achieved through supporting inclusive education in local schools and colleges, improving digital connectivity where it is poorest, protecting low income areas at risk from flooding, and investing in safe, warm homes.

For local authorities to fulfil this potential, it will be vital to rebuild their financial position in the years to come. Local councils have shown, through their responses to Covid-19, the value of their knowledge of their communities, their responsiveness to people's needs and their ability to communicate effectively in ways no national programme could achieve.

In addition to the central role of local authorities, regional public bodies can also play an important part in this process. In the West Midlands Combined Authority, for example, the **Thrive West Midlands** programme has set out an **ambitious**

agenda for improved mental health for all with a specific focus on inequalities including in housing, employment and criminal justice.

Services in future will be re-orientated in each 'place' and larger 'system' – with the aim of greater integration, so people do not fall through cracks. Primary Care Networks and Integrated Care Systems have a significant potential to focus on mental health equality, by combining the collective commissioning power of the full range of health and care organisations over their respective geographical areas (Centre for Mental Health, 2020). This would enable them to pool significant resources to prevent mental ill health and respond more effectively to groups of people currently poorly served by mental health services.

Key areas where local leadership will be especially important for mental health equality include:

Prioritising mental health equality

Local and regional government is uniquely able to understand the needs of communities and use their knowledge and intelligence to address inequalities. Through health needs assessments, public health services can identify local areas or groups of people with the poorest mental health and least effective support for it (Bell, 2016b). And by working alongside communities, they can seek to understand why and what would help.

Leeds: The Leeds Health and Wellbeing Strategy 2016-21 established an ambition for Leeds to become a 'caring city for all ages, where people who are the poorest improve their health the fastest'. To help achieve this goal, Leeds City Council has commissioned Mentally Healthy Leeds, a public mental health programme delivered by a third sector consortium comprising organisations with national experience, strong local footprints, and expertise working with communities. The providers work with individuals and groups in communities to combat mental health stigma and discrimination, increase resilience, reduce social isolation, and gain insights into the needs and preferences of local communities. Activities centred on social interaction or creativity – art, music, food, or exercise – are offered to help communities engage with underlying messages about keeping mentally healthy.

Tackling inequalities is a priority. Public health grants focus on areas of the city where uptake for the Improving Access to Psychological Therapies programme (IAPT) is low, or where there are higher levels of crime, social housing, unemployment, and mental health problems. Mentally Healthy Leeds focuses its efforts on groups considered at highest risk: young women aged 16-24 and men aged 30-60 living in areas of the city with high levels of deprivation. Touchstone, the lead provider of Mentally Healthy Leeds, has decades of experience of working with communities and grassroots organisations who understand the needs and preferences of marginalised neighbourhoods.

Birmingham has a young and growing population where a third of all children live in poverty, the gap in life expectancy between wealthy and poor is more than a decade for men and more than eight years for women, and infant mortality is twice the national average. Birmingham City Council's Public Health Green Paper for 2019-2023 (Birmingham City Council, 2019) was underpinned by an ambition to address these health inequalities. The Green Paper was released for extensive community consultation and feedback to help shape priorities.

This process led to the development of Birmingham's Mentally Healthy City Forum, a multidisciplinary, cross-sector group with representation from the local voluntary and community sector. The Mentally Healthy City approach focuses on improving and maintaining mental wellness across the city, prioritising hope, self-esteem and cohesion across all of Birmingham's communities, while developing more intensive forms of support for those facing the greatest inequality – using the principle of 'proportionate universalism'.

Personal health and wellbeing is included in the apprenticeships curriculum within the Council, and commitments to mirror this have been made by the NHS and police. A number of major changes have been formally ratified by the Council: the public health grant has been rebalanced to allow for a greater number of smaller grants and the pump-priming of projects, while the Public Health team has been significantly expanded from 40 to 70 staff.

Birmingham is home to a diverse population of over 100 national identities. As wellbeing is a culturally constructed concept, there is a need to translate ideas into different languages and cultures. Birmingham City Council therefore partnered with Warsaw City Council to share learning and improve knowledge on the needs and preferences of Polish and Eastern European citizens, and with Lewisham Council to help improve services for young black men.

During the Coronavirus pandemic, Birmingham City Council sought out additional opportunities to engage with its diverse population. Community involvement was facilitated through questionnaires; a youth roundtable hosted by the West Midlands Police and Crime Commissioner, which sought views from young people about experiences of the police, education and mental health during lockdown; and meetings where wider system partners, supported by grassroots organisations, set out to answer questions from communities and hear from the public about the issues which were most important to them.

Economic development

Local authorities and NHS organisations, like many public services, are major players in their local economies. As employers, as buyers of services and as investors in communities, public services can maximise their potential as ‘anchor institutions’ to boost economic growth and

employment opportunities (directly and indirectly). Given the importance of economic wellbeing to mental health, local leaders can use their powers to maximise the benefit of their policies to reduce mental health inequalities. This will be of particular importance in the creation of Covid-19 economic recovery plans.

Lambeth Borough Council has sought to reduce poverty (and thus improve health) by increasing the number of genuinely London Living Wage jobs in and around the borough.

Lambeth Council became a Living Wage Accredited employer in 2012 and now more than 99% of its contractors pay the London Living Wage or above.

Building on this, the council’s two elected member champions for mental health, Ed Davie and Jacqui Dyer, helped persuade the local NHS trusts, Guy’s and St Thomas’s (GSTT), South London and the Maudsley (SLAM) and King’s College Hospital, to get London Living Wage Accredited. All three have committed to doing so and in February 2020 both GSTT and SLAM achieved accreditation meaning a pay rise of over £100 a week to hundreds of cleaners, security guards, caterers and others.

A Lambeth Council office block in Brixton has become the UK’s first ‘Living Wage Building’ with all tenants paying at this level or above, and the borough’s two universities, London South Bank and King’s College, have also become accredited.

Lambeth Council is now working with other local authorities on the South London Prevention Taskforce, hosted by SLAM, with an emerging aim, among others, of getting every major employer across the whole region creating more Living Wage jobs for local people.

Basildon Borough Council takes a Health in All Policies approach which acknowledges that health is closely linked to most other core objectives, and that the local system can influence health outcomes by tackling social determinants of health. This approach challenges the traditional limits of a district or borough council. Mental health emerged as one of three priorities following the 2016 Joint Strategic Needs Assessment (JSNA) for Essex, which highlighted high levels of deprivation and health inequalities within Basildon (Essex County Council, 2016). Since then, the Council has identified opportunities to make a positive difference to health and wellbeing through its direct responsibilities for housing, leisure and public spaces, as well as through its more strategic role which influences other parts of the local system and wider economy.

Basildon’s approach involves creating partnerships to enable new initiatives to be delivered locally and bring new funding to the area. These include successful bids to Sport England and Arts Council England for funding to build community projects using physical activity and the creative arts to boost physical and mental health.

The Health in All Policies approach focuses resources on communities with the highest levels of deprivation. It also maximises the use of local assets, such as shopping centres and green spaces. Wat Tyler Country Park, for example, which itself is situated near deprived neighbourhoods, is the subject of attention and energy from the Council and wider partners so that it can become a more accessible and mentally healthy space for local residents.

Building community assets

Local statutory bodies are not just providers of services to their communities. Local authorities in particular are deeply embedded in their communities and have a major role as catalysts

for social change. By taking a long-term view and using their resources and spatial planning powers to invest in community infrastructure and assets, such as green spaces, libraries and leisure facilities, local authorities can support mental health equality (Cave and Molyneux, 2004).

Thrive Bristol is a ten-year programme to improve the mental health and wellbeing of everyone in Bristol, with a focus on those with the greatest needs. The Thrive programme has six main strands which recognise the impact which the wider environment – not just health services – has on mental health: Thriving Children and Young People, Thriving Students, Thriving at Work Bristol, Thriving Communities, Thriving at Home and Thrive Training and Skills.

The Thriving Communities strand is currently focusing on work with Somali community partners to tailor approaches and develop a shared, culturally informed way of working towards better mental health. These partners are leading anti-stigma work, rolling out mental health awareness training, and working with schools and health services to improve provision. This programme also tailors approaches for different parts of the Somali community, including mothers and middle-aged men.

Bristol is part of a regional partnership implementing a mental health response to Covid-19 in the West of England. This approach was developed by a Mental Health and Wellbeing Cell bringing together 60 partners from across the NHS, local authorities, voluntary sector, blue light services, user led organisations and academia. The response comprises a number of measures to support groups disproportionately affected by the pandemic:

- Extending the learning disabilities and autism Covid-19 community support offer, including more liaison nurses across mental health and care pathways
- Targeted support for children and young people from Black and minority ethnic communities
- Investing in the capacity of Black-led mental health services so that people can get help from organisations they trust
- Increased counselling support for people affected by bereavement, trauma or abuse.

‘Stronger Sandwell’ utilises an ‘asset-based community development’ approach to improving health in the borough (Rippon & Hopkins, 2015). This involves working with communities, focusing on the contributions they can make rather than the problems they face. Stronger Sandwell adheres to three principles which were developed in consultation with the community:

1. Harnessing existing strengths in the community: people, ideas, aspirations and experiences.
2. Investing locally: investing in local people and organisations as part of an ‘inclusive economy’ framework where, by design, local people have more opportunities to participate in activities that improve their wellbeing, prosperity and life chances.
3. Responding to inequalities: understanding who faces the biggest challenges and where there are barriers to good health and wellbeing, such as people who are facing poverty or living with disabilities.

Public health development officers actively engage communities to understand what is happening for them, supporting local projects to grow, and helping ideas become a reality. They offer a menu of practical support to community partners: marketing, small grants, access to external funding streams and support for proposal development; and technical support, e.g. website creation and development. Community based projects include accessible volunteer-led exercise; helping people who have struggled with alcohol dependence to rebuild their lives in the community; and the development of a local alternative to The National Child Measurement Programme, which focuses on eliminating stigma and acknowledges the role of mental wellbeing in childhood obesity.

Housing and homelessness

Decent, safe and secure housing is fundamental to mental health. Yet people with mental health problems are more likely to be living in overcrowded accommodation or poor quality private rented housing. The lack of affordable housing and the significant reductions in housing based support services in the last ten years has been a significant driver of inequality.

An estimated 50% of homelessness need has a related mental health need. Too often, people seriously affected by mental illness have the behaviours that may arise as a result of their illness labelled as ‘anti-social’. Time and money are invested in responding to anti-social behaviour rather than their mental illness.

Local authorities and housing providers can protect mental health through action to address housing inequality and homelessness. This includes a wide range of approaches including:

Preventing homelessness: for example, supporting people facing housing and Council Tax payment arrears, and ensuring people with mental health difficulties are able to get access to good quality financial advice – including help with problem debts.

Responding effectively to homelessness: for example, adopting Housing First approaches for people who are sleeping rough and have complex needs.

Improving housing quality: 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 (Green and Gilbertson, 2008).

Providing effective housing support: for example, to ensure people leaving hospital or prison with mental health difficulties are adequately housed, where necessary with additional support.

Where housing providers have invested in models of neighbourhood management that use coaching and therapeutic skills to address ‘anti-social behaviour’, the results can be impressive, helping people to sustain their tenancy and achieve their goals.

Walsall Housing Group have recruited from among their local resident population and offered staff basic skills in mindfulness, motivational interviewing and asset based coaching to support people to connect to groups and services.

6. PUBLIC SERVICES: SUPPORTING MENTAL HEALTH EQUALITY

It is clear to the Commission that public services need to change dramatically to better address mental health inequalities. Mental health inequality has been at the bottom of the list of priorities, too often an afterthought both nationally and locally. It is time for equality to come to the forefront; and in the aftermath of Covid-19 this is more important than ever.

The Advancing Mental Health Equalities programme, instigated by NHS England as part of the Long Term Plan, is making important steps in this direction for NHS mental health services (NHS England, 2020). It sets out a clear and comprehensive agenda for practical change. The Commission hopes that this programme will receive the resources it requires to make a difference nationwide, and will continue to receive support from leaders nationally and locally for as long as it is needed. It is a long-term programme that must be sustained.

Our recommendations for change focus on the whole system of mental health support. That includes informal as well as formal mental health services: for example in public health and social care, and in schools, colleges, workplaces and the criminal justice system. We must recognise that mental health support is not the sole preserve of the NHS, and that for too many people NHS mental health support has not worked and continues to feel unsafe, irrelevant or unhelpful. But that does not mean that NHS mental health services can never change.

Public services, especially larger NHS organisations, also have significant potential as employers and anchor institutions in their localities. As employers, they can take steps to recruit more actively from the communities they serve: creating good jobs and flexible roles for people living locally (Molyneux *et al.*, 2020).

Apprenticeships are one route by which this can be achieved at scale – an especially important route to work for young people in a time of high youth unemployment and limited opportunities in other sectors. And more broadly, mental health services can take opportunities for skill-sharing with communities: broadening the range of people locally who can provide informal support, using existing networks (including online) to offer training and advice to people in leadership roles, for example in youth groups, faith groups and trusted businesses (Belkin, 2020).

Specifically, we are calling for mental health support that is:

Comprehensive

The Community Mental Health Framework (NHS England, 2019) sets out a vision of a ‘whole population’ mental health service across health services, social care and housing, that leaves no one behind. This is a founding principle of the NHS and Local Government, yet in practice it has been far from evident in mental health services. Too many groups of people find that their needs do not fit the system of support available in their local area. There are multiple gaps in provision, for example for people diagnosed with ‘personality disorders’, for people with ‘dual diagnosis’ (for example of alcohol and mental health difficulties) or people with ‘persistent physical symptoms’ (Newbigging *et al.*, 2018).

There are examples of local areas that have sought to close these gaps through innovative new services; sadly, many are short-lived and few are sufficiently resourced to reach all of the people who could benefit from them. The consequences of these gaps are considerable: often resulting in people being ‘bounced’ from one service to another, never receiving the support they need.

Some local areas are now taking steps to close these gaps, such as closing the ‘chasm’ between primary and secondary mental health care. These include new services offering psychological therapy to people with persistent physical symptoms and other ‘complex needs’ within their own GP surgeries (Newbigging *et al.*, 2018; O’Shea, 2019b). There is an opportunity with the creation of Primary Care Networks and Integrated Care Systems for this to become the norm, as they expect primary and secondary care boundaries to be reduced. While innovative approaches are closing the gaps in some areas, in others they remain.

There is an opportunity now for Integrated Care Systems, clinical commissioning groups, health and wellbeing boards and Primary Care Networks to explore ways they can work at their respective levels to close the gaps. The NHS Long Term Plan will bring significant extra investment to community mental health care, and meeting the promises of this plan will require concerted

effort and sustained growth in provision. While responses and configurations will rightly differ from one area to another – for example between rural and inner city locations – no one who needs mental health support should find themselves with nothing.

Comprehensive mental health support must also be on offer in and around the criminal justice system. Building on the success of the NHS Liaison and Diversion programme, mental health and social care support must be accessible for people diverted from custody, inside prisons and for those leaving custody, including rights to social care support. In a recent study, only a minority of people leaving prison having been supported by prison mental health services were accepted by community mental health services after being released (Durcan *et al.*, 2018). Similar gaps have been noted among people entering the youth and criminal justice systems: in many cases, years of inadequate support from statutory services preceded involvement in offending.

Wish, a national charity, provides gender-sensitive support to women with mental health needs as they interact with criminal justice and mental health systems. Among its services are an advocacy and a community link programme.

Gender specific advocacy services are provided by women, for women and focus on developing trusting relationships, listening, empowering women to express their needs, treating women as individuals with unique needs, and supporting women to achieve both short and long term improvements. Wish also provides training and resources to support women to self-advocate. Advocacy is provided for women who are receiving care and as part of formal processes such as detentions and tribunals under the Mental Health Act.

Community Link services support women to move from hospital or prison into communities. Wish workers support women with transitions by providing information, delivering practical and emotional support, and connecting women into activities and opportunities in communities. These services, delivered in two women’s prisons and in communities in London and Essex, are designed to help women access employment, education and training, increase their confidence, and help them manage and improve their mental health.

“It’s what you expect social workers to do but they can’t because they are too busy.”

Tailored

The Commission has received evidence from multiple groups of people who find mental health support does not meet their needs. These include disabled people, LGBT+ communities and women who have experienced violence and abuse. A ‘one size fits all’ model of mental health support will never be able to address inequality. This requires a system re-design to ensure that services work for everyone, with ‘reasonable adjustments’ offered where they are needed – for example providing high quality interpretation services for deaf people or those who do not speak English – as a right, not a privilege.

Tailoring mental health support to people’s needs has been challenging in services that have historically been under-funded. Years of austerity have seen many services that did seek to meet the needs of specific groups cut back or cancelled. With additional funding pledged for the NHS Long Term Plan and a Community Mental Health Framework that promises to leave no one behind, it is now essential that local systems diversify their offer.

What this looks like will inevitably be different in different localities and for different communities

of interest. For some, interventions need to be re-designed or adjusted: for example for autistic people or those with learning disabilities. For others, including deaf people or those whose first language is not English, specialist interpretation services may be needed. Peer-led services, resourced and supported, can also be helpful for communities in terms of gaining vital hope and empowerment, as well as to fill a gap for those who do not trust formal services.

An essential element for mental health equality in public services is the presence of collective and independent individual advocacy. People with lived experience, in whatever form, bring new and vital knowledge to the table. Dismissing, denigrating and denying this is a foundation for social injustice (‘epistemic violence’). Advocacy from lived experience challenges this injustice and shifts the balance of power towards a more equitable exchange. For statutory service providers and commissioners, this requires a commitment to cede power, to be prepared to learn from lived experience, and to ensure organisations that provide advocacy (collective or individual) are adequately resourced so that they can speak freely without fear of what will happen in the next funding round.

Wandsworth Community Empowerment Network has been working in the South London borough since 2001 to “bring public institutions back into the public sphere”. It has led a number of projects to close the gap between communities and public services in the borough including the training of Church pastors in family therapy techniques, enabling them to combine their knowledge of faith and community with training in a psychological intervention that they could practise in a ‘safe social space’. This approach brought together statutory services with community leaders and provided a ‘bridging’ function between the two on equal terms (Burgess & Ali, 2016).

Manchester Health and Care Commissioning has been working with local voluntary and community organisations in the city to design services that meet the needs of all of its citizens. Mental health services are commissioned jointly between the City Council and the NHS. Together, they have identified communities and groups that have been poorly served by existing services (for example older people from Black communities). They have commissioned support from trusted organisations, and provided those organisations with the necessary infrastructure to enable them to create accessible and welcoming environments. For example they have seven different IAPT contracts, including specific services for young adults, for LGBT+ people, for men who have experienced violence and abuse, and for non-English speakers. Contracts are given for three years to provide continuity.

The commissioning team also offers grant funding to smaller and newer organisations from communities whose needs are not yet well met, or where these are emerging – for example among newly arrived communities in the city.

They are now working with these and other organisations to reach communities with vital information and advice about Covid-19. They recognise that the most effective routes to influence behaviour are through small-scale, often informal, groups and organisations that have credibility among their members, and they recognise that they need to pay for this support at a time when many organisations have lost their usual sources of funding.

Engaging

For communities that do not feel statutory mental health services are for them, a focus on engagement is critical. While many people describe having to ‘battle’ for mental health support, many others are put off trying because they do not believe it will meet their needs or are deterred by feeling it will not be safe. Many of the most successful mental health services we have seen make engagement a priority, meeting people ‘where they are at’ and reaching out to offer help rather than waiting for a formal referral (Stubbs *et al.*, 2018). A growing number are also peer-led: for example those run by community organisations for refugees, providing the additional benefit of using language people are comfortable speaking

in (McIntosh *et al.*, 2019). Peer-led services, and those where the boundaries between professional and peer roles are blurred, are more able to offer a relational approach, for example when responding to a crisis situation (Newbigging *et al.*, 2020).

Engagement can be particularly important for young people, and especially those who are most marginalised. Further education (FE) colleges are an important and often overlooked setting for mental health support, yet they disproportionately serve young people who have had the least opportunities and who find formal health services least attractive: for example those who have been excluded or ‘off-rolled’ during secondary school, and those taking on apprenticeships, where formal mental health support is less available.

At **East Coast College**, serving a deprived coastal community in East Anglia, close working with mental health service staff has been established to ensure young people get access to support when they need it. Further education providers also have opportunities through adult learning for engaging people with mental health support as well as chances to learn new skills: as evidenced in the Community Learning Mental Health pilot programme (Lawson *et al.*, 2018).

MAC-UK works with several projects across London. It aims to radically transform excluded young people's access to mental health services and sees young people as an important part of the solution to the inequalities they face. MAC-UK uses the INTEGRATE approach to support the most excluded young people, and it also helps other projects embed this approach in local areas. INTEGRATE is characterised by:

- Putting engagement at the forefront of the service – requests for support are responded to but relationship-building is the priority
- A peer referral system, which encourages young people to bring their wider peer group into contact with the service
- Employing people with lived experience to co-design and co-deliver services
- Building mutual trust between young people and staff members, achieved in part by employing people from the peer group as peer supporters
- A service delivered in non-clinical environments, wherever young people are – i.e. in the streets or in safe community spaces – and support which isn't bound by formal appointment systems
- A multi-disciplinary staff team offering flexible, holistic support (e.g. therapy, advocacy, and employment/benefits advice) that responds to multiple risk-factors
- Co-producing activities with young people, taking a strengths-led approach that focuses on what young people can do rather than what they can't.

Evaluations have demonstrated that sites using this model increased mental health awareness amongst recipients and reduced stigma; helped bring young people into education, employment and training; led to improvements in mental wellbeing according to clinician-rated measures and young people's feedback; and helped young people avoid offending behaviour (Durcan *et al.*, 2017).

"They don't ask your history, or what you look like, or how you dress, they came with open arms and gave you a fresh start. They put people first and they always stand for us, even though we cause headaches."

(Durcan *et al.*, 2017)

Holistic

Mental health support needs to address and respond to the survival struggles many people face while living with mental health difficulties. Help with housing, money, work and relationships is an important aspect of mental health support that has often been regarded as an add-on to clinical care. Successive surveys by the Care Quality Commission (2019a) find that people using community mental health services are not getting the help they want with work, housing and money advice. Such support with basic needs can be vital to enable people to recover their mental health. Addressing the structural inequalities that underlie poor mental health – for example

maximising income or addressing poor housing – moves services away from an individualised approach that prioritises treating illness or promoting 'resilience' towards a collective approach that sees people in their social context and seeks to make change happen around them too.

The Commission is convinced that all mental health services should offer advice and support with employment, education, housing and welfare rights. Employment support should be delivered through the Individual Placement and Support model that has been proven most effective and is now embedded in the NHS Long-Term Plan, with employment specialists located in clinical teams.

This should be expanded to support people with mental health difficulties who are not currently using secondary mental health services, who may miss out on employment support without a more comprehensive model. And there is the potential for IPS principles to be applied more broadly in other public services, for example for disabled people, in substance misuse services and among Armed Forces veterans.

Help with housing, money and other welfare needs should be similarly easy to access and provided universally, including within children and young people's mental health services. And health services must ensure that they do not discharge people from hospital to the streets. This will require greater attention to the housing support

that can be provided as part of any 'care pathway' within the mental health system (Molyneux *et al.*, 2016; Rethink Mental Illness, 2017).

Youth Information, Advice and Counselling Services (YIACS) operate a model of support for young people aged 11-25. Coordinated and supported nationally by the charity Youth Access, YIACS provide "advice and information services that can help young people access their rights and entitlements, and address broader issues that go hand in hand with mental health - such as housing, money and relationships – sometimes referred to as the 'social determinants' of mental health" (<https://www.youthaccess.org.uk/our-work/yiacs-model>).

Mancroft Advice Project is a YIACS service in Norfolk, which has provided advice and counselling to young people since 1991, combined with youth work.

MAP's chief executive Dann Mobbs told the Commission: "We have been working with young people in the transformation of mental health services. We see social action as a part of social recovery. Young people who have needed or used mental health services take action to improve services and by doing this learn team work, organisational and social skills that in themselves help their recovery.

"The youth work team also take action on discrimination around race, LGBT+ [identity] and disability. It is all young person led and again, through tackling discrimination we see growth in confidence and emotional wellbeing. Having a sense of "control over your life" is central to good mental health.

"We see this as an holistic approach to mental health – so, if you are in debt and depressed, get debt advice not anti-depressants; if you are depressed because you are experiencing racism, work with others to stand up against racism. Counselling/psychological therapies are also very important because they centre on the young person to help them understand their experiences and develop new strategies and insights, but our therapists would agree that if this isn't combined with social and legal approaches we can have a minimal impact."

Project Future is a community based, holistic, youth-led mental health and wellbeing service situated in Haringey. It seeks to transform the delivery of mental health support for young men aged 11-25 years old who are involved in offending, especially those exposed to serious youth violence.

The project delivers evidence-based psychological interventions in accessible ways. The project is accessed by peer referral only, helping create an environment where young people feel comfortable and safe. Young people are consulted at every level of the project and are responsible for co-producing a service that best meets the needs of themselves and their peers.

Project Future is delivered by a multidisciplinary team which focuses on developing trusting relationships with young people and providing tailored support to meet their needs. This support is delivered in a non-clinical environment where young people feel like they belong, where they are respected, accepted and safe. The young people did not feel that they could trust statutory mental health services and would not seek help from them: in some cases services were located in neighbourhoods where they did not feel safe.

Evaluations have demonstrated that this project had a statistically significant impact on lowering the level of mental health needs of its participants, improved access to other services (housing, sexual health, primary care, benefits), improved access to education, employment and training opportunities, and reduced offending behaviour (Stubbs *et al.*, 2017).

“I can now trust the other part of the law, society and the system that I wasn’t interacting with before. This is a system and it made me trust the system more. Before I would never go to a meeting where the police were but trusting Project Future has made me feel comfortable. It makes you feel comfortable to talk to probation, the police, policy people, the system...”

(Stubbs *et al.*, 2017)

Responsive

For many people, mental health difficulty is connected to experiences of oppression, disempowerment and violence. Poor mental health can result from experiences of racism, bullying, exclusion and injustice, and mental health services need to be able to offer the opposite to these experiences. Approaches such as trauma-informed care and cultural competency can facilitate this by creating a sense of safety and by seeking to listen to and understand people’s narratives on their own terms.

Mental health services and their partners can also become more responsive by building relationships at the ‘neighbourhood’ and community level

and supporting small, informal groups and organisations that offer collective advocacy and challenge. This has been noted on a small scale in relation to disaster responses in communities subject to discrimination and racism – for example following Hurricane Katrina in New Orleans (Belkin, 2020) and the Grenfell Tower fire in London. Learning from these responses and seeing the potential of public services to work at the neighbourhood level in partnership with community organisers will be essential. In England, the planned integration of community mental health teams with Primary Care Networks may offer a new opportunity to organise at this scale and take a more open and responsive approach to the people and places they serve.

Women's Centres support women across a range of issues such as health, violence and abuse, employment, education, and criminal justice issues. Services on offer vary depending on local needs, but can include tailored, holistic support provided one to one, drug and alcohol support, counselling, psychotherapy, peer support groups, supporting access to wider health and care services, courses and workshops.

Mainstream services often fail to address the complexity of women's lives, specifically in understanding and responding to the impacts of inequalities, violence and abuse and the implications this has for therapeutic support.

"If I didn't get help from [the Women's Centre] I would've ended up back in a relationship with my ex-boyfriend and taking the abuse for the rest of my life"

(Scott & Frost, 2018).

While approaches vary according to need, there are a number of common principles which characterise Women's Centres:

- Gender- and trauma-informed and led by values – services recognise that the trauma of abuse is a significant factor for many women, but that trauma can stem from other experiences such as racism, poverty, losing a child to care or going to prison.
- Relationship based – staff are non-judgemental and respectful. They also advocate with external agencies on behalf of the women they support.
- Women only – for women who have experience violence or abuse, emotional and physical safety is crucial to supporting their mental health and wider needs.
- Holistic, tailored and multi-agency – services support each woman as a whole person, recognising that, as well as facing problems with their mental health, they may need other forms of tailored support for example with parenting, legal issues or around debt and employment.
- Strengths based and co-produced – services treat women as equals in the provision of their care. They are involved in creating solutions and supported to develop their skills and believe in their own potential. Women can be actively involved in peer support networks and are encouraged to speak out about their experiences (Scott & Frost, 2018).

A range of evaluation data evidences improvements in mental health, work, housing and other socio-economic outcomes, and reductions in reoffending (see Duffy & Hyde, 2011; McNeish & Scott, 2014; MOJ, 2017). Despite this evidence, there are relatively few Women's Centres in operation and so the availability of this valuable support is extremely variable.

Accountable

The Commission has heard on multiple occasions the view that mental health services are not sufficiently accountable for addressing inequality. Whether this is the extent to which they are available to people equitably or whether they offer an equitable experience or outcomes to those they do support, the system remains opaque. This is frequently attributed to a lack of data, and this paucity has been very evident in our research: what data does exist on inequalities in mental health support is fragmentary and often only on a single dimension at a time (for example gender, age or race).

Judging how well services are meeting people's needs on this basis is going to be at best superficial. But poor data and a lack of transparency ultimately reflect what is seen to be important: 'what gets measured is what matters'. Records are not kept and data is not published on topics that are not given priority and are

not regarded as essential. Shifting the focus of accountability towards how far systems of mental health support are meeting their populations' needs is a critical building block for putting equality first, not last.

The Commission is pleased that the new *Advancing Mental Health Equalities* strategy (NHS England, 2020) places a priority on the collection and use of data on this theme. This is a welcome development that will lay the foundations for improved accountability. For that, we hope to see mental health service providers, commissioners and Integrated Care Systems developing mechanisms of accountability to their communities, including communities of interest and identity. Local authorities also have an important role in this process – using their scrutiny powers to hold systems to account for how far they are closing the gaps and addressing inequalities identified through local health needs assessments.

7. NATIONAL LEADERSHIP: ENABLING MENTAL HEALTH EQUALITY

Mental health equality can only be achieved at scale if it is backed by the whole of government and by national leaders across the health and care system. While mental health equality begins in communities, backed up by local systems and services, national action and leadership is the keystone to enable change to happen.

The UK Government has pledged to take action to prevent ill health, reduce health inequality, fund and reform social care, and ‘level up’ between communities across the country. Taking action to enable mental health equality will help it to achieve all of these ends. And in the aftermath of Covid-19, there is now a unique opportunity to ‘reset’ and ‘build back better’ as a result of the needs that have emerged and the endemic inequalities that have become so apparent during 2020.

Commit to mental health equality

The Commission calls on the Government to grasp this opportunity and commit to take the necessary steps to reduce mental health inequality. ‘Mental health for all’ is possible if there is a sustained and concerted commitment to achieve it. The Government can take steps immediately to create powerful incentives to the pursuit of mental health equality. These could include:

1. Set expectations for improvement: identify cross-government goals for greater mental health equality
2. Agree outcome indicators: create a ‘dashboard’ to measure progress towards mental health equality across different domains
3. Hold systems to account: refresh and update the Public Sector Equality Duty as a means to boost commitment to action.

The Equality and Human Rights Commission sets out the benefits of the Public Sector Equality Duty:

“The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public

authorities. If you do not consider how a function can affect different groups in different ways, it is unlikely to have the intended effect. This can contribute to greater inequality and poor outcomes... Compliance with the general equality duty is a legal obligation, but it also makes good business sense. An organisation that is able to provide services to meet the diverse needs of its users should find that it carries out its core business more efficiently.” (EHRC, 2020)

But it has also noted that the duty as it currently stands needs to be strengthened to require public sector bodies to actively pursue equality at a strategic as well as operational level: to take positive steps towards equality, especially where there are the biggest gaps, as well as ensuring they do not discriminate against individuals (EHRC, 2018).

In taking these three crucial steps, the Government could signal a clear commitment to mental health equality and identify priority ambitions that would have multiple benefits across society. Below we set out key domains where national leadership is vital to enable mental health equality.

Tackle poverty and financial inequality

It is clear that poverty (in both absolute and relative forms) is a major cause of mental health inequality, both in the UK and across the world. Measures to reduce or reverse poverty have also been shown to reduce the risk of poor mental health (Ripley *et al.*, 2020). There is also compelling evidence that income inequality is a major risk to mental health: more unequal societies have higher levels of mental ill health (Patel *et al.*, 2018). And there is evidence that it is not possible to reduce poverty without seeking to reduce income inequality (Hills *et al.*, 2019). Nor can this be achieved through economic growth alone – if anything, economic growth is associated with widening inequality (Ripley *et al.*, 2020).

As a society, we cannot improve mental health or tackle the scourge of mental health inequality without tackling poverty and addressing income and wealth inequality. So these must be at the heart of a national effort to boost mental health equality.

We believe the Government must set itself a goal of reducing overall income and wealth inequality as a means of improving public mental health. We do not prescribe the specific mechanisms for achieving this but we urge government to learn from academic work in progress on regulatory mechanisms to limit inequality, on wealth taxes and on poverty reduction. In addition, we set out three crucial steps that must be taken nationally, for which evidence is strong:

First, we need a **real living wage** that keeps people out of poverty. Alongside measures set out below about the nature of work, we believe that the Living Wage is a crucial element of a system designed for mental health equality. Evidence from the United States (Kaufman *et al.*, 2019) shows that raising minimum wages reduces suicide rates among those on the lowest incomes, and the benefits of doing so are greatest at times of higher unemployment. And raising incomes may have long-term as well as immediate benefits, with evidence that higher family income supports positive child development as well as reducing the chances of specific challenges like children developing schizophrenia later in life (Hakulinen *et al.*, 2020).

For people working part-time and on zero-hours contracts with high levels of uncertainty and underemployment, **'living hours'** may be an important component of this approach. While zero-hours working allows flexibility for many, it can also cause significant difficulties. Implementing the Taylor Review's (2017) recommendations for 'good work' would help to address many of the shortcomings.

There is also evidence that employment regulations that seek to protect workers' security within the labour market benefit mental health. For example, studies have shown that more generous severance payments and longer notice periods can improve health, including among the unemployed (Barlow *et al.*, 2019).

Second, we need to rebuild and rebalance our **social security system**. The principles set out by the Child Poverty Action Group (CPAG) (Howes, 2019) are an important starting point to building a benefits system that provides an adequate safety net, that promotes social solidarity and that treats people with dignity and respect. CPAG's three principles for social security are:

1. Prevent and reduce poverty: including support with additional costs (for example resulting from disability) and adequate resources to live on
2. Provide income security: to protect people at times they are vulnerable and to reduce inequalities in income
3. Promote social solidarity: enjoying public trust and support and avoiding divisiveness or 'othering'.

During the first phase of the pandemic, changes to benefits systems and regulations provided a temporary respite from the use of face-to-face disability benefit assessments and the use of conditions and sanctions with people on out-of-work benefits. This was, and could still be, a chance to test a different approach to social security and assess its impact on health inequalities. The recent adoption by The Treasury of the Breathing Space scheme to support people with mental health difficulties dealing with problem debts shows that system change is possible and has the potential to create a more efficient as well as humane social security system.

The forthcoming green paper on disability – a key manifesto commitment – is a vital opportunity for the Government to build in the learning from recent benefit system changes and their impacts: both on the mental health of all claimants and on people with mental health difficulties. The green paper could signal a commitment to ensure that all future benefit changes will seek to improve mental health and prioritise wellbeing: to make better mental health an explicit aim of the system, building in learning from practice to adapt policies and practices where necessary.

For people seeking employment, the benefits system should adapt to the principles of Individual Placement and Support: an approach to employment support that has been shown to work more effectively than any other for people

with long-term mental health conditions. With growing numbers of people facing unemployment in the wake of Covid-19, it has never been more important to adopt evidence-based approaches, especially for young people facing long-term harm to their health and future earnings at this time. This would require a significant shift towards a system that offered employment support when people want it, without conditionality or the use of sanctions, with tailored jobseeking help and independent benefits advice for people taking a step into work. This may include a shift towards more localised approaches to employment support, especially for people with multiple disadvantages (Pollard and Tjoa, 2020).

Third, we need to implement the **socio-economic duty** in the Equality Act on a par with the other ‘protected characteristics’. This important step – already in place in Scotland and Wales but not in England – would place a duty on public bodies to consider how to reduce unequal outcomes caused by socio-economic disadvantage, when making strategic decisions (Scottish Government, 2018). This would fill a major gap in the implementation of the Equality Act, especially in areas of the country with higher rates of long-term unemployment and poverty.

The Commission also notes the potential benefits to mental health of a Universal Basic Income (Gibson *et al.*, 2020). While this remains a contested idea, it has gained ground during Covid-19 as a result of the precariousness of so many people’s livelihoods.

Secure housing for all

Good housing is crucial to our mental health. Insecure housing, poor quality or overcrowded accommodation and homelessness are major risk factors for poor mental health, both immediately and long-term. Action is necessary on a number of levels to tackle the inequalities in housing that contribute to inequalities in mental health. The Commission recommends the Government takes steps to increase the availability of genuinely affordable housing, to ensure people renting housing are protected from poor quality accommodation and unfair treatment, and to tackle homelessness and its causes.

The Commission also recognises the right of people to live independently in their own communities and near their families. For some people with longer term mental health issues, the provision of support within their own homes and tenancies is vital in order to achieve this basic right. Housing support is commissioned by local authorities and has been reduced due to cuts in social care budgets. The Commission recommends that the Government boosts funding for effective housing support, recognising that no one should be left with inadequate accommodation, nor discharged from hospital or released from prison with nowhere to live.

Tackle racism and discrimination

Racism in its many forms and manifestations has a marked impact on mental health. It is clear that all forms of discrimination are toxic to mental health. Among them, racism has taken a particular toll on the lives of people from a range of communities in the UK.

The Government has an opportunity in the light of the Black Lives Matter movement to take affirmative and concerted action to prevent and tackle systemic and structural racism in public life and public services. Learning from tragedies such as the treatment of the ‘Windrush Generation’ and the Grenfell Tower fire can inform efforts to address racism across public services. This must include ending the ‘hostile environment’ and its harmful effects on the wellbeing and safety of Black communities, migrants and refugees in the UK. Evidence from mental health agencies working with refugee communities in the UK describe these policies as creating a continuous sense of danger (itself a risk factor for poor mental health, on top of the trauma and stress many refugees have experienced prior to arriving in the UK) and a fear that if they seek help for their mental health they will face detention or deportation (McIntosh *et al.*, 2019).

National policies in recent decades have sought to tackle many forms of discrimination, and with some important successes. For example, legislation in 2012 to outlaw discrimination against people with a mental illness has removed barriers to participation in public life. And we

have seen important progress in ending injustices through equal marriage legislation and measures to extend inclusive education. It is vital that this progress is sustained, and discrimination in all areas of our lives, and for all sections of society, is rooted out. The Government's forthcoming disabled people's strategy will be an important opportunity to take steps to address discrimination faced by people with mental health problems, including those facing especial disadvantage.

One area in which the Government could immediately improve support and equal access to services for some of the families in the UK most at risk of poverty, is by reforming the 'no recourse to public funds' rules within Section 115 of the Immigration and Asylum Act 1999. This would ensure that people with mental health difficulties and their families have access to basic support and services when they are needed and that they are not left destitute.

Invest in early years

There is compelling evidence that early life experiences are critical to our lifetime chances of having good mental health. Giving children and families the best possible chance of a good start in life has both short- and long-term benefits. Investing in early years interventions can reduce mental health inequalities through a 'proportionately universal' offer, providing families with support according to their level of need. The Sure Start programme has been highlighted as an important element of this approach, including in Michael Marmot's 2010 and 2020 reports on health inequalities in the UK; and Sure Start's economic as well as human benefits have been emphasised by the Institute of Fiscal Studies (Cattan, 2019). Despite this, funding for Sure Start has diminished and many children's centres have either closed or reduced their offer over the last decade.

Nonetheless, there are opportunities to invest in early years support that can make a difference to children's outcomes – short- and long-term. A pilot programme in the Republic of Ireland, for example, showed promise in offering evidence-based parenting support according to 'proportionately universal' principles: combining

a universal offer of advice and information with more targeted training programmes for families who could benefit most from the extra help (Doyle *et al.*, 2018). This could be adopted in the UK as a national programme to scale up access to parenting support (O'Shea and Bell, 2020).

Support inclusive education

Children's experiences of school, and young people's experiences of college and university, have a major impact on their mental health. Education providers at every stage can have a positive and powerful impact on our mental health. Inclusive education in relation to sexuality, for example, has been shown to reduce homophobic bullying in schools, preventing a significant risk factor for poor mental health (Proulx *et al.*, 2018). Adopting a 'whole school approach' to mental health benefits everyone but can have particular benefits to those facing the greatest risks (Abdinasir, 2019).

Conversely, negative experiences, from homophobic bullying to racial discrimination, can have long-lasting impacts on mental health (Khan, 2016). For children facing some of the greatest barriers to a good education, such as those with learning disabilities and autism, and those with severe behavioural difficulties, the use of restrictive interventions and exclusions (including off-rolling) cause significant and lasting harm to both mental health and wider life chances. They also risk an escalation of the problems they seek to solve (Centre for Mental Health, 2019). Black children face a far higher risk of exclusion than their white peers: perhaps reflecting the more punitive, rather than medicalised, approach to poor health identified by Paul and colleagues (2020) in the United States.

Government leadership can help to spread inclusive education principles from early adopters to wider uptake. As Sayce (2020) points out, "One of the biggest obstacles to inclusive education – where all children belong and can flourish – is the lack of belief that it is possible." Government commitment and support, underpinned by policies that enable schools to adopt inclusive education principles, and build up the knowledge, skill and confidence of staff to deploy them, is essential to make this possible nationwide.

Address climate threats

Tackling the climate crisis will benefit mental health as well as having many other benefits. There is clear evidence that flooding affects mental health, and the impact is disproportionately great on those with the least resources (Graham *et al.*, 2019; Cruz *et al.*, 2020). Heatwaves and other climate-related incidents are also likely to have an increasing impact on public mental health; once again affecting those least able to protect themselves from harm, for example those living in urban areas with less access to green space.

At the national level, taking steps to prevent or mitigate climate-related harm will reduce the risk of growing levels of harm in the years to come. This should be regarded as a major public health imperative, as well as having wider economic and environmental benefits. Enabling local authorities and devolved administrations to address the risks from climate threats will likewise protect people whose mental health will be most badly affected.

Close the digital divide

Access to digital technology and the internet is increasingly important for mental health, and to access support for mental health. While much of the public debate about digital technology and mental health has focused on the potential for harm from the use of social media or online gaming, there has been less attention to the potential for digital technology to benefit wellbeing. Remote working, for example, may create new employment opportunities for some, including those with long-term mental health difficulties. And social media platforms have provided some communities and groups of people living with mental health conditions with a new way of networking and campaigning for change (Brown, 2019).

Covid-19 has led to a sudden shift in mental health services moving to remote working, highlighting the gaps for those who do not have the means to use digital technology (Allwood and Bell, 2020). This is an especial concern in rural areas, where access to face-to-face mental health support has always been poor for those lacking transport, and where access to digital mental health support could have especial benefits long-term (Allwood, 2020b). Engagement through digital technology requires people to have the right equipment, to have internet access, and to have an email address. One urban community mental health service visited by the Commission told us that 40% of their service users did not have a current email address. And young people may struggle to engage with services online if they do not have enough data or do not have a safe and confidential space at home from which to speak.

The Government can take the lead here in fulfilling its pledge to increase digital connectivity, especially in areas that have been ‘left behind’, such as remote rural and coastal communities.

8. RECOMMENDATIONS

1. Communities can lead the way in pursuing mental health equality: Communities can make a vital contribution by taking action to tackle inequalities and promote mental health and wellbeing inclusively. But they need investment from public bodies, charitable funders and civil society organisations to lead change. This should include sustainable funding for user and community-led organisations and robust partnerships, so that successful approaches can be scaled up and influence the whole system of services locally.

This is essential to address the determinants of mental health: community leadership and engagement could help improve people's lives, transform access by offering support people value, and change outcomes – all three elements of the 'triple barrier'. Community and user-led organisations would have the resources to enable people facing inequalities to have greater voice and power, to support people 'where they are', with help tailored to physical, cultural and social needs, and to influence public services through partnerships and learning.

2. Local authorities need an urgent funding boost to coordinate action to pursue mental health equality: Close working with partners in voluntary and community organisations, the NHS and other public services should include robust assessments of mental health inequalities locally, combined with action plans to close the gaps.

Local authorities have shown that they can build partnerships to help them to understand needs and assets in communities, identify gaps and inequalities in existing support available, and help develop practical solutions. But to fulfil their potential, local authorities urgently need funding to build their capacity to work in a collaborative way with communities.

3. Statutory bodies should maximise their role as anchor institutions in their local economies: This should include applying inclusive economy principles to create employment opportunities, to boost community infrastructure, and make use of their assets. Local and combined authorities and devolved administrations can use their powers and responsibilities to boost inclusive economies.

Creating more inclusive economies will give local people more opportunities to participate in activities that improve their wellbeing, prosperity and life chances, and have greater influence over their environment. Inclusive employment opportunities will also help to develop a more diverse public service workforce, which better represents the communities which experience mental health inequalities and which offers decent employment conditions including a living wage.

4. Mental health services must implement the *Advancing Mental Health Equalities strategy in full*: The strategy must be given the necessary resources, senior leadership commitment and time to make a difference. Crucial action to support system change and build a more diverse and capable workforce to challenge mental health inequalities will require consistent and persistent leadership. It must not be a short-term or marginal activity that gets abandoned if it does not generate immediate results.

Fully implemented, the strategy will facilitate urgently needed improvements in mental health support: improving access, experience and outcomes for groups that currently miss out. It will increase transparency about how well NHS organisations are addressing mental health inequalities, which will enable greater accountability.

5. Mental health services should provide a genuinely ‘whole population’ offer: No one must be left behind or left out. New organisational networks – like Primary Care Networks and Integrated Care Systems - should collectively rethink the whole system of services and change the way they are designed so that they specifically redress inequalities and provide holistic support, including with work, housing and money advice. This would help build trust with different local communities and communities of interest.

A whole system approach to mental health services should mean no one is left out because of gaps between different services – so people are offered support quickly and not made to ‘battle’ for help. It should mean working in partnership with local and specific communities to ensure services meet the greatest local needs and redress inequalities in access, experience and outcomes.

6. Mental health services should be accountable for reducing inequalities in access, experience and outcomes: This should include accounting to local communities for the steps they have taken and progress they have made towards closing gaps; and transparent publication of progress with benchmarking against other services.

Increasing accountability can lead to improvements in service delivery, produce more learning about what works in addressing inequalities, and foster more trust between communities and statutory services.

7. The Government must tackle poverty and commit to reduce income and wealth inequality: This should include learning from academic work on the best economic and regulatory approaches; taking steps to institute a Living Wage and Living Hours nationwide; a reset of the social security system to provide security, reduce poverty and promote social solidarity; and the adoption of effective employment programmes such as Individual Placement and Support.

Reducing inequality of wealth and income would reduce the number of people who experience poor mental health and also offer people who experience mental health challenges greater security and better opportunities to lead fulfilling and valued lives.

8. The Government must commit to tackling all forms of racism, discrimination and exclusion: This should include action to address injustices in public life and public services (in education, criminal justice, housing and employment, for example) and a commitment to end ‘hostile environment’ policies.

Addressing these injustices will help break the cycles of discrimination which lead to mistrust, trauma, and fractured relationships between those who experience the poorest mental health and the services that should keep them safe and healthy. This needs leadership from national government, but it can also be led by combined and local authorities, NHS organisations, police services and other public sector bodies.

9. The Government should set a clear ambition and roadmap for achieving mental health equality: This should include both immediate and long-term actions to be taken in all departments to enable action towards mental health equality. It should also include an agreed set of measures to assess progress towards this ambition, including public health metrics for local authorities.

Embedding accountability and establishing clear actions across government will drive an immediate response to the inequalities illuminated and exacerbated by the pandemic and create a legacy that tackles mental health inequalities and enables the population to thrive longer term.

10. The Government should refresh and update the Public Sector Equality Duty: It should strengthen the positive requirement for public sector organisations to take steps towards equality in all aspects of their work: including in the development, commissioning and design of services, not just in the ways they are provided to individuals. This should apply to all of the existing ‘protected characteristics’ of the Equality Act and to inequalities in wealth, by commencing and fully implementing the ‘socio-economic duty’ in England, as it is in Scotland and Wales.

This enabling measure would create a bedrock for mental health equality by deepening the duties on public bodies to pursue equality and ensuring that wealth and income inequalities are given the same status in the implementation of the law as the other nine protected characteristics. It would also extend accountability by placing greater expectations on organisations to demonstrate to their public how they are addressing inequalities and what progress they are making to close gaps.

CONCLUSION: BUILDING A SYSTEM DESIGNED FOR EQUALITY

Our recommendations identify some of the large scale changes that are necessary to make a system designed for mental health equality possible. They are not exhaustive, and they will not achieve results overnight. But taken together, they will reset the mental health system towards greater equality and help to break the triple barrier of unequal determinants, access and outcomes. Our system has four key elements:

Addressing the determinants of mental health: addressing economic inequality and social injustice to give more people a better chance of good mental health throughout their lives.

Empowering communities: boosting the capacity of communities to support good mental health, to secure access to earlier and more appropriate support, and to lead systemic change across local systems, with partners and allies.

Creating transparency and accountability in services: to drive progress in improving experiences and outcomes, improve trust between communities and services, and support shared learning about what works.

Committing to change: from businesses and charities to local authorities and central government, to come together to make a difference and create a legacy.

Change is possible, and there has never been a better or more important time to commit to mental health equality. We hope that this report will prompt action, stimulate creativity and ultimately transform people's lives.

ABOUT THE COMMISSION

The Commission for Equality in Mental Health was set up by Centre for Mental Health in 2018 with an 18-month mission to investigate inequalities in mental health in the UK and produce policy and practice proposals to tackle them.

The Commission is chaired by Liz Sayce and includes members with personal and professional knowledge and expertise about mental health inequalities. It issued a call for evidence at the start of 2019 and received about 100 responses from across the country. The Commission sought evidence from as wide a range of people and places as possible, from published academic papers to narratives from groups and individuals. We particularly welcomed evidence from people and communities that experienced mental health inequalities first hand.

The Commission sought to understand why and how inequalities in mental health happen, the ways they manifest, and most importantly what can be done to prevent or mitigate them. Our call for evidence sought evidence about inequalities in the determinants of mental health (the factors that have an influence on how good or poor our mental health is during our lives), in access to help (of all kinds) for our mental health, and in the outcomes that people get when they receive support.

The Commission has particularly sought solutions to mental health inequalities. It has explored solutions at every level: from community-led initiatives that seek to challenge power or resource imbalances locally to national policies that could help to make mental health more equitable.

The Commission's ultimate aim has been to bring about a significant and sustained reduction in mental health inequalities. This final report sets out our recommendations for what a system designed for equality should look like.

The Commission was generously funded by the Elliott Simmons Memorial Trust. We are grateful for their support in enabling us to carry out this important piece of work.

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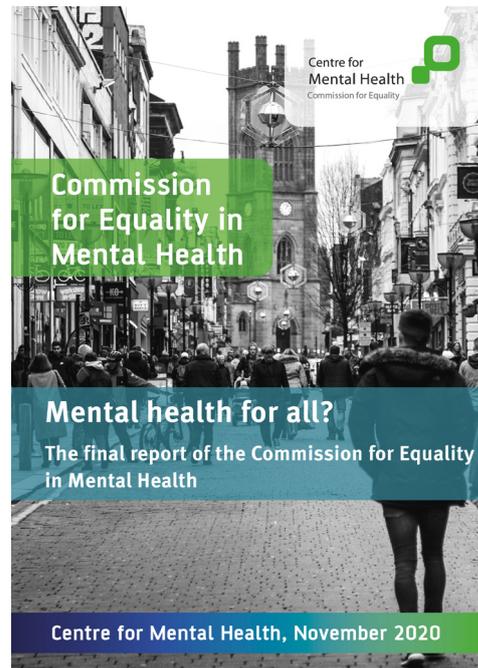
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