

From crisis to **RENEWAL**

Redesigning the mental health
system around
people and communities



Caroline Wierzejska
Nick Webb
Ella Walding
Daisy Carter

This research forms part of the Covid-19 response from the Living Well UK programme.

Innovation Unit is a social enterprise that grows new solutions to complex social challenges. By making innovation happen we help create a world where more people belong and contribute to thriving societies. We build alliances with ambitious places, organisations and systems around the world to adapt, adopt and scale innovations that deliver lasting impact and reduce costs.

Living Well UK is funded by The National Lottery Community Fund and is led by Innovation Unit. It supports four pioneering places in the UK to build Living Well systems of support for good mental health and wellbeing. Living Well systems put people's strengths and lived experience at the centre and are designed to help people recover and stay well as part of their community.

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Introduction

This report makes the case for a different kind of mental health system. Based on interviews with people with lived experience, front line professionals, managers, leaders and commentators, it draws out a series of insights into how the system has responded to the Covid-19 pandemic, and what this tells us we should drop, maintain, change and grow if we are to improve mental health outcomes and reverse the worsening of our collective mental health.

Other organisations have looked at how the crisis is affecting people's mental health or local communities. While this report covers some of that ground, we are mainly interested in how the system has responded and the lessons we can learn for how we might move from crisis into a dynamic process of renewal. Renewal means reviving, changing, or giving up what has been lost or destroyed.

By 'system' we mean the established arrangement of structures that define how and when help and support is offered and provided. Structures include everything from how money is managed and where it flows (via established commissioning protocols), how services relate to each other (e.g. via patient pathways, referral routes and handoffs), and what kinds of support are favoured (e.g. clinical/medical models). In our definition, the system includes family, friends, neighbours, community, the voluntary sector, as well as the statutory sector, and we are interested in how energy, ambition, money and other resources are unevenly distributed across these domains.

Our contention is that the ways in which the system has responded to Covid-19 reflects deeply ingrained, and long standing structures, patterns of behaviour, biases, deficits and strengths. Equally, crisis impacts are accelerating pre-existing social, cultural and economic trends, many of which are, rightly, being moved from the margins to the centre of debate. At the same time, the response to the crisis has proven the ability of the system to change at pace: we have seen organisations mobilising collaborative new services within weeks, the rise of grassroot community initiatives, hundreds of thousands of volunteers and individual acts of kindness and support. New possibilities have emerged.

Many systems are increasing the urgency for planning processes of recovery to return to normal. At the same time, there is a story of emerging possibilities that challenges the idea that we could ever return to where we were before the Covid-19 crisis started, or indeed whether we would want to. This tension asks us whether the frame of recovery is what we need, or instead whether our collective desire is for a process of renewal; where we ask ourselves, our organisations and our systems, what do we wish to abandon, retain, grow and nurture?

Summary

What did we find?

1. The Covid-19 crisis has contributed to greater mental health inequalities in the population

- Lockdown and social distancing has contributed to anxiety and distress and created hypervigilance in many people. Some people felt trapped. Isolation from friends, family and broader society led to loss of meaning and purpose. It has disrupted the progress people had been making in improving their mental health.
- The crisis has brought existing social and economic inequalities and injustices to the fore and made them much more visible and painful.
- In contrast, some people with poor mental health had a more positive experience of lockdown and social distancing. They saw an opportunity for self-reflection, self-determination and self-care in stepping back from pressures they faced prior to Covid-19.

2. The Covid-19 response from mental health services has made accessing support harder

- Some people felt abandoned by the system and found it more difficult to access services. Some people felt they were shut out completely. Others said that because services had an increased focus on managing risk, the support they eventually received felt more paternalistic and less human.

3. As access to services became harder, people described increased importance of, and reliance on informal networks and called for shared community spaces for compassionate support

- We heard a strong case for the importance of social networks and personal relationships, and powerful arguments against the medical model of mental health, as well as a call to 'normalise' human suffering.
- At the same time, many people advocated passionately for the importance of informal, shared community spaces where people can simply be together to share experiences of suffering and hope, and be supported compassionately.

4. Greater use of technology in service delivery created new possibilities for some and new barriers for others; user choice and flexibility made the difference

- Some people had positive experiences of remote service delivery: they felt safer and more in control having conversations with clinicians over the phone. They described a power shift - they felt more empowered in their relationship with staff.

- Some mental health practitioners felt that the 'therapeutic alliance' between clinician and patient can be achieved successfully while working remotely.
- However, some people described how they lacked access to technology. Some people have low levels of digital capability. Some do not have safe spaces within the home for private/emotionally difficult conversations. And many had difficulties in establishing trust and connection over the phone or across a screen.

5. Staff had very different and unequal experiences of working in the mental health system during Covid-19

- Some staff described how they felt energised by working in different ways, especially where their role shifted from management and office work to more direct frontline practice. Some staff were well supported by detailed guidelines on how to provide care.
- However, other staff felt that guidance and protocols were unclear and unhelpful. Others felt unsafe and under pressure, and did not feel well supported. Some staff felt they were left alone to make difficult and critical decisions without support from a wider team.

6. Response to Covid-19 has shown that rapid change in the mental health system is possible, and highlighted the potential of collective civic action

- Collaboration and partnerships were strengthened between organisations across the system. Some commissioners relaxed red tape and trusted providers to get on and deliver differently and use their judgement and discretion more.
- Fast-paced changes to delivery were made in a matter of weeks. Some areas were able to discharge people into community based services in ways that were well planned.
- Collective civic action was crucial in supporting the vulnerable - the community and voluntary organisations rose to the challenge. People described an opportunity to significantly increase the role of communities in taking care of one another and moving towards better mental health.
- However, rapid changes were not successfully implemented everywhere. In some areas secondary care services were closed too quickly. Some people feel they were prematurely discharged into the community and found it difficult to get any help from secondary care.
- Some people expressed anxiety and scepticism about the involvement of people with lived experience in the design and implementation of change.

Vision for a different and better mental health system

Based on the research findings and our wider work in the mental health sector, we describe a vision for a new mental health system, one characterised by a shift of power towards communities.

We recognise that the current system revolves around diagnosis and treatment of illness. When people become unwell, we attempt to fix them with mental health services. Since illness is thought to lie within and inside the person, wider social and environmental influences remain instead largely unaddressed. In the current system, power resides with professionals who often occupy a dispiriting role of assessing and controlling access to support.

In contrast, the new system we advocate for is centred on the role of people and communities. Suffering and distress are understood as a universal experience. People are viewed holistically, in the full context of their lives. Care for self and others is emphasised as a key part of cultural life in the UK and communities become places for mutual care and support where distress is accepted and made sense of.

Services work in the service of mentally healthy communities, with professionals being part of a non-hierarchical ecology of support. All forms of support are invitational, and need and demand are embraced, not managed.

Achieving this vision will be difficult. It will require a change in our attitudes to mental illness, changes in where money flows, and significant effort to build a new culture of self care and care for others.

The report finishes with appeals for ambitious partners to join us and work on two big priority areas that will help realise this ambitious vision.

Priority Area 1: Support localities to deliver the community mental health framework, through new integrated multidisciplinary teams, enabled by technology, powered by staff from primary and secondary care, and the voluntary sector

Priority Area 2: Support local public health leaders and their partners to develop a new vision and narrative for public mental health and deliver new community-based initiatives to create a new cultural movement of care for self and others

We invite everyone who would like to work in these areas to get in touch with us.

Methodology

Our insights are based on a series of in depth interviews with 28 individuals, ranging from people with lived experience of poor mental health (8), to front line professionals (8), managers and leaders working in statutory and voluntary parts of the mental health system (8), and academics and commentators who focus on mental health (4). The full list of research participants can be found in Acknowledgements.

In the interviews we used different questions, tools and activities to understand diverse perspectives, allowing us to analyse the system from multiple viewpoints and draw out common themes.

This report also includes knowledge and insights we have gained from our wider work in social care, health and mental health - specifically the National Lottery funded Living Well UK programme. Throughout this research, we have taken care to honour the perspectives that people have shared, and to avoid overlapping pre-existing insights that do not directly support and amplify what we heard in the interviews.

Insight 1

***The Covid-19 crisis
has contributed
to greater mental
health inequalities in
the population***

For many people, lockdown created mental health problems, including anxiety and hypervigilance. It undermined some people's sense of meaning and purpose, and as highlighted by some system leaders and commentators, confirmed the damaging impacts of long standing injustice. For a minority, lockdown brought a greater sense of self-determination and provided time and space for reflection, renewal and self care.



Increased anxiety and hypervigilance

Lockdown has been a disruptive event in the lives of people we spoke to, and prevented some from working on their mental health.

“Basically, I was feeling optimistic for the first time in a while. Lockdown came along and it has knocked everything dead and threw me back into a hole. It basically made me dust.”

- John, person with lived experience

One of the common challenges people struggled with in lockdown was an increase in anxiety. This is not unique to the Covid-19 pandemic. Professor Richard Bentall quotes a psychological study that looked at the 2009 H1N1 pandemic in Hong Kong, which found a spike in anxiety around the time that the H1N1 pandemic started. This increase in anxiety is particularly pronounced for people with existing health and mental health challenges. So for many, key messages during lock down reinforced obsessive patterns of thinking and validated fears.

“The main messages were ‘wash your hands’ and ‘make sure you stay clean and healthy’, for people with OCD or anxiety hearing those messages in an obsessive way mimic the patterns we already have ingrained into our minds already. And I’ve managed to control it, but then seeing that broadcast everywhere validates that way of thinking, it brings it back, so I was obsessive about washing my hands.”

- Aurora, person with lived experience

“Then it was just like an overwhelming flood of anxiety. I was just really, really miserable. I was terrified. I started getting terrified and I was just like, cause I’ve been starting to get worried lately just going outside. I thought if I cough or if I sneeze that someone would attack me or something.”

- Sarah, person with lived experience

On top of increased anxiety about the pandemic, some people were worried that amidst social isolation, their deteriorating mental health might not be noticed by others who would normally help them judge if they are OK. Lots of touchpoints, ordinarily in place to hold people, shifted to virtual check-ins. This made them feel less in control:

“Normally, there’s a lot of people that I would be seeing every day that would see a warning sign if I was going to become more hypomanic or manic or whatever. Now, there isn’t. Most of what I do is just phone calls so there’s no one really to notice. No one will know until it’s so bad, it’s a disaster.”

- Sarah, person with lived experience

“Normally there’s a lot of people that I would be seeing every day that would see a warning sign if I was going to become hypomanic”

The language used in Government messaging may have caused additional anxiety for those more susceptible to worry. Professor Paul Gilbert and Doctor Amy Pollard were critical of the words chosen to talk about the pandemic and instil new social norms. Terms such as social distancing, lockdown, stay alert! focus on threat and feed anxiety. The phrase ‘Stay alert’ in particular can encourage hyper vigilance. Instead, Gilbert argues we should be talking about safe relating, which emphasises the importance of staying connected.

Increased loneliness, loss of purpose and feeling trapped

Many people felt lonely. Links between loneliness and poor mental health have been increasingly well documented.¹ During the pandemic, social interactions have decreased for most of the people we spoke to. This was particularly difficult for those who contracted the virus and who needed someone to care for them:

“Within a few days of lockdown, I was diagnosed with coronavirus. It was very bad timing, so I was already very depressed and fragile. Then, I was really, really physically sick. I couldn’t breathe at all, and I just wanted someone to take care of me. I couldn’t wash my own dishes. I could barely make it to the toilet. I would just lay there and cry, but I couldn’t even really enjoy my crying, because I couldn’t breathe. I was just having a meltdown.”

- Sarah, person with lived experience

Lockdown damaged some people’s sense of purpose. Given the restrictions of lockdown, many people we spoke to were unable to engage in their usual activities and as a result their lives have lost some meaning.

“The thing is there’s no reason for me to get up, there’s nothing for me to do the next day, I have no motivation to go to bed, no motivation to even get up in the mornings because I literally have nothing to do.”

- Aurora, person with lived experience

“I was beginning to start to meet some very interesting people. Starting to plan to make music, starting to plan to teach youngsters how to play guitar and there was potential for work in the future to be teaching people bass and teaching people drums, teaching people how to record music using their own computers. I was feeling optimistic and then the virus came along.”

- John, person with lived experience

The feeling of being ‘trapped’ during the pandemic was common across people we spoke to.

“I haven’t been able to get outside that definitely affects my mood. Then, I feel really shut in the house and I feel trapped and I don’t like to feel trapped.”

- Aurora, person with lived experience

As Professor Paul Gilbert points out, the term lockdown itself is close to lockup. For those with experience of prison, lockdown triggered memories:

“Feels like we ain’t got no oxygen, so you can’t breathe. That’s the best way to explain. I had a couple of dark dreams where I’d shout out like, ‘No, don’t shut the door.’ The first time, I felt like I was having a panic attack in the middle of the night because I felt like I was back in prison. We usually sleep with the door shut, but I have to have the door open now and with the light on outside to realise that I’m at home, not in there.”

- Jonathan, person with lived experience

Lockdown has exacerbated a sense of isolation for those who already felt marginalised.

Existing social injustices made worse

Covid-19 and its impact on health and mental health has not been felt equally. In many ways, the current crisis has brought existing inequalities and social injustices to the fore and made them much more visible and painful.

The national concern ² about the differential impact of Covid-19 on Black and Asian minority ethnic people came across from our respondents’ local experience. We may all be in the same storm, but we all are in different boats.

“In our local area, 67% of the people who have died of Covid-19 weren’t born in this country. People know it. Where it struck, it’s very clear within those communities, where multiple people from the same family are dying, that sense of the risk being heightened is very much there. The risk of feeling discriminated against; feeling like the environment is relatively hostile rather than benign.”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

“The key messages that are coming through from the community are this is just highlighting what we know already. So the inequality. That we [Black people] have been dying earlier, quicker.”

- Programme Director at a mental health voluntary sector organisation

And injustice and inequality need to be a central,³ animating issue in mental health system redesign.

“The absence of progress on the issue of Black mental health over decades suggests to us that we believe that - there is a fundamentally flawed evidence base and that it’s actually quite a racist set of assumptions that are leading to this. If the evidence base is not delivering, we surely look at the evidence base rather than keep on trotting out, ‘Oh, it’s evidence-based. It’s evidence-based.’ Well, the evidence base is producing a lot of rubbish, frankly.”

- Programme Director at a mental health voluntary sector organisation

People’s mental health was also affected by where they live. Some were confined to small urban spaces.

“We do try and do a 15-minute walk but we need to go round in circle, round the block of flats but yes, because we’re on the first floor we only have a balcony. That’s the only outside we can do in the flat.”

- Jonathan, person with lived experience

For many people the crisis has resulted in increased financial stress. Worries about money and employment are contributing to anxiety.

“I think they’re worrying about their finances and how they’re going to pay the bills and food and worrying about their parents or other family members who might have underlying health issues as well. I think [this is] really increasing depression symptoms, general anxiety, symptoms of that have really escalated as well. The things that people usually do to cope with some of these things are not readily available.”

- Health worker

It is clear that the crisis has worsened pre-existing inequalities and made it harder for people with mental health problems to cope.

Lockdown gave some people more agency

Counter to the dominant public narrative of a looming mental health crisis caused by the effects of Covid-19 ⁴, we heard some positive stories of lockdown, and of people using the time to step back and reflect.

A minority of the people we spoke to saw lockdown as a chance for self-reflection and an opportunity for change. Altered circumstances actually helped them. With no pressure from external sources, many were forced to develop their own routine and this sense of control over their lives helped them. They felt more self-determined: ⁵

“I went into isolation on my own. Just started doing a lot of self-reflection, realised that I was totally miserable. I knew that deep down but I suppose I never really faced it. I’m sober again and this time it feels a bit different. It feels like I’m doing it for me rather than another reason. Getting really back into my fitness, doing a lot of meditation, learning a lot from reading. I’m grateful in a sense to having this time to do that without the distractions of feeling of keeping up with the world and things.”

- Chris, person with lived experience

“For some people, the lockdown is almost making them feel a bit better about not going out into the community. I’ve got a couple of clients that don’t want to come out into the world. They actually feel better within themselves because now they’re being told not to go out. It’s almost taking the pressure off them. That this is almost normalised now so people can get off their backs to do what society tells them they should be doing.”

- Voluntary sector worker

Many people talked about how they have discovered new ways to cope, including focusing on good memories, exercise, meditation and reaching out to friends or neighbours who are struggling.

For some people this time to reflect and plan their own routine without any outside pressure, and the awareness of the need to look after their health, meant that they adopted healthier lifestyles. They felt proud of themselves for doing this. This in turn led to an increase in the feeling that they were worth something, and it was worth taking care of themselves.

“I think it’s just self-respect. It’s self-love in a way. It’s understanding that-- if you care for yourself, you should treat yourself as though you’re somebody who you’re looking after. I have been doing that for the first time. I have been eating a lot of soy beans, a lot of good foods, whole wheat pasta and just trying to be super, super healthy. I think it all subconsciously makes you respect yourself more. There’s the looking after yourself, the caring about yourself, the exercise, the routine, all that I think is very, very important, and all together, it just makes you feel like, ‘I’m never not all right.’ I feel great for doing it”

- Chris, person with lived experience

Some people found that in the absence of many societal pressures their well-being increased.

“I think the outside source is this constant bombardment of, ‘You must be better. You must strive for more. You must attain this.’ Do you know what I mean? Social media is just ramming it down your throat, ‘Look how great my life is. Look at what I’m doing. Look where I’ve got.’ No wonder you feel like you’re a piece of crap. Having a nice car, and a nice house, and six kids, doesn’t make you the best guy in the world. What’s more important than having all that or having an understanding of who you are and who you are as part of a human society and what you can do to help people and how we can all make each other better?”

- Chris, person with lived experience

This was reinforced by the fact that many people we spoke to expressed fears about having to rejoin what they perceived to be a society that was often overwhelming, once lockdown eases.

“It’s like when you come out of prison isn’t it, it’s facing the big world again, the big bad world. Everybody’s out, everything’s back to normal, the adverts are coming back on TV, you have to buy this. It all starts to get back to normal. You have to face everything again.”

- Jonathan, person with lived experience

“I’m also fearful of going back to an angry city”

- Alfie’s Mate, person with lived experience

For some people, the reduction in social pressures was liberating and helped them develop a sense of agency, and this had positive impacts on their well-being.

“We may all be in the same storm, but we all are in different boats.”

Insight 2

The Covid-19 response from mental health services has made accessing support harder

During lockdown some people felt abandoned by the system. They found it more difficult to access services and some people felt shut out completely. Some people said that because services had an increased focus on managing risk, the support they eventually received felt more paternalistic and less human. At the same time, we found evidence of pockets of great support, tailored to individual needs and often practical in nature.

WAIT
UNTIL
ME IS
OR IF

RECEIVED A
TEXT MESSAGE.
THANK YOU!

IS YOU BEEN WAITING
LONGER THAN 15 MIN OF
YOUR PICK-UP TIME TEXT 415-
999-4428

P.S.

THIS IS THE PLAN FOR RIGHT
NOW, UNTIL WE FIND A BETTER
WAY TO SERVE YOU, AT THE
TIME, KEEP

People in lockdown wanted support but found it hard to access

This research highlights the patchy nature of mental health support, a kind of postcode lottery, depending on where you live. Some places struggled to maintain care and support, others were more successful. Accessing and navigating mental health services can be difficult at the best of times, and the crisis made it much harder.

“I was petrified so I was like, ‘I got to find out what it is, this ain’t normal, I don’t know what’s going on’. I went to the GP. He didn’t kind of give me an opportunity to ask and he just gave me a prescription and told me to go. I remember I broke down in bits to my partner and I said to her, “I don’t understand. I thought the doctor’s meant to help you.”
- Jonathan, person with lived experience

“We do gatekeep quite a lot of the services for mental health. The local SPA, for example, is the gate keeping part of the organisation for the acute services and people in crisis. But if people don’t know how to contact the SPA, you wouldn’t even know to Google CNWL because you don’t know that they’re the local provider.”
- Paula Arnell, Head of Commissioning, Hillingdon CCG

Some services, such as crisis support, became harder to access during the pandemic, leading to increased difficulties for people with lived experience of poor mental health. Some people felt there was just enough support to get them by, but if their mental health deteriorated they would be in trouble. Several people felt altogether abandoned by the system.

“My standard everyday care, while it’s not as good as it was before coronavirus, it’s still fine, but if I were to get really depressed again tomorrow I would be screwed because then I would need more than just a phone call. That other stuff isn’t there. Normally I’ve ingrained in my head this is what I do in a crisis. They haven’t really provided an alternate thing for what I do now. If you are already half-dead, you can call 999, I guess.”
- Sarah, person with lived experience

“I haven’t heard anything from the NHS at all. For weeks and weeks and weeks, I thought, “Oh, I’ve been abandoned. I’m in the nowhere zone.” I can’t live without the asthma medication. The other week, they cancelled all my asthma medication. Fuck it, I’m totally stressed. I felt like they were mad to be throwing me in the bin and saying, ‘Look, you claim too many benefits, you’re a waste of space, fuck off.’”
- John, person with lived experience

Going forward, how can we make sure that people who are not experiencing immediate risk are still held and supported? The fact that someone is not in immediate danger does not mean that they won’t need a safety net. The disruption of services led to some people feeling that no one cared.

An increased focus on risk and safety made support feel more paternalistic and dehumanised

Quite rightly, most major statutory, voluntary and funding organisations have been focused on providing an immediate crisis response, on what they can and should do to limit the impact on the NHS, limit disruption to ‘essential’ services and minimise contagion.

We know from this research and from wider conversations with our partners in the public sector that many senior leaders and managers relied on ‘command and control’ to make decisions and deliver initiatives at pace. At the ‘frontline’ of services this in turn led to paternalism and disempowerment of staff, and in some cases a loss of sensitivity to, and focus on, mental health needs. The immediate physical threat of the virus pushed other concerns to the side. Understandably, keeping people safe from infection and addressing their most basic needs became the top priority.

“Instead of promoting people to go out into the community to engage with whatever it is out there, we’ve been, ‘No, you need to stay home and no, you shouldn’t be getting into that person’s flat, and actually, you can’t play chess in the communal area.’”
- Voluntary sector worker

“She was like, ‘Why don’t you start going outside?’ I was like, ‘I can’t really go outside, because a little over a week ago, they told me I had coronavirus. They said I’m fine now, and I can, but I can’t barely breathe when I go out.’ Then, she launched into this huge thing. It was like, forget about my mental health. She was just lecturing me about protecting the public, and I needed to stay inside.”
- Sarah, person with lived experience

“It’s like, if you have really really bad coronavirus, you’re very important. If you have moderate or mild coronavirus you’re just an awful vector for disease and you should hide in your home in shame and if you have any other problems, mental or physical, you’re just not important. You can wait your turn. It makes me feel like crap.”
- Sarah, person with lived experience

Keeping people safe from the virus meant more support was ‘done’ to people rather than with them. There was a cultural shift in some organisations from empowering people to doing things for them. On a practical level, this has meant things like filling in applications on their behalf, instead of with them, and sorting out housing.

“I’ve been abandoned. I’m in the nowhere zone.”

“The lady with the learning disability, I manage her Universal Credit account. I’ve done it all. I’ve made up a PowerPoint. I’ve literally done it all. I haven’t done it with her and I have to manage it because she hasn’t got the internet and wouldn’t know how. It’s about promoting independence and having to do it for somebody it’s not, but it’s the only way we can get it done.”

- Voluntary sector worker

The processes and guidelines for interacting with people at times felt dehumanising.

“I think it’s outrageous, personally. Dehumanisation. ‘Oh, don’t let them come in. They’re the lepers,’ when we could have the virus ourselves. We all go home to our families. I also find it personally really quite offensive walking in all gloved up and masked up so I just use precautions.”

- Voluntary sector worker

“I remember someone said to me once ‘you know you don’t have to see people’ and I was a bit like, ‘well yeah I do, it’s my job’. It just depends on what service users want.”

- Health worker

Social distancing reinforced pre-existing stigmas. In a world where many people already felt judged, social distancing was mixed up with feelings of worthlessness and rejection, and triggered old traumas. Sometimes, what was intended to be support caused greater anxiety.

“I got this text from the NHS saying what to do if you’re suddenly going to die. I went cold. It’s almost like I’m not in need. I’ve been put in the bin, ‘Well, if you get [coronavirus], you’re going to die, so just sign here.’ It’s not right, it’s really appalling. My mental health has gone downhill over the last few days just reading that, unbelievable. Even thinking about it now I get the shakes. I’ve gone right into panic. It’s disgusting, it’s revolting really.”

- John, person with lived experience

The necessary adjustments that services made to keep people safe had an effect on culture and practice, and these in turn reduced people’s sense of agency and self-worth.

Some people experienced great support

There were of course fantastic pockets of support and we got to hear about some of them during our interviews: GPs offering a security blanket, therapists providing excellent remote care, peer coaches trying their best to focus on client’s goals.

“I always end up hanging up with a smile. Even when I was really, really depressed and miserable, My GP is like a security blanket. She just makes me feel better.”

- Sarah, person with lived experience

“I was feeling quite upset and down. I was getting quite stressed that I was wasting time. I rang the centre, and literally two hours later, my worker had rang me. Then I spoke to her and we sorted everything out and I left the phone call feeling a lot better than I was. It was really good.”

- Aurora, person with lived experience

For the people we talked to, formal and informal support has been vital, including practical help that can make a significant difference to everyday life.

“I had a lady yesterday who wanted to order some food from a deli. She’s agoraphobic and doesn’t speak on her phone. I wanted her to make this call, I said, ‘Why don’t we try today to take the opportunity?’ So, we wrote it all down first, got an outline of exactly what she wanted to do and she made that call! It was fabulous. I said, ‘Wow. Look at that. You’ve done it.’ She was absolutely amazed herself”

- Voluntary sector worker

Our research shone a light on committed staff working hard to help people as best they can. A lot of the support offered during the crisis was practical, helping people to solve everyday problems.

“The fact that someone is not in immediate danger does not mean that they won’t need a safety net.”

Insight 3

Where services were harder to access, people described increased importance of and reliance on informal networks and called for shared community spaces for compassionate support

We heard a strong case for the importance of social networks and personal relationships, and powerful arguments against the narrow medical model of mental health. We heard a call to 'normalise' human suffering, and to engage with it compassionately. Many people advocated passionately for the importance of informal, shared community spaces where people can simply be together to share experiences of suffering and hope.



For many people, the crisis was a moment of reflection on the strength and importance of their social networks

"I'm very grateful to have my brother. I definitely wouldn't be where I am now sober or have even possibly looked for help if it wasn't for him. Having somebody that you trust to just give you a little nudge. 'Look, You're all right. You're doing the right thing.' That bit of support - it totally gets you back on track"

- Chris, person with lived experience.

"I do miss discussion with people. I miss people's opinions. You're not seeing anyone, you're not meeting anyone in the pub or inviting people to dinner. You're not finding out anything that's going on in their world"

- Alfie's mate, person with lived experience

The closure of organisations and the lack of opportunities to volunteer limited opportunities to connect with and support others.

"Dropping into certain cafe group things and with certain particular people on a weekly basis was really, really helping me to feel confident and get my confidence back and remove depressing times and remove anxieties. Then it's all stopped."

- John, person with lived experience

In spite of physical restrictions, some people felt more connected to informal support networks.

"Yes, I've spoken to new people. They've said that they've basically had the same experience as me. I just felt like we could connect again as well there and then understand each other. I think my support has grown."

- Mia, person with lived experience

For many people, narratives around mental health have changed. There has been a proliferation of conversations about mental health, and more permissions to ask for support. But for people already struggling, it is not always easy to hold someone else's emotions alongside their own. The crisis response made some feel that their problems were not taken seriously. As one person with lived experience told us:

"While on the one hand that's really helpful to know that you're not alone in this and everyone else is getting the same, on the other hand, it makes you feel like your emotions are slightly less valid than they were before"

- Aurora, person with lived experience

Our learning from this research and the Living Well UK programme is that what counts as 'essential' service is not self evident. For most people, what counts as essential, or not, is subjective and personal. We heard many people emphasising the importance of informal support. The idea that there is a clear line between essential and non-essential services feels counter intuitive. Perhaps it is time that people with lived experience define 'essential' on behalf of the system, not the other way around.

Many people argued against the medical model

"That's a key issue for me that, if we over-medicalise these problems and we see them as disorders rather than consequences of abnormal forms of living, then we're going to be stuck. If we can see them, partly as a result of lifestyles that we've had since the advent of agriculture which has made us all mad really, then I think we get a way of thinking about how do we not only prevent mental health problems, but also how do we work with people with mental health problems by having a sense of commitment, having a sense of community, having a sense of connectedness, having a sense of being cared about and cared for, all of those compassionate issues that are fundamental to well-being."

- Professor Paul Gilbert

"We're creating a system where mental health and support around mental health is everybody's responsibility in terms of nurturing environments, endorsing everybody, we don't need mental health experts to do all of that. We just need to make sure we don't try and turn this response in terms of recovery into an ultra clinical medicalised model that is a treatment pathway because the majority of people don't need a treatment pathway."

- Charlotte Ramsden, Director of Children's Services

We also have a tendency to describe people's normal experience of negative emotions as a result of adverse life events as mental health problems, and this is not always helpful.

"The experience of suffering does not mean that you have a mental health problem. That's always been the issue. That somehow if you're not happy, then there's a problem with your mental health. Actually, you can be in an intense state of suffering but actually, you are mentally healthy. If you've lost your partner, you're going to be in an intense state of suffering because you are mentally healthy, because you were loved, because you grieve. You'll feel a pain for somebody who you loved most dearly. That is not a mental health problem. It's a suffering problem."

- Professor Paul Gilbert

We heard strong support for understanding and working with the wider social determinants of health. Mental health services are not always the answer. We can support people to live well by helping them to have good housing, safe neighbourhoods, meaningful work, access to green space, to connect with and support others.

"The experience of suffering does not mean that you have a mental health problem."

“It seems to me that the more we can do to make a fairer society, a more supportive society, a society where people feel that they belong in their neighbourhoods, where they feel safe, where they think that they can trust their neighbours, then that it’s going to make a much bigger difference to the mental health of the nation than a whole army of CBT therapists.”

- Professor Richard Bentall

Our neighbourhoods, the places that we live, should feel like safe spaces to be and connect with the people around us. The challenge is both structural - access to good housing and green public spaces, and relational - how people come together and connect in shared space.

“If you see things happening in your environment it creates anxiety; neighbourhood incivilities - people languishing around street corners or people dropping bottles in the road - that has a knock-on effect in terms of the extent to which people feel that they belong to a neighbourhood and they can trust the neighbours.”

- Professor Richard Bentall

We heard what it means for people to feel held and loved by a support network that sits outside of a service offer.

“I’ve been trying to get in contact with my mum and tried to explain to her that I’ve changed. She basically just rejected me and was, “I don’t want nothing to do with you.” I felt so crap in myself. I had a little mini panic attack upstairs in my room, I just felt like I couldn’t breathe. It just felt like at that moment in time I didn’t have anybody until the kids ran upstairs and saw me the way I was and just gave me a cuddle and said, “We love you, daddy.” It just made me realise, “You know what? I have got something to live for.”

- Jonathan, person with lived experience.

And we heard a powerful case for the role of shared community spaces that offer compassion and understanding

A number of people in this research described a vision for new shared spaces where people can give and receive support; spaces that create opportunities for storytelling, compassion, self care and care for others.

“I guess it would be just having them groups that you can go to, having people you can call any time, people that will listen. Yes, just groups and people you can speak to no matter what time of the day, you can call up then they can offer you an appointment straight away. Making the services available and noticeable as well. Making them look attractive for people to come to.”

- Jonathan, person with lived experience

The many examples across the UK of kindness and compassion hint at a different system based

on support for open access, holistic care built on compassionate relationships where people have spaces to share suffering and support each other.

“How do you make sure that people are not isolated if you’re living in the community? What kind of networks can you help them develop? How do you provide that kind of support? It would probably be much more potent than having a clinical psychologist knock on your door once a week. What can we do to incentivise neighbourhoods so these kinds of networks are maintained? An intelligent government which is focused on well-being would be thinking about those things. I’m not convinced that they are.”

- Professor Richard Bentall

“I think my hope is that actually, since it sounds ridiculously idealistic, but we can create more caring communities on the back of it, that we were showing that there were people out there who genuinely did want to work with and support their neighbours. Not just in the world of mental health treatment or support, but actually we create communities that are healthier as a result of it.”

- County Council Mental Health Commissioner

We need to find ways to enhance people’s feelings of self worth and self compassion. Too many people carry shame, guilt and self-criticism. We also need to help people to hold each other. We are poor as a society at looking after ourselves and one another.

“We need to learn to be able to talk to each other a bit more, share our stories a little bit more, be able to talk about when things are not going well, being able to talk about things when we feel we can’t cope, rather than having to always present this idea that life is great for us we look good. These little things that we can have a lot or a little of, loneliness obviously, self-criticism, shame’s another one. I think the problem is we all become very insulated, isolated in our suffering. We’re not allowed to talk about suffering. Because people are ashamed of it.”

- Professor Paul Gilbert

“We should look out for each other. It should be a more humanistic approach I would say. Like I said as well, the stigma, we’ve got to get rid of that. People have to feel comfortable to say, ‘Help. I’m not okay.’ Do you know what I mean? ‘I need help,’ and not feel like they’re failing in life because of it.” -

Chris, person with lived experience

Supporting people who are suffering means creating compassionate relationships. We know that people with lived experience want relationships to feel human, comfortable and safe.

“People have told us it feels good to use their own experiences to help others.”

“I think what people forget as well is that human on human interaction is personal. Whether it’s a patient-doctor relationship, mentally or whatever, you still have to have certain similarities. What does that person enjoy? What do they do when they’re not Doctor such-and-such? I think that’s quite important. Compassion is just the biggest one really. They have to want to help which I’m pretty sure the vast majority of people do. It’s not just a job.”

- Chris, person with lived experience

We also need to move towards invitational, participatory offers that disrupt the traditional demand management of criteria, threshold, referrals and discharge.

“It comes back to services becoming invitational rather than firm wooden doors that people need to walk through when they’ve got a letter telling them that they can walk through. This presents an opportunity both for greater mutual support. It produces an opportunity to enable people to engage in slightly different ways”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

Mutual support can be a source of healing. People have told us it feels good to use their own experiences to help others. It is also a great way to create meaning and purpose in our lives.

“When I was working with people who had agoraphobia, the idea was to have a group of people with agoraphobia, you take them out. In the end, we established a large community with about 150 people. They all knew each other, and they checked up on each other. They formed their own group called The Way Out Club, and they’d organise little coast trips and that sort of thing. When they could actually share their stories with many others, when they could find that their experience wasn’t abnormal really, this was extremely helpful to people. Mobilising communities to help themselves, I was very, very keen on.”

- Professor Paul Gilbert

“We all just stood beside each other, sat beside each other talking a lot of shite and at the end of the conversation the guy shook my hand, he goes “Thanks very much for that. I haven’t spoken to anybody like that for a long time. My wife died three or four years ago and I haven’t spoken to anybody like that before, for that length of time.” He said thank you very much for that. And just getting that back from somebody, it’s like, “Wow, I’ve just helped, I’ve just changed that guy’s life there. He’s no longer this alone person. He knows he’s got people around him that he can talk to and stuff.”

- Road runner, person with lived experience

“We need to learn to be able to talk to each other a bit more, share our stories a little bit more, be able to talk about when things are not going well.”

Insight 4

Greater use of technology in service delivery created new possibilities for some and new barriers for others; user choice and flexibility made the difference

Covid-19 has prompted a dramatic shift to virtual support. Mind reported that 94% of local Mind services switched to virtual within a few short weeks. Some people found this a positive experience; they felt safer and more in control having conversations with clinicians over the phone. They described a power shift - they felt more empowered in their relationship with staff. Some mental health practitioners felt that the 'therapeutic alliance' between clinician and patient can be achieved successfully while working remotely.

But most people found virtual support challenging and raised concerns. Some people described how they lacked access to technology. Some people have low levels of digital capability. Some do not have safe spaces within the home for private/emotionally difficult conversations. And some had difficulties in establishing trust and connection over the phone or across a screen. What made the difference was giving people choice and flexibility on forms of engagement.



Some people found virtual support a positive experience

Some felt more in control than during face to face engagement in offices. Doctor Amy Pollard recounted how the power dynamic of receiving care has shifted and as a result she feels safer.

She told us how her conversations with secondary care over the phone from her home are much more “unguarded” compared to when she had to go to their offices pre Covid-19. She feels that “In their place” the professionals make the rules and have the power to stop her leaving. For her face to face is sometimes too intense.

Virtual communication seems to resonate particularly well with young people.

“We are getting quite a lot of positive stories about people who engage differently, young people who like virtual communication as opposed to having to sit in front of somebody.”

- Charlotte Ramsden, Director of Children’s Services

Virtual support promises efficiency. Some mental health professionals noticed that they can now get more done in a day, as appointment time has been reduced and there is no need to spend time travelling.

“What it has allowed me to do is speak to more people. I will call them and I’ll say, look, I’m calling out the blue. If you’re okay to go ahead with an interview now, or schedule another time to speak. So I have ended up talking to people more.”

- Consultant Psychiatrist

“It’s interesting, because I think some things have been proven that we can do that over the phone. And like, doctors time seems to be a bit freer because some stuff that can be done over the phone, and meetings and stuff tend to be a bit more streamlined.”

- Health worker

Being able to skip travelling time is especially important in rural areas and virtual support might help with reaching those living in remote places.

“We’ve got 20 local Minds in Wales, where the travel can be challenging - to go in and have your counselling session in an actual physical space, you could be driving three hours there and three hours back or you can just have a Zoom call.”

- Gavin Atkins, Head of Community Services, Mind

The therapeutic alliance is a key element of successful mental health interventions and seems to be achievable in the virtual world.

“I’ve worked both over the telephone and on Zoom and Skype internationally. I do know that you can develop a therapeutic alliance. It just takes a little bit more time and effort perhaps than face to face would.”

- Khalida Haque, Clinical Services Manager at Mind in the City, Hackney and Waltham

Virtual support was challenging for other people with lived experience

For one thing, many people expressed a craving for human connection. Conversations mediated via technology seemed like a replacement and less than the ‘real thing’.

“You’re going through the airwaves so you’re not really getting the one to one connection as you would do with normal talking to people. You’re not seeing their faces. You’re not seeing them as human beings, you could say it is talking to a computer in a way.”

- Roadrunner, person with lived experience

Navigating digital spaces is tricky and many people, even those digitally fluent, find the remote interactions difficult.

“I see a counsellor and of course it is now online. In a superficial way it works but for me it is much less satisfactory - I really miss the human connection - and for me it’s probably much easier than for others as I’m so used to the medium”

- Julia Unwin

“This whole etiquette, Zoom etiquette, is brand new space. I guess this is my Asperger’s talking, it’s really hard for me when I have 12 people talking all at the same time over a computer.”

- Sarah, person with lived experience

Even in one to one conversations, showing vulnerability, an important element of mental health support, feels more uncomfortable in remote interactions.

“My therapist has been ringing me when I email her and ask her if she can give me a call, and while it has been helpful, I can’t really ... I don’t know, I don’t really want to cry down the phone to someone. If I’m crying in person to them it just feels easier in a way. But I still find them helpful to a certain extent, but definitely not in the way I find it helpful when I’m there.”

- Aurora, person with lived experience

The environment in which people receive support has a significant impact on how they feel. Some people do not feel safe in their own home and might not be able to openly talk to a therapist.

“If they’re in a house where they feel or where there is potential abuse or aggression it’s really difficult to have those really honest conversations if they’re holding back for fear of being overheard or somebody is listening into what they’re saying. It’s really tricky.”

- Health worker

Many others simply do not have access to tools or skills needed to engage with support online.

“I don’t have a lot of money, I don’t have a laptop, I don’t have a tablet or nothing so I can’t do this

Zoom thing or whatever really unless I do it on my phone.”

- Roadrunner, person with lived experience

As a result of all these challenges, many people who need support, say they do not want to access remote services.

“Around 35% of our current clients have said that they don’t want to access remote delivery or remote services. There’s a range of barriers there. I guess trust and resources are fundamental themes.”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

People with lived experience of mental health were not the only ones who found the virtual contact challenging.

Adapting to virtual service delivery was also challenging for some staff

Adapting to supporting people remotely has also been challenging for the staff working on the frontline. Many found that it was much more difficult to support their clients without physically seeing them.

“When you’re trying to talk someone into having a discussion about how they might be feeling or what might have led to the increased drug use or you want to think about minimisation and safe using, a telephone conversation doesn’t really have the same impact as seeing someone face to face.”

-Voluntary sector worker

“I have a lady I speak to regularly in Twickenham. She is a hoarder. Before lockdown I really started getting close to her, started opening that box, took a few of that stuff that she’s hoarding and she’d never have actually done before. I was going to be there and help with stuff. Obviously, lockdown prevented me from being able to do that. So, it’s a real setback for her.”

- Voluntary sector worker

Some front line staff members found themselves in new and stressful situations.

“I was working with somebody yesterday and the phone went dead and he’d been sharing with me that he’d had a real increase in suicidal ideation and obtrusive thoughts. Initially, I thought the phone had just gone dead. Then, I just suddenly thought, ‘Oh, gosh. What if he’s hung up because actually he’s thinking about doing something?’ I tried to ring him back and couldn’t get any connection but then, I thought, ‘Actually, I’m going to have to ring 999, get somebody out to his house.’ Then, I was just logging on to my computer and then I thought, ‘I should try him one more time.’ I rang him and he answered and he said, ‘I’m so sorry my phone completely died. I didn’t even realise it was dead.’ Then, literally, two seconds later, he said, ‘Oh, there’s a police car outside my house. Have you phoned the police?’ It’s been a real learning curve.”

- Health worker

It can be particularly difficult to talk about very sensitive topics remotely.

“A couple of people I’ve come into contact with, who aren’t engaging now, we’ve almost burned our bridges with them because that first point of contact is so important. We have to ask if people have been sexually abused in the second meeting. So is he really going to be telling me this over the phone, to a stranger? No. He has disengaged. I get it. I understand.”

- Voluntary sector worker

Some staff were nervous about their own and their client’s privacy because they did not always know who else was present in the house. They also felt there was boundary confusion between work and home.

“You know, in terms of teams, we’re expected to do a lot of this contact in our own homes. And I think no, very few of us would have taken this job if we knew that our homes would have been used as an office ... I think there’s probably going to be a real negative impact of never being able to leave work and work following you around at home and potentially seeing your pictures on the wall and just feeling invaded.”

- Health worker

There are different views on what this means for the future of virtual delivery

There is a growing acceptance that new rituals will emerge - prolonged social distancing, greater use of technology and reliance on virtual networks, stronger attachment to private spaces over the public realm and growth in the number of self help community groups. But it is not at all clear what shape this new world will take and how much of it will stick. Because of its apparent efficiency, it will be tempting to replace face to face interaction with technological solutions. For some this will work well.

“I can squeeze in more appointments, which means that I’m more likely to call people back. I think that is what people really want. I think I’ve been able to provide that to more people.” - Consultant Psychiatrist

But many people worry that austerity might use virtual support to save money.

“My biggest worry is that virtual support is cheaper and it will take away that human contact. There is a risk that we end up thinking that “human contact does not matter”, but it does. For some encounters, the transactional is fine, but for most, we need relationships and real contact, especially when we are distressed. We need the “subtlety” of face-to-face and continuity of contact.”

- Julia Unwin

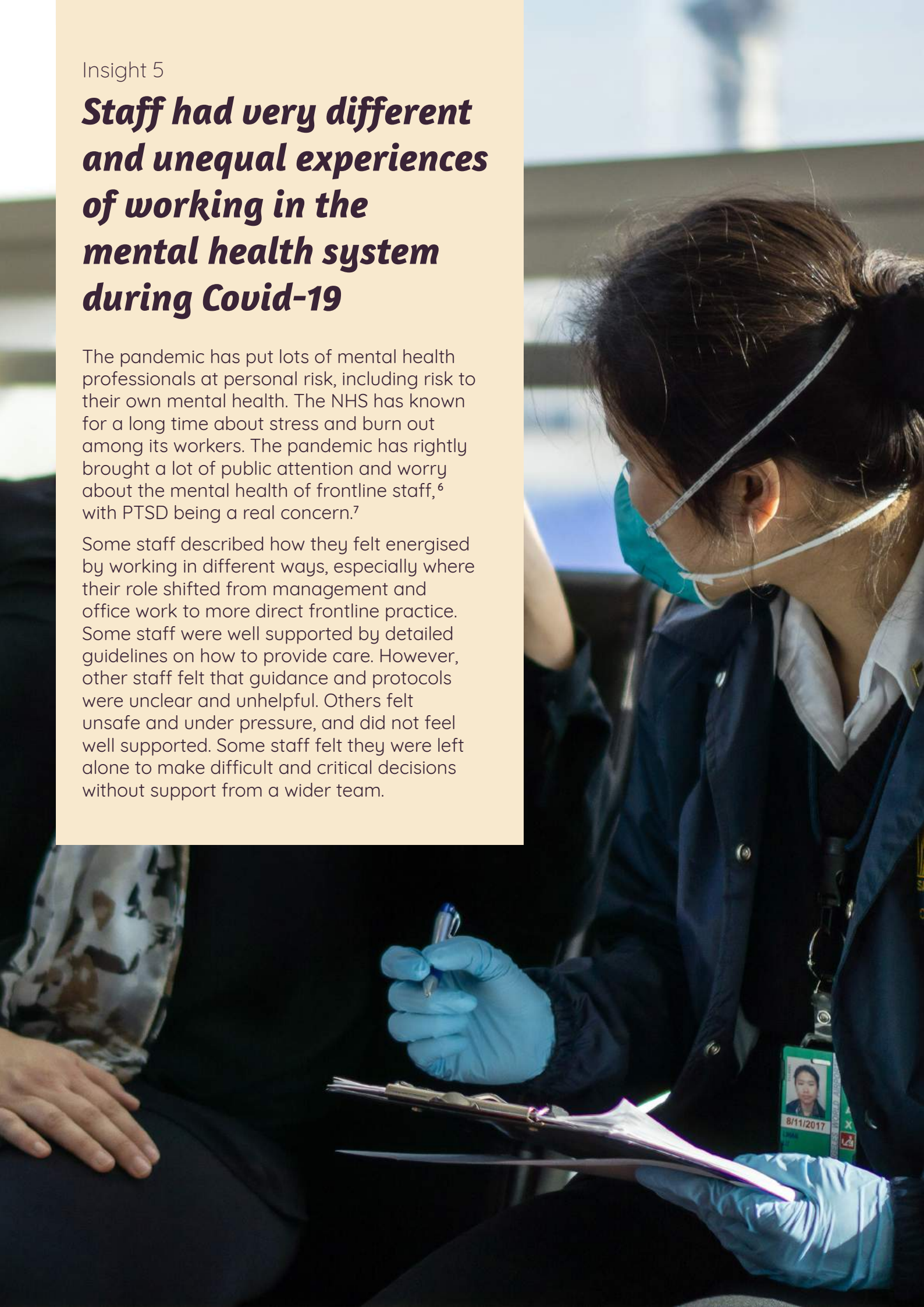
Many services won’t be going back to face to face delivery for some time, if ever, and so we need to pay serious attention to the challenge of integrating technology and person-centred digital tools with ‘analogue’ services that may themselves have to be reimaged.

Insight 5

Staff had very different and unequal experiences of working in the mental health system during Covid-19

The pandemic has put lots of mental health professionals at personal risk, including risk to their own mental health. The NHS has known for a long time about stress and burn out among its workers. The pandemic has rightly brought a lot of public attention and worry about the mental health of frontline staff,⁶ with PTSD being a real concern.⁷

Some staff described how they felt energised by working in different ways, especially where their role shifted from management and office work to more direct frontline practice. Some staff were well supported by detailed guidelines on how to provide care. However, other staff felt that guidance and protocols were unclear and unhelpful. Others felt unsafe and under pressure, and did not feel well supported. Some staff felt they were left alone to make difficult and critical decisions without support from a wider team.



Some staff were energised by the crisis

Interestingly, and counter to what we might have expected, some staff told us they felt energised by the crisis, and we heard about people being moved into roles that are much more suited to them, and more rewarding.

"I am learning lots of new things, which has been really, really good as well. Because I've learned a lot of things that I would've probably never had the opportunity to do. So, that was really positive for me."

- Voluntary sector worker

"We've reassigned a lot of people to different roles, especially the CCG commissioning side, and I think people are actually in roles that are much better suited for them than the jobs that they had before. Suddenly they move from working in a back office, very boring bureaucratic role to actually working on something that's quite exciting and meaty and substantial"

- Joe Nguyen, Managing Deputy Director, Hillingdon CCG

This suggests there is untapped energy and an opportunity to rethink staff roles in a future mental health system. This could include minimising back office roles, reducing 'red tape' and freeing up more people to work on the front line. Through the Living Well UK programme, we have found that often more time and energy is spent processing and assessing than providing therapeutic care. The Covid-19 crisis has hinted at opportunities for rebalancing resources towards the frontline.

Some staff felt unsafe and stressed

During the Covid-19 crisis staff have had to cope with the challenge of keeping themselves safe and trying to reassure service users who are more anxious than usual. They have become vulnerable to the emotional distress of encountering more people losing their lives and some have had to confront their own mortality.

"Colleagues who are working with the front line as well, the amount of deaths that they have to deal with, and loss, and bereavement. I don't think that we've even scratched the surface in terms of how this is impacting people."

- Joe Nguyen, Managing Deputy Director, Hillingdon CCG

"We've got staff that are fearful to come out of their own houses, let alone do work and come into the office."

- Voluntary sector worker

"There was a huge amount of fear. A lot of it was that staff felt they could die. I guess you can die. I'm now thinking it's important that we don't take that off the table."

- Voluntary sector worker

Managers worried about keeping their staff safe.

"PPE is an ongoing issue. The majority of my staff take public transport and their anxiety when the lockdowns had started around traveling was massive because other people were still going to work."

- Voluntary sector worker

But this wasn't experienced by all members of staff. As one health worker commented: *"It's almost like being in a bubble. There's only five of us in there and we're at very different ends of the office and you never have anybody else coming in, so actually it feels quite safe."*

Whether staff felt safe or unsafe depended on the approach of the organisation and individual viewpoint.

Some staff felt they were given unclear instructions and felt poorly supported. This mirrors the patchwork quality of effective support for service users. Into the future, how might we ensure that all staff, and all service users feel well supported?

Not all staff felt well supported

Some voluntary sector staff described how team supervision was replaced with 5 minute updates, and others reported absent managers:

"I was really poorly. I phoned up, as you have to by protocol, and I couldn't get through to any of the managers. Well, I text to say, 'I really don't feel well, I'm going to bed.' No response. I emailed. No response. Half-past three I phoned all the managers again. No response. That tells you the level of care."

- Voluntary sector worker

Staff also missed opportunities for peer support opportunities that were less likely to occur in a virtual world.

"It does feel very separate, it just feels a bit more you're on your own - you're not really on your own because everyone's on the other end of the phone - but it's just not quite the same as walking into a room and saying, 'Oh, I've talked to a person. I just need a little bit of support'"

- Voluntary sector worker

Several people commented that multi-disciplinary working had been one of the first things to be sacrificed, and that this had been an important space for shared decision making:

"Before the service manager would read out the report and we would think together as a group, everyone's opinion was part of it. Now we do on Zoom, but it's just not the same."

- Voluntary sector worker

"I think what has been missed from this is

"There is untapped energy and an opportunity to rethink staff roles."

that there were certain functions of morning meetings. For example, before we would discuss all new allocations every morning. Now the team leaders discuss them and allocate them out. The multidisciplinary response has disappeared. That's a real loss."

- Consultant Psychiatrist

But this wasn't everyone's experience. In organisations that were already sensitive to staff appetite for reflective discussion and supervision, staff felt that support had been maintained:

"We did a lot of staff wellbeing stuff beforehand and we still do now. We have reflective practice groups. And that's still been going on with social distancing, so there's more groups with less people."

- Health worker

"We have weekly supervision and that all still goes ahead as normal. The support is just fantastic in this team."

- Voluntary sector worker

There were also examples of how the crisis led to new, better and more frequent support, including greater access to specialist advice and information on research:

"A lot of the clinical academics have come out and started working in frontline services. They started setting up new things like a telephone line for all staff to just call them up and give advice. The ADHD service has done the same and they've been involved in setting up Consultant Connects for GPS. Clinical academics are now really bringing the research into the frontline - to have that recent information has just been brilliant."

- Consultant Psychiatrist

There is good practice across the UK in staff wellbeing programmes, but we wonder how extensive and effective they are, and what lessons can be learnt from the crisis about how to care for frontline mental health workers. In the Living Well UK programme, we have heard many staff saying that behind their lanyards, they are people with lived experience too.

What distress are we missing? How might we improve support?

Some staff felt they were given unrealistic, unclear and unfair instructions

We heard complaints about excessive guidelines constraining how professionals were expected to act and what decisions they could make. In some places there was a lack of shared decision making, shared responsibility and multidisciplinary team working. This left staff feeling exposed and individually responsible.

Staff weren't always in agreement about how to support clients. For the most part, staff were being told to see their clients virtually, instead of face to face. However many staff faced challenges that made

virtual delivery inadequate, such as supporting those who are deaf, providing practical support when people needed to use a computer, or helping them to care for themselves more effectively. Staff felt that there wasn't enough guidance to help them understand what to do in these situations, so they used their own judgement. This led to tensions between staff about the best ways to support people.

"I'm still doing things pretty much the same. That's kind of like a personal choice. I'm young and healthy and don't have anyone vulnerable in my family."

- Health worker

Some clinicians received forensic guidelines detailing how to work, and how to keep themselves and clients safe. But this still left them with the responsibility of making a judgement on whether or not to see clients face to face, so the guidance did not actually help them make decisions:

"As a clinician, I'm constantly being bombarded by guidelines. Increasingly stringent guidelines about what I'm allowed to do. I can't pass my pen to a colleague, I can't sit anywhere near them. I can't possibly visit a client unless I have an overwhelming clinical need. If so, I have to be fully dressed in PPE. It just feels quite scary as a professional to have to decide what is important to somebody. It is clear what to do if someone wants to end their life, but what if someone is saying they feel they are trapped at home and they are never going to leave again? Is that essential?"

- Health worker

Ultimately, they felt they were at risk of being personally held accountable for life or death decisions:

"The responsibility is entirely on me. If I do that, and somebody gets unwell, they don't sue the Trust, they sue me. I can understand why they are doing it as they don't want a lawsuit and I get it. But I am afraid. We need that element of security. When I ask a manager if I can go for a walk with someone they say, 'well I am not going to put anything in writing as that puts me in a really vulnerable position'. No one is going to understand why we took that person out on a walk. They don't understand that person was losing all meaning. They aren't going to say that was essential. That scares me more than the virus to be honest."

- Health worker

In Living Well UK, as in a number of innovations in children's social care, the freedom to exercise professional judgement and autonomy is both important and enabling, but it is always 'held' in strong multidisciplinary team cultures where staff can get help and support in decision making.

What lessons can we carry forward in balancing individual responsibility with shared accountability?

Response to Covid-19 has shown that rapid change in the mental health system is possible, and highlighted the potential of collective civic action

At the start of the crisis fast-paced changes to delivery were made in a matter of weeks. Across the country we have seen:

- Diversion of access to mental health support away from hospitals
- Restriction of access – tightening still further the number of people eligible for secondary care, including stopping informal or voluntary admissions
- Closure of mental health wards
- Creation of physically separate mental health A&E departments
- Community facing psychiatry, replacing inpatient/ward-based care

Collaboration and partnerships were strengthened between organisations across the system. Some commissioners relaxed red tape and trusted providers to get on and deliver differently and use their judgement and discretion more. We found that some areas were able to discharge people into community based services in ways that were well planned.

However, rapid changes were not successfully implemented everywhere. In some areas secondary care services were closed too quickly. Some people feel they were prematurely discharged into the community and found it difficult to get any help from secondary care. Senior managers found it difficult to meaningfully involve



people with lived experience in the design and implementations of changes.

At the same time we have seen a significant increase in collective civic action in the face of Covid-19, which is a natural psychological response to crisis. Individuals, communities and voluntary organisations were crucial in supporting the vulnerable. If we are able to build on this energy and new grassroots networks of support, we have an opportunity to significantly increase the role of communities in taking care of one another and moving towards better mental health.

The system changed at pace in response to the crisis

In the space of a few short months, we have witnessed the mental health system flex, stretch and shrink. Understandably, most major statutory, voluntary and funding organisations are focused on the need for an immediate response, on what they can, and should do now, to limit the impact on the NHS, minimise contagion, and, most importantly, keep people safe. In many areas demand is high.

“Our Local Mind was reporting that their waiting list had gone up hugely since the end of February. They’d literally quadrupled, their waiting list and they were struggling.”

- Paula Arnell, Head of Commissioning, Hillingdon CCG

Systems are struggling to meet people’s needs. People with lived experience told us how they have struggled to access services, and some voluntary sector contributors described statutory support as “non-existent”. There is some evidence that cases have been closed if people could not be reached:

“The protocol is, if they don’t engage, you just close them. Equally, some of our guys haven’t even got phones. How do we know that their phone hasn’t had to be sold? In these times, I think it’s a bit too quick to just close somebody because you can’t get hold of them”

- Voluntary sector worker

People have also seen a reduction of community-based voluntary support because the voluntary sector did not have the same resilience as statutory organisations.

“Our third sector charity groups have completely shut down. All the organisations we would usually refer people to aren’t open any more. They don’t have the same support as bigger organisations and as a result, they kind of all fall apart. We’ve taken them for granted a lot as a Trust, these people that sacrificed their whole lives but when something like this happened, they have no idea how to respond.”

- Health worker

These new challenges in accessing support also made it easier for people to fall through the cracks.

“There were all sorts of feelers out there before where we might have picked someone up and said, “You need some support and get involved.” And I worry we might miss them.”

- County Council Mental Health Commissioner

“We’re seeing a lot of people not actually accessing support because they’re in lockdown. For various reasons, either that be an access issue or it being just people don’t really want to go to the hospital, or they don’t want to leave the house”

- Joe Nguyen, Managing Deputy Director, Hillingdon CCG

Changes in protocols have had perverse consequences for some people. For example,

removing the need to have two doctors sign off a Section was designed to free up medical staff, but as one Programme Director at a mental health voluntary sector organisation reports: *“one particular member of our working group was sectioned a few weeks ago, didn’t have a ward round for three weeks, she says that wouldn’t have happened before Covid.”*

Many inpatient wards across the country have been closed. Some staff noticed difficulties in admitting or discharging people. But some staff found the opposite to be true; people were discharged with the expectation that the community would hold them - but without checking that the community had the resources to do this effectively.

“They had seen a lot of their beds or staff moved from mental health wards into Covid response, they then had to discharge a lot of people, essentially onto the streets. We were hearing from local Minds saying-- I got people ringing us saying, ‘you need to support me now.’ The Trust had not communicated that they had even closed those services”.

- Gavin Atkins, Head of Community Services, Mind

By contrast, we heard some examples of planned and strategic disinvestment in hospital care in favour of community resources:

“The wards I think are actually functioning much better. The Covid crisis has increased the skills and physical bodies within the crisis team and increased the pressure to discharge people as soon as physically possible. There’s been a massive reduction in beds who have been on inpatient wards, and there hasn’t been a massive reduction in need, obviously need stays the same. There’s been a strategic change there, which I think was needed. It has meant there are less people on the ward who are more intensively given support who can then be discharged to a community team that are fully prepared to take them back, with a crisis team that is much better equipped to support them.”

- Health worker

And new ways of supporting people at scale were mobilised within weeks:

“A new helpline was set up very quickly. We recruited 900 volunteers to do the running around which obviously was led and managed through our voluntary sector. Then below that helpline were a whole load of Covid response work streams around support and chat, around food and medicines, around crisis loans, etc. etc.”

- Charlotte Ramsden, Director of Children’s Services

In the face of crisis, system changes were made at speed. Some commentators, including campaigning mental health charities, may resist some of these changes, including the closure of hospital wards, and the resulting loss of beds. But in many places the community has risen to the challenge, and there is a big opportunity to sustain this shift in provision towards community settings.

The crisis oiled the wheels of collaboration

Although not everyone experienced increased collaboration, there were many examples of how the crisis helped to bring people at a local level closer together:

“We’ve been able to develop with the volunteer center and the local authority, both in identification of groups of people who might be in best position to be first responders and how to maintain resilience and develop their skills in Mental Health, First Aid trauma, awareness, psychological first aid, working with anxiety, and emerging trauma. That feels like it’s a very valuable set of partnerships to have accelerated in the circumstances.”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

“There’s been a real positive, I think, in working together on the Covid response. I would hope we’re going to continue this post Covid. We need to agree that we play in our own areas, but we can also work together really well.”

- Gavin Atkins, Head of Community Services, Mind

These partnerships often involved the rapid transfer of learning and the chance for professions to come together to learn from and support each other:

“We started having a daily morning call with all of the consultants in the local area, which has now been dropped down to twice a week. You’d have someone who’s chairing the call and other senior medics feeding back news that they are hearing. We have a lot of consultants who are from Italy. So at the start of the pandemic, they were feeding back the Italian experience constantly. I felt much more aware because of that.”

- Consultant Psychiatrist

People noticed a significant decrease in the barriers that normally stopped things from happening and the creation of a ‘can do’ approach to tackling the crisis:

“Certainly, for the system leaders on those regular calls that we have, it is very refreshing how little we talk about the barriers to doing things. The focus has been very much on, ‘Let’s try and problem solve this as a system together, as a group of organisations who can do what’ It’s a very practical approach. It’s literally focused on, how do we make this better for this group of people or for this individual, or even for the whole of Hillingdon?”

- Paula Arnell, Head of Commissioning, Hillingdon CCG

“We helped a man get a council flat within a week which was absolutely fantastic. The social worker was on board straight away. She’d done the referral to the OT. The OT contacted me. What does he need? Told her what he needed. She got on in touch with a provider. They delivered it Tuesday. It was all done within a week.”

- Voluntary sector worker

Trust replaced bureaucracy

Local leaders noticed more central control from Government but they have been able to abandon bureaucracy and rely on trust.

“In terms of the providers that I’m currently involved in commissioning for, we freed them up a lot through this and said, ‘Do what you need to do. We’re not going to hold you to KPIs. Just make sure you demonstrate you’re in the spirit of the contract.’ I actually think I’m very privileged to be able to do that because the current providers I work with I know would not have exploited that.”

- County Council Mental Health Commissioner

And as a result people noticed that things were getting done much faster:

“In terms of practical things we’ve done, we managed to release a grant fund about four weeks ago where we just bought them all more equipment, more laptops, more smart phones, whatever. I’ve been at Mind for eight years. We’ve never in that time had a grant fund that nearly all the network received. 120 out of 121 local Minds accessed that. It was only 5K, they had to fill out a form that took two minutes.”

- Gavin Atkins, Head of Community Services, Mind

“The day to day governance has been a lot less formal than normal. We’ve been very fortunate because we’ve got strong and trusting relationships with our politicians. The fast-paced action has meant we’ve had to take very rapid decisions and that we haven’t had time or capacity to write complicated reports to justify some of the things that we’ve been doing.”

- Charlotte Ramsden, Director of Children’s Services

We need to build on this new collaboration, increased trust and reduced bureaucracy. Commissioners and providers need support to minimise bureaucracy and create a more agile system that is better at understanding and responding quickly to changing needs. This new system must not be characterised by tiers and thresholds and gatekeeping and handoffs - the things that so often leave people falling through gaps and waiting too long for help.

Leaders will need to be supported to be confident in applying the same boldness into the future, in order to ‘build back better’ and achieve genuine transformation.

“We need to agree that we play in our own areas, but we can also work together really well.”

But anxiety and scepticism remains about the involvement of people with lived experience in the design and implementation of change

Some commissioner expressed concern about engaging with the voice of lived experience:

“I’m in this huge debate in commissioning about how far you involve the people using the services and writing specifications involving them in the tender process. There are lots of reasons why it’s quite hard e.g. time pressures, but some of it I think is purely fear that if somebody came and told us everything we’ve been commissioning doesn’t work and we want it done differently, how would we react?”

- County Council Mental Health Commissioner

Others were sceptical for different reasons, because engaging people with lived experience often does not go far enough:

“I think that within the mental health system the whole experts by experience sitting on these boards is the most shambolic, ridiculous and terrible thing I have ever seen. They have these people they drag off the streets with mental health lived experience, get them to sit on these dreadful boards of NHS trusts. Then everyone goes away pretending that the voices are in the system. You know that it’s a bunch of rich white people that made the decision. It’s this thing where you pretend it’s all inclusive and when you look at what’s going on, it’s not at all. There’s something about being genuine about the democratisation of the system and it’s not easy.”

- Programme Director at a mental health voluntary sector organisation

Most people called for renewed focus on co-production of services.

“Having different forms of leadership and an acceptance of co-leadership with local communities is going to be really important. If we don’t have the level of resources that we have had which is entirely possible. The need to co-produce is going to be incredibly important.”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

“I want mental health services to have people with lived experience in management positions. Maybe we will have more chance to push that going forward.”

- Health worker

Co-design and co-production are at the heart of the Living Well UK programme, which offers rich learning on the tools and methods that can be used to create truly co-productive cultures that put the voice of lived experience at the heart of change. Understanding the barriers to effective and genuinely inclusive participation is going to be important to the future of service design and to the broader challenge of addressing health inequalities and hearing all

voices, particularly Black and Asian minority ethnic communities and other groups that are vulnerable to poor mental health.

The community rose to the challenge

The statutory and voluntary mental health sectors have responded to the crisis with fast paced change. But one of the most extraordinary changes occurred within communities themselves. Over the last few months, we have seen an explosion of individuals stepping up to care for one another and self-organise into support groups; a cadre of new community leaders has emerged. This is a typical psychological response to a crisis.

“When existence is tricky, what you find is communities really do pool together, and they support each other and care for each other. We have a brain that does that. What we found now in Covid is that we’ve created this environment again. We do it in war as well, where suddenly, we all need to pull together and support each other. That is our basic psychology, but that psychology is only recruited when there is a need for the community to work together.”

- Professor Paul Gilbert

We are seeing the unlocking of community; all over the country hundreds of thousands of people decided to volunteer⁸ and we heard many stories of community action.

“One of the things that I think is really special and I hope is maintained, is really around how volunteer capacity and mutual aid has started to develop. Our local volunteer center, who set up a volunteer hub, and have acquired 1,500 volunteers in the space of a week.”

- Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

“There’s an organisation called Men’s Health Matters. It’s to support men who recently become fathers or whose partners are pregnant and I know they’re also offering online groups as well.”

- Health worker

“I work in a couple of primary schools in Tower Hamlets and they’re dealing with mutual aid, ensuring that food and other things can be accessed, as well as, obviously the children having their welfare checks, there’s so much, that the staff and the schools are doing in relation to the community.”

- Khalida Haque, Clinical Services Manager at Mind in the City, Hackney and Waltham

Many people advocated for the power of local networks.

“I start from a belief in places and communities and we have seen an explosion of neighbourly support. I think where the good local authorities have worked well, they have created something that doesn’t feel like a system, it feels like

a network. Maybe it technically is a system involving all sorts of different people. I think the neighbourliness and the sense of place and the sense of care has been extraordinary - you'd want to bottle that."

- Julia Unwin

Civic action in response to the crisis has not necessarily been focused on mental health, but we believe that going forward there is a real opportunity to capture and grow this new sense of community to change how we look after one another, holding mental health in the community. It will be of key importance that local leaders mobilise, nurture and sustain these networks of support, and the national outpouring of civic action, so that communities take their rightful place at the centre of how we move towards better mental health.

"That is our basic psychology, but that psychology is only recruited when there is a need for the community to work together."

A new vision for mental health

Based on insights from this research, as well as our wider work in the mental health sector, including the Living Well programme, we see a need for a major shift in how we talk about mental health and how we develop at mentally healthy communities. Many shortcomings of the current system have been exacerbated during the Covid-19 crisis. Below we characterise the current mental health system and share a vision for what it could look like if we normalised suffering and distress and shifted the power towards communities.

The system we have inherited - services in control

The system we have in the UK today is not a mental health system, it is a mental illness system, one that is set up to diagnose and treat illness, not prevent it or build stronger mental health. It's no accident that much of the clinical language of mental health is negative: symptom, illness, disease, disorder, problem, remission, relapse, crisis, risk.

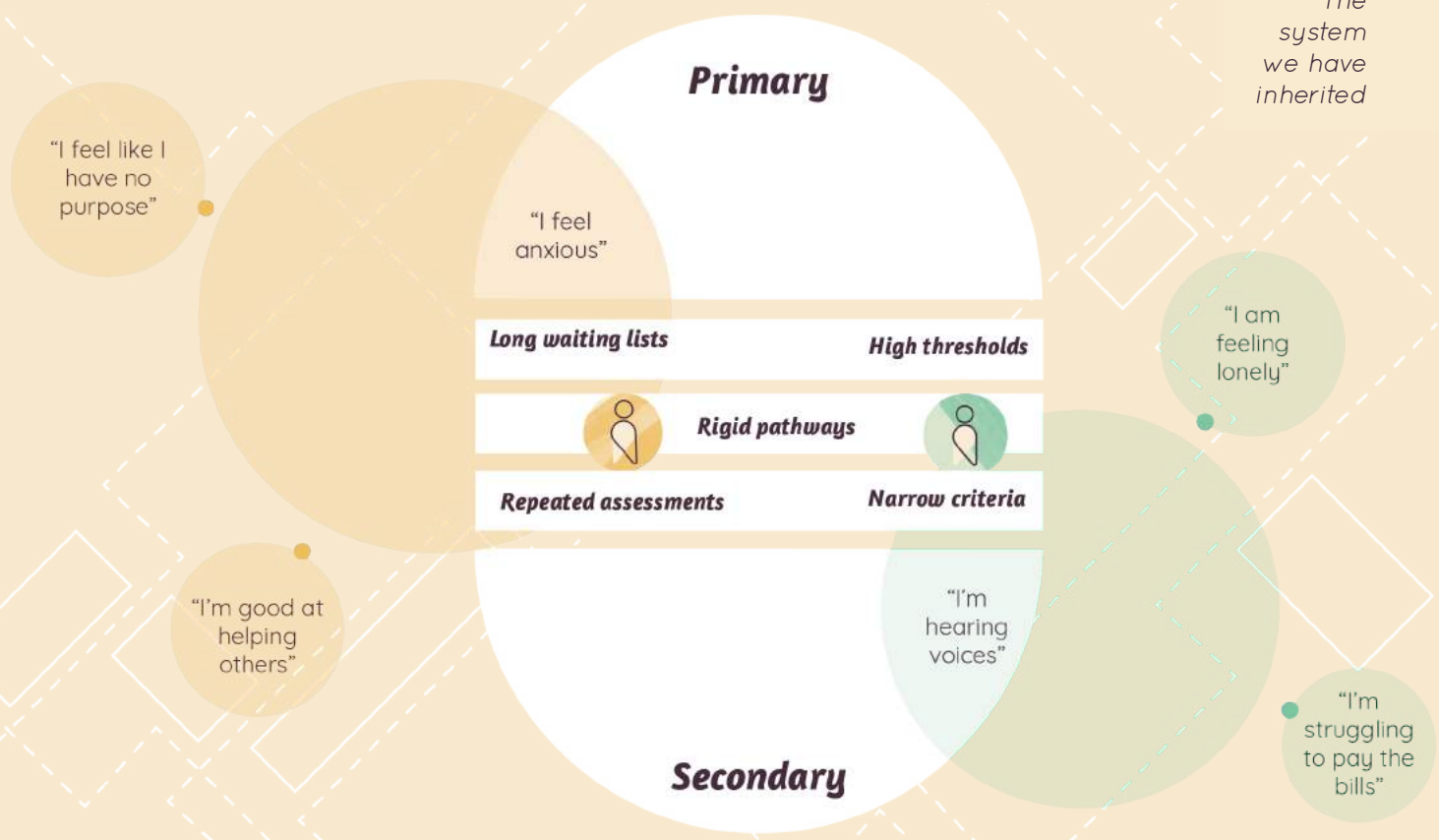
When people become unwell, we assume that the solution is to 'fix' the problem with treatment from a mental health service, often provided by another individual (an expert professional) and often only offered for a very short period of time. Yet, as this research highlights, what people often need is something very different; simple, practical help with everyday problems, compassionate conversations or words of encouragement and emotional support from friends and loved ones.

Because treatment is often medically focused, and because illness is thought to lie within and inside the person, wider influences remain invisible. This includes the impact of everyday conditions of life (housing, neighbourhoods, poverty), of relationships and networks, and of a sense of meaning and purpose that comes from family, faith and work. Within the medically focused approach, people's circumstances and their search for meaning, happiness, and wellbeing are considered only tokenistically, not deeply, fully or genuinely.

The current system is not geared up to respond to the range of personal and social issues that commonly undermine people's mental health. Instead, medical services are designed to diagnose and treat physical and mental conditions. Many clinicians rightly point out that their skills and training don't equip them to address these issues and often the NHS refers people to charities who can help with housing, debt, finding work, loneliness. Here many people find care, compassion, and practical help from skilled workers, but these charitable services are insufficiently funded, staff are poorly paid, and there is very little integration with health or social care services.

Many of the social determinants of health are characterised by structural inequalities, often along race lines. This in turn contributes to unequal mental health outcomes for white and BAME communities across the UK.⁹ Wider social determinants cannot be addressed in medically focused treatment plans.

The system we have inherited



But over the last 50 years, significantly more energy and investment has been given to the development of professionalized mental health services than to addressing wider determinants and inequalities. The almost inevitable result is that mental health services have become overrun with demand.

In turn, the response has been to limit access only to those with the most clinically 'acute' conditions and those at greatest risk to themselves or others. This hierarchy of need and rationing of provision has to be constantly policed. A huge amount of energy is expended in regulating access and managing demand. People entering the system face a series of disempowering obstacles: narrow criteria, very high thresholds, tiers, triaging, long waiting lists, rigid (and often confusing) pathways, and referrals and handoffs from one service to another that lead to repeated assessments. Many people lose their way or fall through the gaps between services (between 'primary' and 'secondary' and statutory and voluntary sectors). Fragmentation of this kind does not allow for continuity of care or a holistic understanding of the whole person.

Nor does it acknowledge the reality that people's mental health moves dynamically (and often rapidly) along a continuous spectrum, all the way from languishing to feeling good. The current system wants to fit individual mental health into diagnostically driven categories of need and tightly managed service specialisms. Binaries, thresholds and tiers mean that you are either ill enough, or you are not. Understanding mental health as a spectrum, and boxing it into categories, are incompatible approaches.

Most of the power and agency in this system lies with professionals, who are in control of admissions and care plans and who allow or deny access to services elsewhere. This is a dispiriting role and often forces professionals to spend more time assessing and gatekeeping than providing therapeutic care.

All of this combines to leave many people waiting and hoping for clinical treatment that often doesn't come, or comes too late, or doesn't provide the help that is actually needed. This is especially true for BAME communities. Black people are four times as likely to be detained under the Mental Health Act compared to the white population¹⁰ while being less likely to receive treatment such as talking therapies.¹¹ Loss of trust in the system is a common response. It is also true for those with 'severe and enduring' mental ill health, whose need for community is rarely seen or understood. The 'community', and its rich 'assets', are generally not acknowledged by clinicians, and when they are, it might only be as a set of concerns associated with risk-taking behaviours (such as misusing substances). Community is a mystery to professionals trained narrowly to diagnose, treat and discharge.

A different and better system - communities in control

There is a radically different way of thinking about and responding to mental ill health. This narrative challenges the default move we make as a society when someone is unwell, which is to automatically refer them to professionals for treatment in services. It emphasizes instead a positive language of mental health and wellbeing, the capacity of communities to 'own' responsibility for their own and each other's mental health, their identity as citizens leading lives within communities (not patients) and their ability to define what a good life looks like and how to achieve it.

During the crisis we have seen many inspiring examples of community action and mutual aid. There are to be applauded, but idealising them is unhelpful. In this report we saw how many people turned to informal networks for support as mental health services tightened their thresholds or were closed. In a different narrative, we would pay attention to the ordinary and everyday acts of kindness and care that are so clearly important for mental wellbeing, and that need to be nurtured and encouraged as a key feature of social and cultural life in the UK. It is not enough to rely on rarefied examples of mobilisation when things go wrong.

In this different narrative, suffering and distress are normalised (not pathologised), and 'held' compassionately within communities. Vulnerability is acknowledged as a universal experience, not as a label for the few (if nothing else, the Covid-19 crisis has demonstrated our common vulnerability). Communities become the places where distress and acuity of all kinds is accepted and made sense of and worked through. Storytelling, dialogue and conversation are at the centre of sense making, and clinical expertise is invited in, when needed. The traditional model of clinicians inviting patients into waiting rooms and consultation rooms is abandoned. People, understood holistically, in the full context of their lives and personal histories, are at the centre of the system and their stories are at the centre of change. All forms of support are invitational, and need and demand are embraced, not managed.

Our vision is for a new system centred on the role of people and communities in exercising control and agency over how mental health is understood and how help is organised. In this vision, there are recognised spaces and places in communities for mutual care and support. Support is everywhere - talking to a friend, a life coach, going to a peer support group, creating art, enjoying a mindful garden, going to your GP, and, yes, getting help from a mental health service. Support happens in informal and incidental spaces: pubs, hairdressers, barbershops, cafés, supermarket as well as in more organised initiatives such as support groups and food banks. All are equally valid and trusted.

Within localities and their communities there is a common language of mental wellbeing and shared way of understanding and thinking about it. There are shared values across local systems, so that the way someone relates to you in one part of the system is echoed everywhere else. At every stage people are offered the opportunity to participate in the design and delivery of help and support. And when people seek help from services, professionals invite them into this narrative as a standard part of their relationship and intervention, educating people about the belief system of the community, championing competency, agency, participation, and kindness.

In every place there are opportunities for seeking and receiving support (feeling connected) but also for offering and or cultivating support opportunities that people feel are valuable. The community recognises that wellbeing is created through mutual concern for each other. People are supported to develop their understanding of their own mental health, that of others, and given practical skills and tools to build mental wellbeing across local communities.

Professionals and services are part of a non-hierarchical ecology of support. There is a 'side by side' culture, and the wisdom, skills and knowledge of all actors (including clinicians) are recognised and combined to achieve the best outcomes. Boundaries between professionals, experts and help seekers are softened. Services are precisely that - in the service of mentally healthy communities.

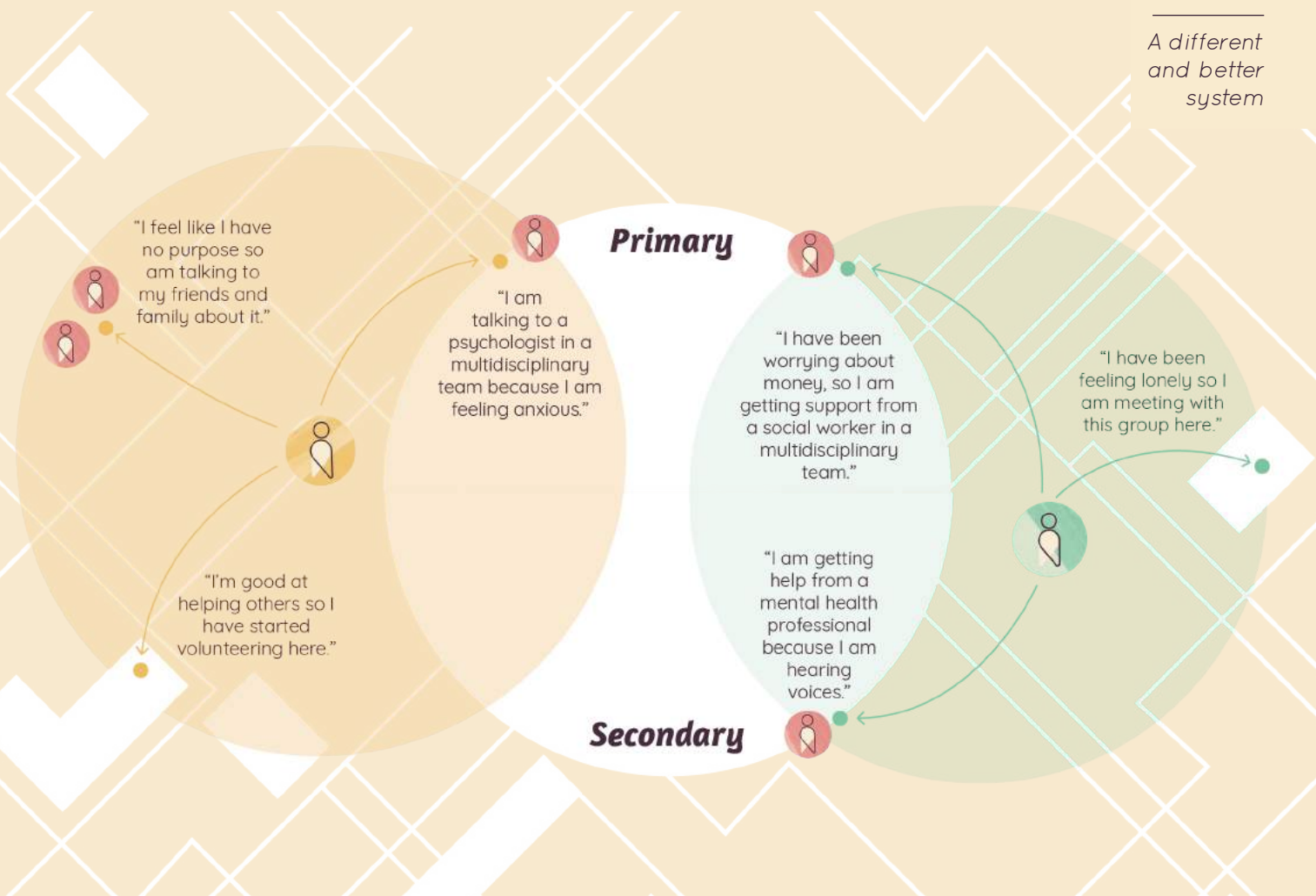
The difficult task ahead

Achieving this vision will be difficult. It will require a sea change in our attitudes to mental illness, huge changes in where money flows, and significant effort to build a new culture of self care and care for others. This last challenge is critical - through this research and our work in Living Well, we have noticed how difficult it is for many people to care for themselves, let alone others. We lack the time, energy and capability to wish ourselves and others well.

Staying resilient to everyday suffering is going to be much harder for many people adversely and disproportionately affected by the economic and social impacts of a post Covid-19 world. This includes staff and peers working in the current mental health system. The vision we have sketched here for more compassionate, caring communities will help minimise Covid-19 impacts, but we recognise too that good mental health for many people is not possible without radical new policies to address broader structural inequalities.

There is no time to lose ... we must devise new solutions that at least limit the damage and at best open up meaningful and fulfilling care and support to everyone. Putting people and communities in control of the narrative and vision for mental health has to be a fundamental part of a new and better system.

A different and better system



Priority areas for redesigning the system

The scale of the challenge feels overwhelming. Despite this, and based on what we heard from the people we interviewed, we see two big priority areas for new alliances and collaborations that can help realise a different and better mental health system, out of the disruption of Covid-19.

We sketch the priority areas here and invite you to make contact if you want to work with us to make them a reality.



Support localities to deliver the community mental health framework:

Through new integrated multidisciplinary teams enabled by technology, powered by staff from primary and secondary care, and the voluntary sector

The problem

The community mental health framework sets out the case for change: too many people across the UK are struggling with their mental health but are not getting the help they need when and where they need it. Many services have responded to rising demand by restricting entry to only those with the most complex mental illness. Services are often highly medicalised and not designed to deal more holistically with the social and economic factors that affect someone's mental health.

Partners

-  People with lived experience
-  Clinical Commissioning Groups
-  Community organisations
-  Foundation Trusts
-  Local authorities



Support localities to deliver the community mental health framework

The opportunity

Support localities to deliver the community mental health framework by developing new multidisciplinary teams (MDTs) providing 'easy in, easy out' holistic, person-centred support enabled by digital technology. These teams would operate as a new front door to the mental health system, and provide brief clinical therapeutic support and practical help with housing, debt, benefits alcohol and substance misuse. The team would integrate staff from primary and secondary care, statutory and voluntary sectors and use digital delivery to help reach many more people.

“These teams would operate as a new front door to the mental health system”



Impact



Access to effective, holistic help and support for mental health when and where they need it



Significantly increased mental health & wellbeing



Reduced demand on the NHS

Support local public health leaders and their partners:

To develop a new vision and narrative for public mental health and deliver new community-based initiatives to create a new cultural movement of care for self and others

The problem

The Covid-19 crisis has opened up a powerful place for public health in the national consciousness. Inevitably, this narrative has so far been dominated by the language of risk, illness, social distancing, separation and threat.


The second half of 2020 is likely to bring increased mental health distress for many people. In local areas many thousands could lose their jobs, and their homes, and as winter approaches there could be more loneliness for more people as localised lockdowns are put in place to deal with repeated outbreaks.

Public health leaders need to have the right tools to face the challenge. There is a need for a different public mental health narrative, and for new, practical initiatives to build community resilience as much as possible.

Partners

 Public health leaders and their partners (e.g. local authority, CCGs and voluntary sector)

 Politicians and local leaders

 People with lived experience

 Community spaces



Support local public health leaders and their partners

The opportunity

Support public health leaders and their partners to develop a new public mental health narrative that frames mental health around the language of connection, kindness, occupation, compassion and mutual aid. Use this new narrative to help rebuild community resilience and social capital, and as a frame for a set of new community-based, practical interventions that respond to mental health need and demand in a post Covid-19 world. We see two distinct opportunities:

Mobilising local communities and civic action to support vulnerable groups as furlough ends and winter approaches.

Inspiration can be taken from the Government's call out for volunteers to help the NHS. A similar initiative could be launched to mobilise large numbers of volunteers in local places to be ready to help vulnerable members of communities with a range of practical and emotional support. Local mental health campaigns could be launched to bolster community resilience, particularly for the most vulnerable, for example those at risk of suicide (for example Salford's evocative Reach Out - Start to End Suicide campaign). New networks that enable citizens to support each other in the public realm/ in public spaces could be developed. Programmes supporting citizens to grow their capacity for self care and care for others could be launched.

“These spaces could invite people to talk about their mental health without referrals or thresholds”

Growing networks of community spaces such as barbers, libraries, and cafes in every locality, that are mental health informed and offer compassionate conversations.

These spaces could invite people to talk about their mental health without referrals or thresholds and based on the core principle that communities are made up of people who both give and receive support to one another. Community spaces and community groups could receive help, training and guidance on removing stigma, becoming mental health informed, and providing compassion focused support. Localities could use community development approaches to recruit and grow the network. There are a few places like that already; Frazzled Cafes, and the Lions Barbers Collective, for example. However too often they are small pockets of excellence in an ocean of need. We need a robust approach to setting up and scaling these types of community spaces.

Impact



Kinder, more nurturing public spaces



Increased capacity for citizens to support each other's mental health



Easily accessible help and support where and when people need it



Reduced demand on the NHS



Stronger Communities

Acknowledgements

We would like to thank people for sharing their personal experience and perspectives so openly. We hope that this report contributes to the public debate about how the UK might more effectively respond to mental health needs into the future.

Interview Participants

People with lived experience

People with lived experience have chosen an anonymised name to protect their identity.

Alfie's Mate

Aurora

Chris

John

Jonathan

Mia

Road Runner

Sarah

Front line professionals, managers and leaders of statutory and voluntary mental health organisations:

A full list of staff professions is given below, but in the text we have generalised their roles to protect their anonymity. Some system leaders have chosen to be identified by name.

Service Lead at a voluntary sector organisation
(*Voluntary sector worker*)

Peer coach in a multidisciplinary team
(*Voluntary sector worker*)

Operational Manager at a complex care voluntary sector organisation
(*Voluntary sector worker*)

Occupational Therapist at a Community Mental Health Team (*Health worker*)

Mental Health Nurse (*Health worker*)

Psychological Therapist at a Mental Health Trust

Consultant Psychiatrist

Service Manager at a complex care voluntary sector organisation (*Voluntary sector worker*)

Programme Director at a mental health voluntary sector organisation

County Council Mental Health Commissioner

Charlotte Ramsden, Strategic Director for People
(*Director of Children's Services*)

Khalida Haque, Clinical Services Manager at Mind in the City, Hackney and Waltham

Gavin Atkins, Head of Community Services, Mind

Paula Arnell, Head of Commissioning, Hillingdon CCG

Joe Nguyen, Managing Deputy Director, Hillingdon CCG

Vanessa Morris, CEO of Mind in the City, Hackney and Waltham Forest

Programme Director at a mental health voluntary sector organisation

Academics, thought leaders and commentators

Professor Paul Gilbert, FBPSS, PhD, OBE, Professor of Clinical Psychology at the University of Derby and Consultant Clinical Psychologist at the Derbyshire Health Care Foundation Trust, author of several books including *The Compassionate Mind: A New Approach to Life's Challenges and Overcoming Depression*

Professor Richard Bentall, FBA, Professor of Clinical Psychology at the University of Sheffield, author of several books, including *Madness Explained*, winner of the British Psychological Society Book Award in 2004

Dame Julia Unwin, Chair of the Independent Inquiry into the Future of Civil Society and Carnegie Fellow 2017-19

Doctor Amy Pollard, Founder and Director of Mental Health Collective, co-founder and chair of the Beyond 2015 campaign

Thanks to Matthew Horne, who edited and reviewed this report.

Report design by Ellie Hegarty

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