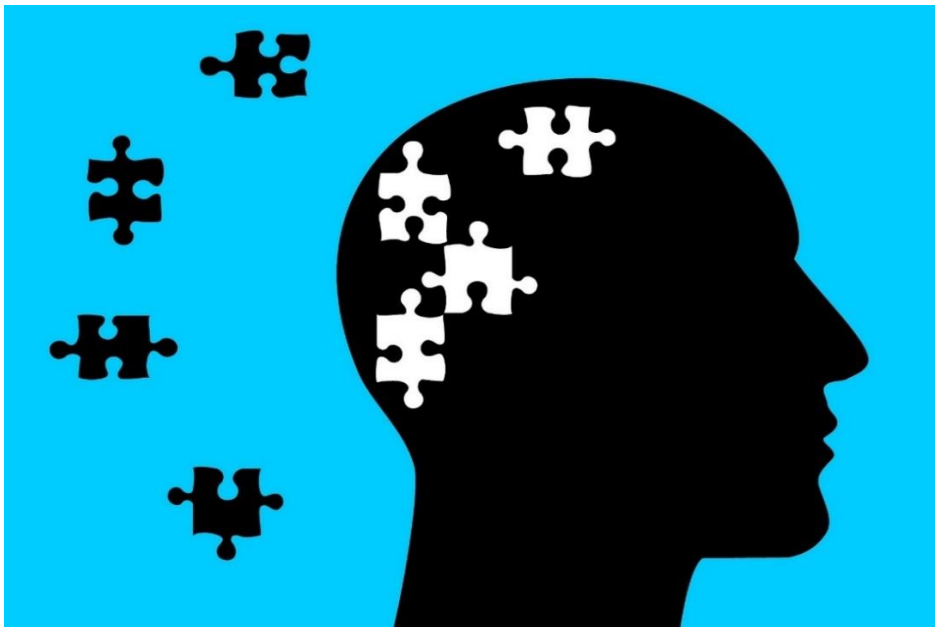
EVALUATION OF THE BETTER MENTAL HEALTH FUND IN SOUTH TYNESIDE



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Final report

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Executive Summary

Background

South Tyneside is one of the 20% most deprived local authorities in England and many health indicators are worse locally than the national averages. South Tyneside Council were a grant recipient of the Better Mental Health Fund (BMHF) following a successful bid to government. The funded projects were selected specifically to meet the mental health needs that have been shown to be the causes of poor mental health and represent a particular risk to local populations.

Methods

Researchers from Newcastle University were commissioned to undertake a local evaluation of the BMHF. The aim was to understand what difference the fund had made to the organisations involved and their beneficiaries, as well as capturing and exploring any wider impacts. In total, 14 service providers and 7 beneficiaries took part in individual and group interviews online and in person. The interview data were analysed thematically with the help of qualitative data management software.

Findings

The three main groups of beneficiaries reached were 1) vulnerable adults, through mental health training and facilitation, 2) specific groups of vulnerable adults i.e., women, veterans, and older people, and 3) the younger generation, i.e., sixth formers, vulnerable young women, and care-experienced young people. The programmes of work were able to fill identified gaps in services, widen impact through extending their reach and build workforce capacity and community mental health resilience. Barriers to outreach and retention were identified, including COVID-19 effects and the shortage of time.

Discussion/Recommendations/Next steps

The delivery of projects was constrained by the short-term nature of the funding and the challenges faced by projects starting up, particularly those that were attempting new work, and/or late to commence. Some client groups were typically difficult to engage with, and COVID-19 effects and other barriers took time to overcome. The precarity of funding risked staff roles and the continuity of care for service users. Funding bodies providing seed-corn funding for mental health such as the BMHF need to appreciate the longer-term processes of being able to deliver outcomes from mental health interventions in the community.

Acknowledgements

This evaluation was funded by the Better Mental Health Fund and South Tyneside Council. We wish to give special thanks to everyone who gave up their time to participate in this research, and those who helped arrange interviews with beneficiaries and offered case studies for inclusion in the analysis.

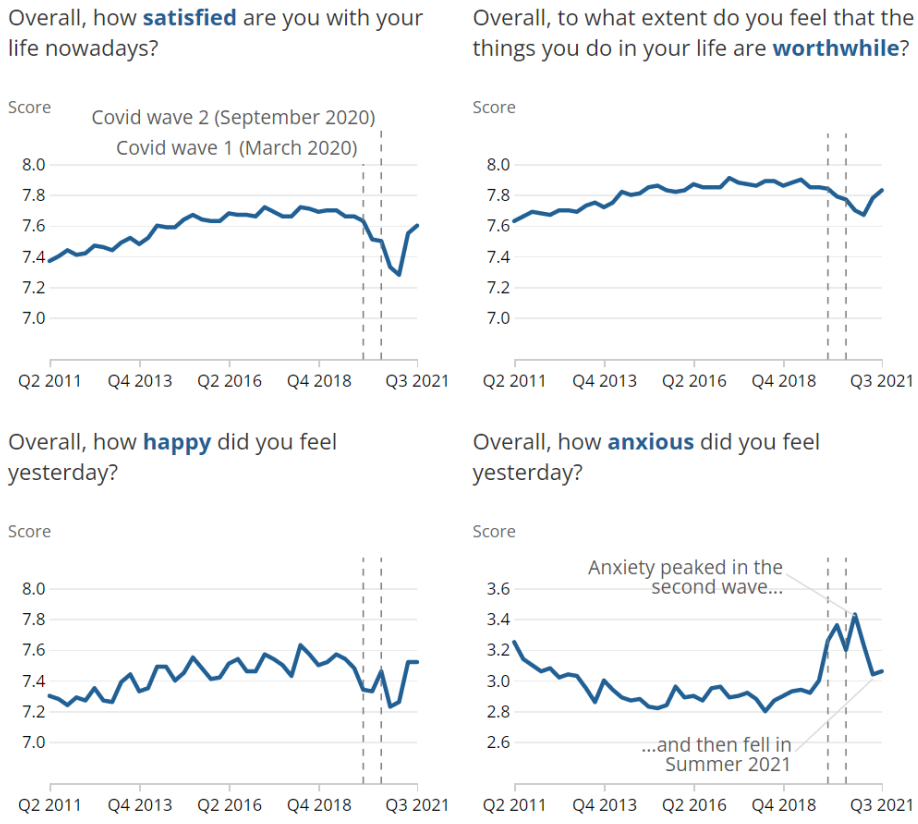
Contents

Background

National context

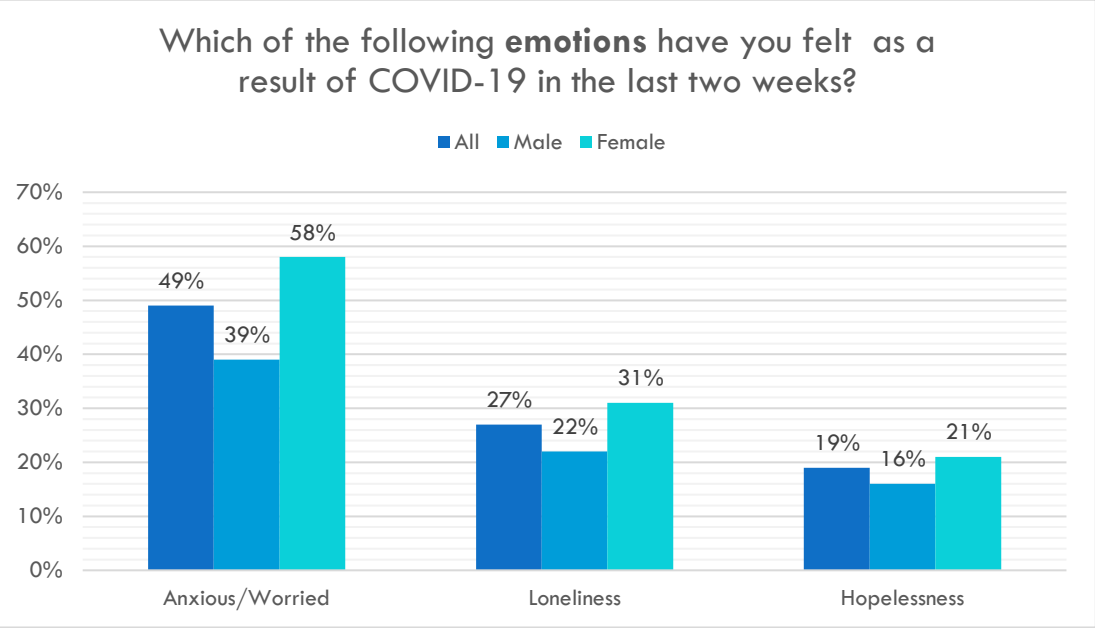
The COVID-19 pandemic has impacted negatively on the mental health and wellbeing of the UK population. Increases in psychological distress, anxiety, depressive symptoms, loneliness, sleep problems and stress have been observed across multiple studies (for examples, see Daly & Robinson, 2021; Falkingham et al, 2021; Fancourt et al 2021; Kwong et al, 2020). However, there is some disagreement about whether these increases have been sustained or followed by a period of recovery and/or a return to pre-pandemic levels. See figure 1 for an illustration, using national wellbeing data from the Annual Population Survey (ONS, 2022). The government's latest *COVID-19: Mental Health and Wellbeing Surveillance Report* states that, 'The 'up and down' nature of these changes coincides with the periods of national lockdown and high COVID-19 cases followed by easing of lockdown and reducing cases' (Office for Health Improvement & Disparities, 2022).

Figure 1: Impact of COVID-19 on personal wellbeing



There is also significant variation within the UK population, with women, young adults, those with pre-existing mental or physical health conditions, living alone, in deprived neighbourhoods, and out of work or experiencing financial difficulties, being amongst the groups more likely to experience poor or deteriorating mental health. See figure 2 for an illustration of gender differences in reported feelings of anxiety/worry, loneliness, and hopelessness during June 2020; these findings come from the fifth wave of data collection carried out as part of the *Coronavirus: Mental Health in the Pandemic* repeated cross-sectional study (Mental Health Foundation, 2020). Women, young adults, and older adults who complied with recommendations to shield reported higher levels of loneliness (Zaninotto et al, 2021; Ellwardt et al, 2021; Xue & McMunn, 2020), while maintaining frequent face-to-face (but not virtual) contact during the pandemic was associated with better mental wellbeing in older adults in the US and UK (Yang & Yue, 2021).

Figure 2: Sex and mental health during the COVID-19 pandemic



The UK government's *Mental Health Recovery Action Plan 2021/22* sought to ensure that the mental health impacts of COVID-19 are rapidly addressed, services can respond quickly, and pressures on the NHS are reduced. The cost of poor mental health to the economy has been estimated at around £99 million per year, with common mental illness such as anxiety and depression the second most common cause of years lived with a disability. The Better Mental Health Fund (BMHF) was a single-year fund designed to incentivise investment in prevention and promotion interventions for better mental health in the most deprived local authorities. Specifically, it aimed to mitigate mental health impacts arising from the COVID-19 pandemic, reduce widening mental health inequalities by targeting at-risk and vulnerable groups, and ensure adequate distribution of funding to support minority ethnic communities.

Local context

South Tyneside Council were a grant recipient of the BMHF following a successful bid to government. The funded projects – as described in the grant application (table 1 below) – were selected specifically to meet the mental health needs that have been shown to be the causes of poor mental health and represent a particular risk to local populations. South Tyneside is one of the 20% most deprived local authorities in England and many health indicators are worse locally than the national averages, including: life expectancy for men and women, premature mortality from cancer, hospital admissions for alcohol-related harm, excess weight in adults, and smoking prevalence (PHE, 2019). Although the local suicide rate is slightly below the national average, the rate of hospital admissions for intentional self-harm is much higher (298.8 admissions per 100,00 South Tyneside residents, compared with 181.2 admissions per 100,000 nationally). It is estimated that 19.1% of the local adult population has a common mental disorder, in comparison with 16.9% of the national population. Furthermore, compared to England, older adults in South Tyneside are more likely to live alone and to live in an income-deprived household, both of which are factors that contribute to social isolation (South Tyneside HWB, 2022).

Table 1: South Tyneside BMHF Programmes

Project	Provider organisations	Details
Mental health peer support and peer mentor programmes for young care leavers	South Tyneside Council	Meeting the needs of a particularly vulnerable group of young people leaving care by providing social and emotional support, for example, developing resilience, providing debt advice, tenancy support and group activities.
Debt and financial support	Age Concern South Tyneside	Aims to provide debt advice and support for residents especially men over the age of 50 year of age, in the most deprived wards. This age group is at particular risk of suicide and depression.
Tackling loneliness and social isolation in over 65s	Age Concern South Tyneside	Local research shows a high level of need in this age group especially for residents who have needed to 'shield', with poorer health outcomes over time. Residents were reached and assessed by a Mental Health Link Worker and supported to access local groups.
Tackling loneliness and social isolation in over 65s	Age Concern South Tyneside	People over 65 self-identifying as isolated [less than 2 contacts with non-care staff in a week]. Aim to provide regular telephone support and advocacy into local groups.
Mental health support service for vulnerable women aged 18-34	Women's Health in South Tyneside (WHiST)	Nationally and locally, the pandemic has increased the need for mental health support. This project aimed to offer mental health support, counselling to address underlying issues, reduce anxiety and referral to groups and activities.
Women's Advocate Programme	WHIST	Aimed at women living in poverty, unemployed women, economically inactive women, women experiencing DV, carers, low waged. Evidence is clear that these issues cause chronic stress and mental ill-health. Project aimed to provide 1-2-1 support and advice to increase financial resilience and confidence.
Vulnerable young women's engagement programme	WHIST	Delivery of Young Women's Support Group for young women, black and minority women, women with disabilities,

		lesbian and bisexual women. Project aimed to set up and deliver support groups/classes based on need.
Developing Community Resilience Front Line Key Workers	Washington Mind	Aimed to support staff around developing their resilience around issues related to grief and loss. Evidence suggests the pandemic has adversely affected many front-line workers causing a range of mental ill-health effects. The second element is the delivery of suicide prevention training, *A Life Worth Living*, a local training programme delivered by Mind to key workers.
Reducing Loneliness in Young People Peer Project	Washington Mind	Restrictions put in place by government to contain the spread of COVID-19 have caused extended periods of physical isolation for children and young people away from their friends, teachers, extended families, and community networks. This has had a long-term adverse effect on some young people. This project aimed to provide a peer education arts project, to engage young people, who have been affected.
Community Kind Mind	Mental Health Concern	Aimed to provide a community-centred approach aimed at people with lived experience of mental health, pre-existing mental health issues, from deprived communities in South Tyneside. Providing a range of support around anxiety management, depression, and access to other services.
Suicide prevention training	Tyneside Mind	11 half-day courses for voluntary sector organisations to help them to identify and respond to suicide.
Seascape	National Trust	Project working with veterans to deliver well-being opportunities around coastal activities.

Methods

Evaluation aim and questions

South Tyneside Council commissioned researchers from Newcastle University to undertake a local evaluation of the BMHF. The aim was to understand what difference the fund had made to the organisations involved and their beneficiaries, as well as capturing and exploring any wider impacts. Specific questions to be answered through the evaluation were as follows:

1. How have the BMHF activities been implemented, in terms of learning from any challenges and successes reported by the provider organisations?
2. How might these activities and their impacts be sustained into the future?
3. What difference have these activities made to local people receiving them?
4. Has the BMHF led to any wider impacts on the organisations and their local communities?

Sampling and recruitment

A combination of convenience and purposive sampling approaches were employed to address the evaluation aim and questions. Convenience sampling involves identifying participants from available and easily accessible groups; this approach saves time and resources and is appropriate for use in exploratory or service development research. At least one service provider representative involved with each of the projects shown in table 1 was invited to take part in the evaluation. Our intention was to sample beneficiaries purposively. This would have allowed us to focus on particular characteristics of interest, ensuring that the sample included younger and older people, women, frontline workers/volunteers, and people with lived experience of mental health issues. We had hoped to recruit groups of up to eight beneficiaries from six BMHF projects; this did not happen for reasons that are explained further below.

Data collection

The following qualitative methods were used to provide in-depth insights into the process and early outcomes of the BMHF in South Tyneside:

i) Interviews with service providers

Representatives of the projects shown in table 1 were invited to take part in a semi-structured interview to explore their experiences of: applying for BMHF funding; setting up their project/programme of activities; engaging community members; delivering the activities; working with the local authority and other partners; meeting the BMHF reporting and monitoring requirements; and planning for the future. We were particularly interested in learning from what had worked well and where challenges have occurred, as well as any observed benefits from these activities. See the topic guide at Appendix A for details. Most interviews took place remotely – via Zoom or Teams – but a minority were conducted in person at a mutually convenient time and venue. Participants were offered the option of taking part in a one-to-one or joint/group interview, for e.g., the latter approach was used where more than one key staff member had been involved in delivering the project. Follow-up interviews were also attempted with projects that had a late start, but only one of these

interviews was conducted. When the first round of interviews with service providers was completed, an interview with the Public Health mental health and suicide (PHMHS) lead who commissioned the evaluation was conducted. The following table lists the interviews conducted.

Table 2: Interview participants

Provider organisations	Staff interviews (no. of participants)	Beneficiary interviews (no. of participants)	Total number of participants
South Tyneside Council	Joint interview and follow-up joint interview (2) Individual interview (1)	Group interview (3) – in person	6
Age Concern South Tyneside	Individual interview (1)		1
WHIST	Group interview (3) – in person and online Individual interview (1) – in person	Group interview (2 + 1 staff) – in person	7
Washington Mind	Individual interview (1) Joint interview (2)	Individual interview (1)	4
Mental Health Concern	Individual interview (1) Individual interview (1)		2
Tyneside Mind	Individual interview (1)		1
National Trust	Individual interview (1)		1
Total number of interviews	12	3	-
Total number of participants	15	7	22

ii) Focus groups and interviews with beneficiaries

The service provider interviews allowed us to develop an understanding of how the projects were being delivered and whether beneficiaries might be comfortable taking part in a focus group discussion. This method can be particularly useful where people are already known to one another and feel comfortable meeting as a group. We anticipated that it would allow us to generate shared understandings of how the BMHF has been experienced by those taking part in the activities and identify any reported benefits or setbacks. We relied on the provider organisations to help in identifying and approaching potential participants, as standard recruitment approaches (i.e., sending out information packs in the post) can be off-putting to vulnerable individuals. It was our intention that each focus group would involve up to eight participants and be held in the location where people were already meeting for BMHF activities. The option of taking part in a discussion remotely via Zoom was also offered, in recognition that some groups might be more comfortable with this format given ongoing COVID restrictions and other factors (e.g., caring responsibilities). We also offered the option of a one-to-one interview to anyone uncomfortable with the idea of taking part in a group discussion. However, with the time available, we were only able to conduct three sets of interviews with beneficiaries, as indicated in the table above.

iii) Case studies, observation, and documentary evidence

Although provider organisations were asked for case studies, only two were submitted. These were analysed together with the interview data, which contained anecdotes of how the fund had made an impact on beneficiaries. The lead researcher also made detailed notes (for which she asked for verbal consent) at a meeting with service providers and the PHMHS lead that she was invited to attend. This was held towards the

end of data collection, which made up for the lack of follow-up interviews for updates on progress. Service providers also offered a newsletter and zine[1] as documentary evidence.

Data analysis

Qualitative data generated through this research were analysed using thematic analysis. The interviews (with participants' informed consent) were audio-recorded during in-person interviews, and transcripts downloaded from Teams. Due to the technical delay in Teams transcripts being available, non-verbatim detailed notes were made from the video recordings, as well as in-person audio recordings due to time constraints. These notes (including of the final meeting with service providers), case studies and documents were used as the basis for analysis using NVIVO qualitative data management software. The audio-recordings and Teams transcripts (which were accessible much later) were reviewed to confirm data interpretation, as well as to search and retrieve verbatim quotes to support the key findings. Coding took place inductively, rather than deductively applying an *a priori* analytical framework. However, we were mindful of the evaluation aim and questions, in terms of the need to identify successes and setbacks in relation to how the BMHF had been implemented locally.

Ethical and safety considerations

Two separate applications for ethical approval from Newcastle University were submitted as soon as funding for the evaluation was confirmed. The first concerned the service provider interviews, which were low risk and therefore approval was granted without further review (ref. no. 18675/2022). The second concerned the focus groups and interviews with beneficiaries. Given that this sample involved people with lived experience of mental health issues as well as recruitment via gatekeepers, it was deemed potentially high risk by the ethics committee. This meant that the study documentation needed to undergo full peer review before ethical approval for this aspect of the evaluation was received (ref. no. 2285/18675).

All evaluation data were treated as confidential and stored securely in a Microsoft Teams folder to which only team members and key collaborators had access. Personal data will be destroyed at the end of the evaluation, while research data will be stored securely for 10 years in line with Newcastle University data management guidelines. Tailored information sheets and consent forms were used to obtain informed consent from participants, who were assured that they could exit the evaluation at any time and without giving a reason. Where data collection events took place in person, appropriate social distancing and hygiene measures were employed in line with national and local public health guidance.

[1] A zine (pronounced *zeen*) is an independently or self-published booklet, often created by physically cutting and gluing text and images together onto a master flat for photocopying, but it is also common to produce the master by typing and formatting pages on a computer. The publication is usually folded and stapled. (What is a zine? Zines and magazines. What's the difference? - Flipsnack)

Findings

Disbursement

The Public Health mental health and suicide (PHMHS) lead at South Tyneside Council developed and submitted the expression of interest to the Prevention and Promotion Fund for Better Mental Health 2021-2022. Working on the themes generated from the Public Health England (PHE) [presently the Office for Health Improvement and Disparities (OHID)] North East Mental Health network and North East Voluntary Community and Social Enterprise (VCSE) COVID-19 Impact Survey (2020), the areas of work that were targeted were: the effects of loneliness, isolation, and bereavement, the lack of access to information and advice, including financial advice, and the impact of digital exclusion. With the constraints of time, staff with executive or managerial responsibilities in VCSE organisations known to the lead applicant were contacted directly, based on their work in the areas identified. In addition, the lead applicant was aware of the need to support care leavers' mental health and access to appropriate services and contacted the council's Leaving Care team. Discussions with the service providers on how the funding could be utilised led to the final application being submitted.

Service providers in particular the programme leads not only appreciated the work the council put into securing the funding, and reducing the administrative burden for them, but also the approach taken in purposefully contacting their organisations and negotiating ways to use the funding in a collaborative rather than directive way.

And I know that [lead applicant] had to work really hard in a very short amount of time to put in for money and. And so, I think that kind of approach where the council have shouldered a lot of the, mmhm, admin, bureaucracy, kind of stuff that we haven't had to think about. So, all we've had to do is say, alright then, we'll accept this money and and run a project. I think that's a whole new way of working. Rather than saying there's an application form, tell us about this. Tell us about your constitution. Tell us about your last year's finances. It's like 'what do you need and how can we do that? There's the money for it'. Yeah, yeah, I think he really understands where, where the needs are and that's why he's done it in this way. - ST01[2]

This could only have happened because of the existing relationships and goodwill built up through the links that the lead applicant had with the VCSE. The following interviewee described it as a 'joint enterprise'.

so, it's not the case like it's not a competition or you know an advert out there and then you bid for it. It was more a relational relationship that was there. Yeah, and I think that's the strength of it - ST09

Despite the short turnaround time, the lead applicant managed to use his experience in getting the complex administrative paperwork such as contracts and governance completed. Programme leads expressed

[2] ST refers to staff and B refers to beneficiary

appreciation for the freedom they were given to choose how they spent the monies, and the relative ease in putting in their bid for the funding. Only one interviewee expressed some reservations about the process.

I think sometimes that ambiguity at the beginning can be quite frightening because what you want is you want somebody to say, this is some money, and this is what you need to do with it and it will be a bit frightening to think I've got some money and I've got this responsibility. I wasn't quite sure if spending it on a member of staff was the right thing to do, or should we do a project you know, should we? Put on some courses or using the money and I think. I think at the beginning that lack of clarity was a little bit daunting. A little bit disconcerting, but actually it's it works in our favour because it just meant that we could be more flexible with the money anywhere. - ST01

The resulting set of programmes funded ranged from those that used the funds to 1) support or expand provision from an existing contract by employing new staff, or redeploying staff, 2) develop a broader more innovative role based on a previous role, 3) start new projects based on previous experience or piloted projects, and 4) build resources e.g., for activities to promote and improve mental health.

He had mentioned the Better Mental Health Fund because there was such a heavy demand from internal services and he asked, could I use the Better Mental Health Fund to supply the courses that we're going to deliver to the community? ….. So, when we discovered how much demand there was on the other contract, we realised very rapidly that we were going to have to do something else for the community because everyone needs help with mental health - ST03

One organisation knew that they could use the funds to increase their hours of provision through moving staff and backfilling other positions. In this way, they were able to bolster and boost capacity for overstretched services.

OK, so I ain't gonna start something new what I'm gonna look at is if I flex up what I already do, to do more of what I do then I'm not having to recruit particularly. I'm not having to do anything. We can just see more people which will mean that the money does good work without it being, 'cause of how the time frames were - ST02

The post for the women's advocate at WHiST funded by the BMHF was based on the role of focus support worker funded by the Police and Crime Commissioner and the idea was to expand this to include debt management with a novel approach to financial management. In Washington Mind, the benefit of building upon previous work in another locality meant that they knew they could recruit a youth worker relatively smoothly. The plan was that their Loneliness project with young people would lead to resources and materials being developed that could be re-used in schools or in the community for future mental health promotion campaigns.

Recipients of the funding were also brought together monthly by the PHMHS lead to share their progress online in a mutually supportive way. This brought about greater awareness of each other's services as well as the sharing of information, ideas, and opportunities, while creating valuable links with the statutory sector and funding opportunities. One service provider admitted that seeing how other organisations used the money had been interesting, for e.g., pathways into employment that were made available by the funding.

Sustainability

The difficulty with the one-year time-limited funding was that towards the end of the funded period, service providers would have to 'drop everything to fulfil a bid or procurement' because 'there's always the worry at the end about staff having to leave' (ST09). When staff left for better jobs before the end of their contract, a service provider then faced having to redistribute the remaining work among existing staff and volunteers because it was not possible to recruit for just one month.

One factor that contributed to the ability of programmes being sustainable beyond the one year of funding was the situating of the project within a larger programme of longer term funded workstreams. The National Trust surf training for veterans sits within the Heritage Lottery funded SeaScapes (Homepage - Explore Seascapes) so the programme lead was positive about the work being continued, because the veterans' involvement in surf coach training would contribute to the sustainability of the surf school.

Like in my bigger SeaScapes job, there is sustainability, so it's working with local businesses, the water sports providers about how we help their businesses into delivering health and wellbeing to the local communities. And for that health and wellbeing to be increased over time. - ST12

Without this pressure to deliver within the time limits, she was able to use the time to plan, publicise and recruit. As surfing was weather-dependent, they sat with people in the surf school, asking them what was realistic for them to deliver, what were the costs in terms of time and suit hire, and all the variables or the 'golden number' for sustainability, i.e., how many people they would like to train as surf coaches. They had the added advantage of being able to base their application for funding on their experience of having piloted a similar course.

Other organisations like Washington Mind were also in a better position than others. Having had ten years of commissioning from the Primary Care Trust to deliver the community approach to suicide prevention training, they hoped to be funded to continue delivering the training on grief and loss. Mental Health Concern (MHC) is commissioned by the NHS, so they expressed the likelihood that they would continue to fund the fulltime Recovery College facilitator post made possible by the BMHF.

In contrast, other programmes faced issues not only with staff retention but also the discontinuation of service provision because of the sudden drop in funding. There were ethical issues to consider as the termination of a service could leave service users at a loss of where to turn for alternative support, as the following group interview account explains.

ST08's role is only till December, and L expressed worry about meetings being scheduled after December, when she knew ST08 might no longer be around to support her. ST08 just reassured her that she would still support her even if she didn't get funded for her role, because she can't let her down, with the trust placed in her. Even though L's confidence has increased, ST08 doesn't feel L is ready to go it alone yet. But they are working towards her being independent. L is worried about things 'going backwards', where she may miss something, and things don't happen as expected. – (B02&3)

The impact of the short-term funding is captured in the following reports:

ST02 is trying to get some funding to continue the wellbeing calls. They are still getting referrals to take on new clients, on a regular basis. This is a challenge with older people, because South Tyneside is a very 'old' borough with lots of older people, who are not getting out and about like they were. (Meeting notes)

ST06 will approach other funders for money to employ ST07. She is pulling together applications to ask for one more year of funding. At the moment, there is a lot of pressure on the service, the number of women in counselling has doubled and they are engaging in counselling for longer due to complex needs linked to poverty and Covid. (Group interview)

For the programme of work with care leavers within the local authority, the programme lead believed that there was a high chance it could be sustained because of the culture of wanting better services for care-experienced young people. Although they now have evidence that it works even with a small cohort, they believe that a coordinator post is needed to continue the work. On another note, a small charity would benefit from funding for infrastructure for sustainability that larger more established organisations would not require. For example, the employment of the new administrator cum facilitator expanded the work increasing the need to have office space.

The team has doubled during her time there, but there is a need to have a 'base' and not having to always hot desk. They use Jarrow Focus where they have a room, running courses on Monday and Friday, and Boldon, with a room or two in community centres. She would love to have a room with a printer, as she is responsible for monthly newsletters sent out to 300 people. - ST05

The BMHF aimed to incentivise investment in prevention and promotion interventions for better mental health in the most deprived local authorities. From the feedback gathered, it appeared that this can be more difficult than envisaged because of the short timescales due to a variety of factors. The lead applicant (PHMHS lead) believed that dispersing the funds to established organisations was a good way forward, but even then, there were hurdles to surmount with no guaranteed follow-on funding.

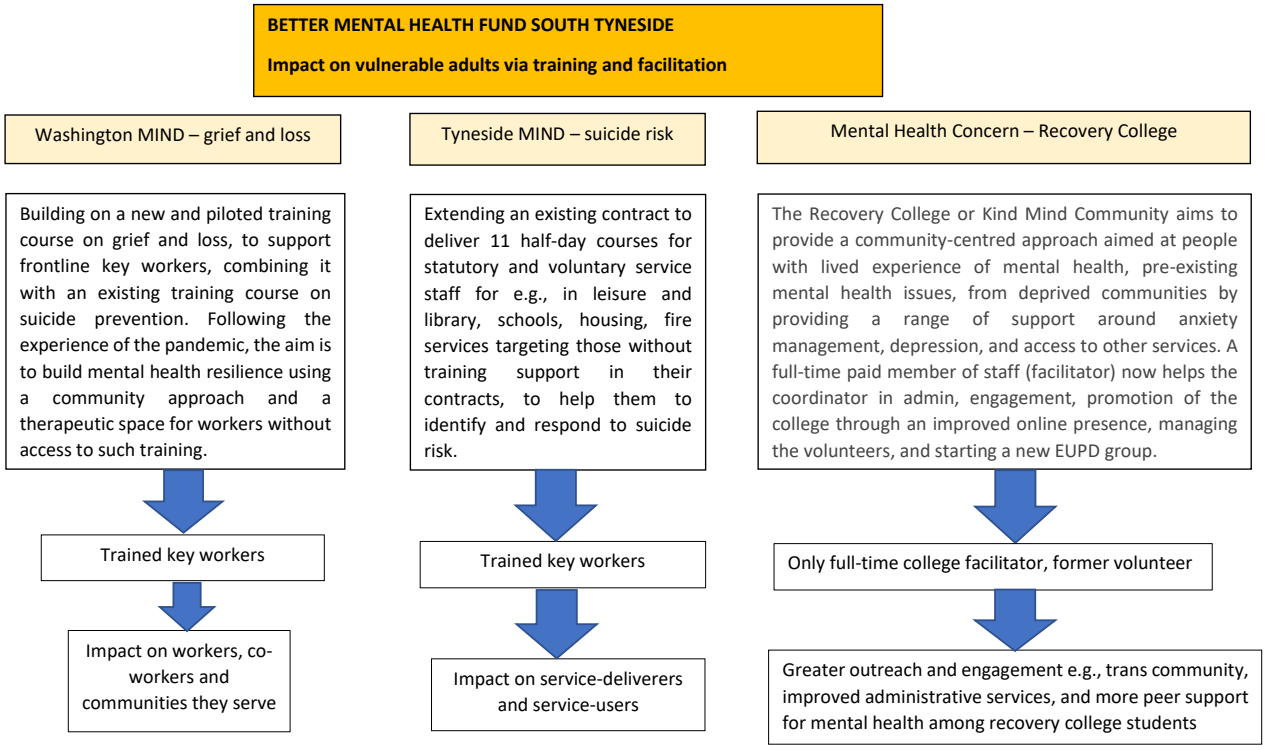
Service promotion and delivery

One of the specific aims of the BMHF was to reduce widening mental health inequalities by targeting at-risk and vulnerable groups. The following diagrams and accounts describe what the data has shown to be the resulting impact of different programmes on:

1) vulnerable adults through mental health training and facilitation,

2) specific groups of vulnerable adults i.e., women, veterans, and older people, and

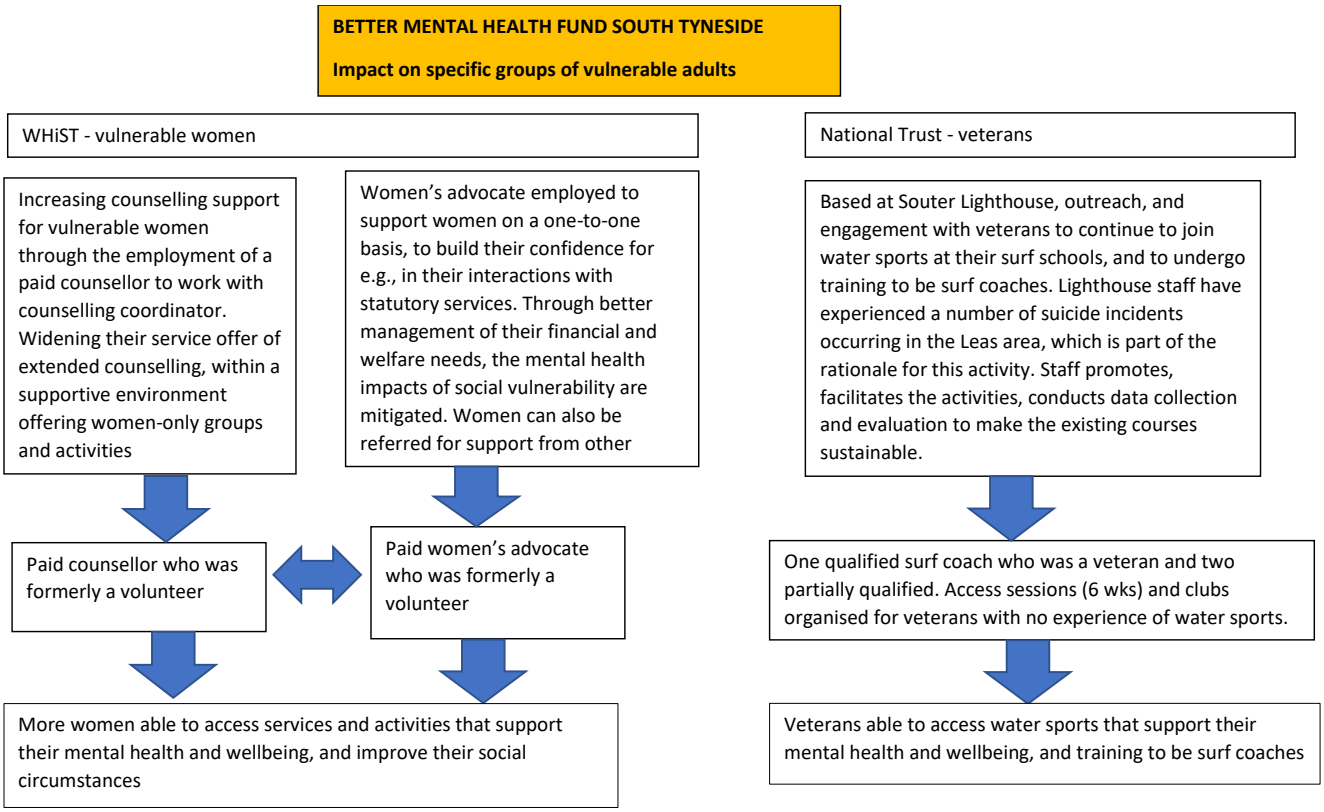
3) the younger generation, i.e., sixth formers, young women, and care-experienced young people.

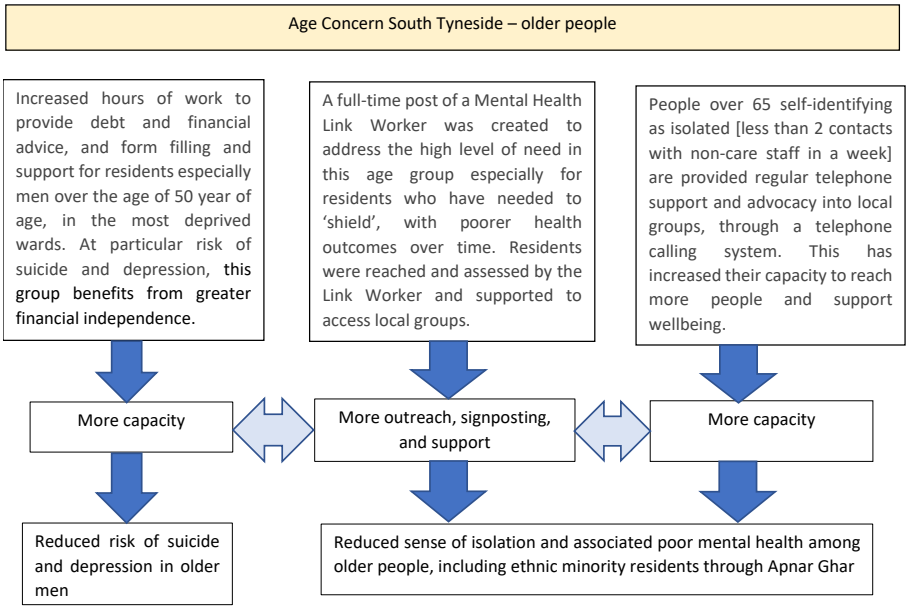


Training courses

Training was one of the main areas of work that was funded. The training for suicide prevention by North Tyneside Mind was targeted at front-line workers who do not normally access training, such as those in youth services, probation services, and those working in foodbanks. A flyer was designed with the fully funded training information, which the council helped to target at groups that were less engaged in training. Demand was great, so they targeted those who were not supported in existing contracts. It was a case of first come first served with no more than two representatives per organisation to widen participation in the 11 half-days of training.

In the case of Washington Mind's course on grief and loss, participation rates were slow to start with, despite their courses being advertised on their website, on social media, Facebook, and Instagram pages, Healthwatch, newsletters, with training dates circulated to network members, and requests for them to be forwarded to all their own members. All the courses were fully funded by the BMHF, and they provided online training as well as face-to-face because venue hire was costed up.


BETTER MENTAL HEALTH FUND SOUTH TYNESIDE
Impact on specific groups of vulnerable adults
WHiST - vulnerable women
Increasing counselling support for vulnerable women through the employment of a paid counsellor to work with counselling coordinator. Widening their service offer of extended counselling, within a supportive environment offering women-only groups and activities
Women's advocate employed to support women on a one-to-one basis, to build their confidence for e.g., in their interactions with statutory services. Through better management of their financial and welfare needs, the mental health impacts of social vulnerability are mitigated. Women can also be referred for support from other
Paid counsellor who was formerly a volunteer
Paid women's advocate who was formerly a volunteer
More women able to access services and activities that support their mental health and wellbeing, and improve their social circumstances
National Trust - veterans
Based at Souter Lighthouse, outreach, and engagement with veterans to continue to join water sports at their surf schools, and to undergo training to be surf coaches. Lighthouse staff have experienced a number of suicide incidents occurring in the Leas area, which is part of the rationale for this activity. Staff promotes, facilitates the activities, conducts data collection and evaluation to make the existing courses sustainable.
One qualified surf coach who was a veteran and two partially qualified. Access sessions (6 wks) and clubs organised for veterans with no experience of water sports.
Veterans able to access water sports that support their mental health and wellbeing, and training to be surf coaches


Age Concern South Tyneside – older people
Increased hours of work to provide debt and financial advice, and form filling and support for residents especially men over the age of 50 year of age, in the most deprived wards. At particular risk of suicide and depression, this group benefits from greater financial independence.
A full-time post of a Mental Health Link Worker was created to address the high level of need in this age group especially for residents who have needed to 'shield', with poorer health outcomes over time. Residents were reached and assessed by the Link Worker and supported to access local groups.
People over 65 self-identifying as isolated [less than 2 contacts with non-care staff in a week] are provided regular telephone support and advocacy into local groups, through a telephone calling system. This has increased their capacity to reach more people and support wellbeing.
More capacity
More outreach, signposting, and support
More capacity
Reduced risk of suicide and depression in older men
Reduced sense of isolation and associated poor mental health among older people, including ethnic minority residents through Apnar Ghar

Meeting unmet need among vulnerable adults

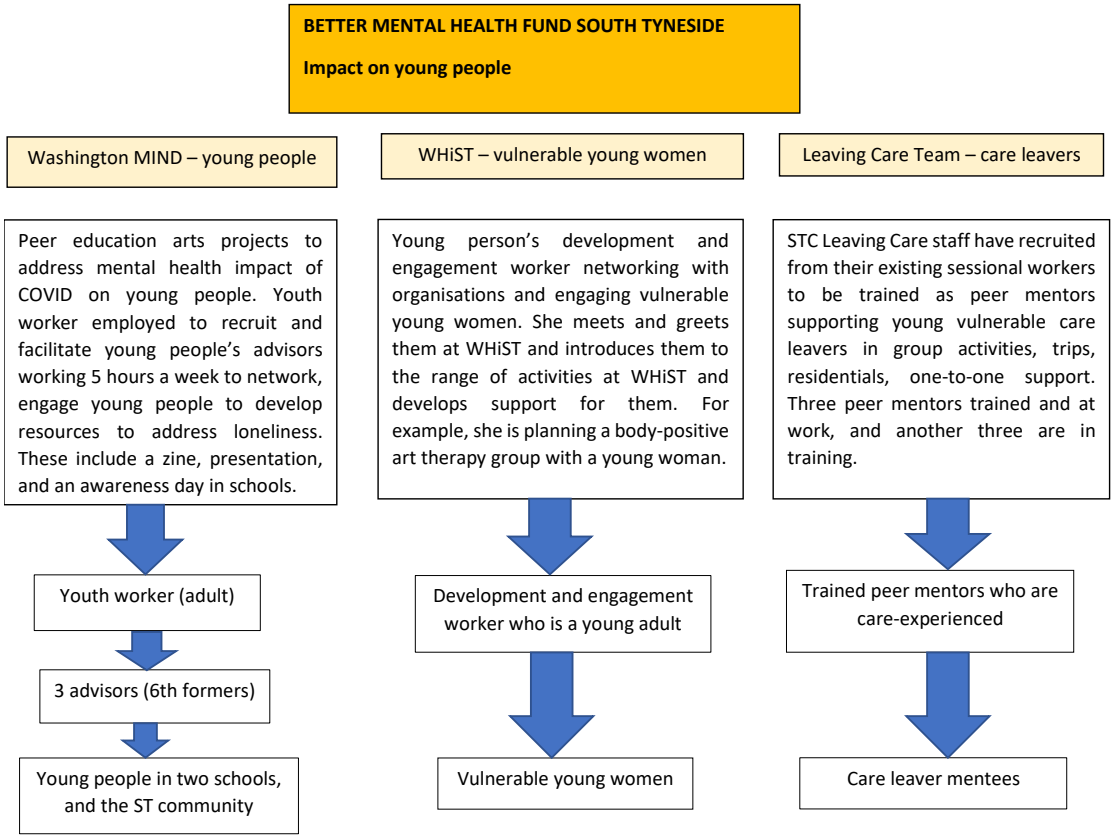
The funding was also used to increase provision to meet unmet demand for services in organisations such as Age Concern and WHiST. The contract with Age Concern was agreed in July 2021, and rather than waiting for the funds to arrive, they started delivering in August to put them in the best position for refunding. Otherwise, as the programme lead explained, outcomes of 12 months would be put back to 9 months, then 6 months. As an established organisation, they were able to start immediately with their existing funds.

In services involving debt advice, signposting, support, advocacy and counselling, there was not as much outreach or engagement that was needed but what they faced were overstretched services. The paid counsellor at WHiST was able to provide more mental health support for women, but this resulted in an ethical obligation for continuity of care, particularly if their model of counselling was not as time limited as that provided by other service providers.

ST07 works with the women from between 6 weeks to 30 or 40 weeks, depending on their need rather than time scales……Other services like Talking Therapies require a difference commitment, and they refer women to WHiST. For example, the Rape Crisis centre will only help women for 18 weeks, regardless of whether you miss a session, although this is presently under review. Because of the pandemic, women are more at risk of complex financial problems and job losses, affecting their mental health, and counselling sessions have continued for longer than before Covid. – Group interview

On the other hand, getting veterans interested in surfing and eventually to be trained as surf coaches was challenging and the programme lead worked hard to promote the programme using available networks. She provided information flyers about the free Access Sessions, the supportive club system and surf coach training to the different community groups connected with SeaScapes, Recovery Colleges up and down the coast, as well as through the Suicide Prevention Team. The veteran who had benefited from surfing previously and was running the sessions used his contacts in different veterans' charities while the programme lead contacted other veterans' groups not among his contacts. She shared the following message about an Access Session:

'There were 8 people turned up on Sunday, hopefully more people will come as the weather picks up. One guy made it all worthwhile, this guy [J] was injured in the Afghanistan in 2012 and has hardly been out of the house in the past decade. He managed to come down to the beach with a support worker and get in the water. He had a blast and hopefully he will be back next week.'



Young people's work

Programme leads who were starting new projects embarked on a range of methods to develop, promote, and deliver their services. However, among those who worked with young people, time constraints meant that they were not able to recruit more widely as they had planned. Nevertheless, there was a strong belief in the importance of working collaboratively with their user group to develop ideas, activities, and resources. The young advisors were sixth formers recruited from two local schools, even though the youth worker had tried approaching young parents' groups and alternative education providers. The young advisors and youth worker met every week on Teams to discuss, co-design and co-produce resources for their Loneliness project, with input from their own peer networks.

The Leaving Care team put out a call for expressions of interest for the peer mentor roles to their 20-30 sessional workers and young people were encouraged and supported to apply. The peer mentors recruited for this new work were already employed on zero hours' contracts within their service, and had experience for e.g., in consultation work, and help in interview panels, so were not required to go through a full appointment process. They thus managed to get young people on board quite quickly to co-design the pilot. Meetings were held with the mentors to reflect on the skills gained from the mentoring training they attended, to get them to think about the aims and objectives of the programme, and how they would want to support the Leaving Care team in delivering the programme. Eventually, the hope was that the mentors would commit to owning, developing, and leading the programme themselves.

Young women tend not to participate in the various activities at WHiST, so the young person's development and engagement worker did outreach, one-to-one with young women, with her networking taking her to various organisations such as family centres in the area. She aimed to build relationships with these agencies, careful not to duplicate what they were already doing but to seek to work in partnership. She offered the following example:

[Beneficiary] has often expressed to me that her other support workers do not listen to her needs or how she feels about the way they are dealing with her, so I make sure that she does feel listened to and reassure her that whoever else she is working with are working within their own organisation's guidelines to provide support in the most safe and appropriate manner. – Case Study 2

WHiST staff recommended contacts to her and presently, there are close to 50 organisations she has contact with. To find out about young women's needs, she visited South Tyneside College to give talks about healthy and unhealthy relationships. When young women come into WHiST for a meet and greet, she would engage with them, inviting them to suggest activities they would like to see organised. She has made use of WHiST's Facebook page posting notices for local community groups and her poster about the Art therapy group has generated a lot of interest.

Added value and benefits

Filling a gap, providing opportunities

The BMHF aimed specifically to mitigate mental health impacts arising from the COVID-19 pandemic. The impact on community mental health was affected by service delivery where in-person contact was suspended and moved to digital platforms, reducing access to services for many vulnerable groups. Without sufficient funds to build back on staffing levels, some service providers would have struggled if not for the availability of the BMHF fund to enable the employment of workers. In one charity, the pandemic led to a loss of volunteers, but in MHC and WHiST, there were volunteers who were recruited as paid members of staff. MHC described it as

…a positive start to something which otherwise, we wouldn't have been able to pick up after the pandemic and be where we are now. It would have taken a couple of years - it would have been like starting all over again - ST01

They were filling a gap in services for e.g., with carers of people with mental health issues facing their own problems i.e., depression, financial difficulties, loneliness, wellbeing needs, which are not being addressed by generic carer groups. They have 60-70 people that they are supporting, attending courses, or 2-3 activities, getting involved in transgender support, and Emotionally Unstable Personality Disorder (EUPD) support, both areas of work that were missing in South Tyneside.

The gap that was filled of holistic one-to-one support to build confidence provided by the women's advocate is demonstrated in the following comment from a social worker shared by the programme lead:

When [advocate] started to support B, she was seen by social services as difficult and not being able to put her son's needs first. [Advocate] has helped B to express her views in meetings and to understand what social services expect of her. [Advocate] realised that B had a learning disability and did not understand the majority of what was being said in meetings. As a result of her intervention, B now has a diagnosis and social services have been

able to work with her in a different way. I believe that the power dynamic has shifted in the meetings and J is now confident in sharing her views and challenging when she disagrees. [Advocate] has worked with B for 7 months and the statutory professionals involved with B and her son have reduced from 14 to 4 in that time because they now understand her situation and can see she is supporting her son. They are now considering lifting the child protection order. The impact on B's mental health is huge. She had been struggling in the system for years and now feels positive about the future.

The gap identified by Washington Mind was the need to address the impact of COVID-19 on those suffering bereavement and at risk of suicide. Mental health conversations are often about the meaning of life, but death and dying are not often talked about. The grief training developed that was called 'The Stories We Tell and Are Told', was successfully piloted before the pandemic. That funding ended, so BMHF came at the right time as a chance to spread the training more widely. For those who attended 'The Stories We Tell' – a narrative approach to death and dying - it was the therapeutic value and the safe space that the training provided for many who attended. The training increased not only their understanding of grief, but of their own grief during the COVID-19 restrictions and provided the opportunity to tell their grief stories within the learning process.

The benefit of shared experience has also been one of the ways services successfully provided much needed support. Care Leaving team peer mentors are given a level of independence not available to the sessional workers, so the care-experienced young mentees have the benefit of the time and flexibility of their mentor. The age-related understanding, knowing that the mentor may have gone through the same or similar crises in the past and can identify with them, was valuable to mentees. This would serve to fill a gap in care-experienced young people's lives, as mentor trainees testified from their own experience.

In the veterans surfing project, an environment was provided where risk was present and the adrenalin from that risk was something veterans were familiar with. With the cold, wind and weather, and exhilaration from catching a wave, the men were having the opportunity to experience the outdoors, but within a supportive structure of other veterans who have shared experiences. As far as the programme lead was aware, this opportunity was not available elsewhere in the North East.

Extending reach and widening impact

Another specific aim of the BMHF fund was to reduce widening mental health inequalities by targeting at-risk and vulnerable groups. One of the outcomes arising from the different programmes of work was how services were extending their reach to a range of these groups. The facilitator at MHC was able to use her social media and administration skills to contact more organisations that have registered an interest in their courses, groups, and activities. A new EUPD support group was started by the facilitator, with referrals from the community psychiatric nurses and social workers. On a different service called 'Moving Forward', she records the statistics on how many touchpoints there have been with students. In one month for example, of the 60-70 people in that service, she reported knowing at least 50-60 personally. As a result of her appointment, the Recovery College has grown with more groups and courses available.

The range of beneficiaries from training courses has also been described as having widened. Tyneside Mind attendees included public-facing staff from leisure and library, schools, (e.g., pastoral staff), social workers and care home staff. Rather than more conventional health care professionals, they targeted mental health advocates working with the council, e.g., staff and volunteers from Age Concern, Mental Health Concern,

neurodiversity services, the Recovery College, Early Help, Children's Centres, Housing, Fire Service, Probation service and Prince's Trust. Their courses provide the needed information and tools so that frontline staff are better equipped to manage their own mental health issues. Washington Mind reported reaching out to people who have never had training on suicide prevention for e.g., care home staff, local bus-drivers, hairdressers, police officers, funeral directors, coroners, and chaplains.

The aim of the BMHF to reduce inequalities included more inclusive access to services and ensuring adequate distribution of funding to support minority ethnic communities. With the funding from BMHF, Age Concern are now able to reach more people, in more communities, including marginalised groups that they had not worked with before, including other charities. South Tyneside has a large Bangladeshi community and Apnar Ghar, the organisation for minority ethnic women (predominantly South Asian) has asked for support in the past which Age Concern was not able to provide. This has been addressed with improvements in staff capacity through the BMHF.

In some projects however, this proved difficult, especially because of the timescales that they were working within. In the case of the Loneliness project, the young advisor who was interviewed did try to engage with five to six youth groups including those for asylum seekers and the LGBT community. He was keen to get their insights about being in the minority because he was not a part of those groups. Unfortunately, no replies were forthcoming, but they were thinking of offering them the zines they had produced.

Language difficulties were a barrier to reaching marginalised groups. However, WhiST is fortunate enough to have a worker proficient in several languages and the young women's engagement worker has been able call upon this colleague's help. Newcastle Interpreting Services is often unable to provide local interpreters and there is reportedly no funding for interpreters in the borough. WHiST has strong links with Apnar Ghar and Crest, so she attends their events to meet with minoritised women, for example during the event on International Women's Day at the Customs House.

In terms of suicide prevention training, there exists a cultural barrier to discussing suicide among South Asian communities, according to Washington Mind. According to their training manager, the myth is that it could 'plant a seed' in people's minds, leading them to consider taking their own lives. In her experience, this thinking existed in the mainstream community but over the years, it has shifted so that there is greater openness. At present there are a few mental health advocates trying to encourage a similar shift in South Asian communities, but it takes time.

Among the care-experienced young people, most are from areas of deprivation, from varied backgrounds. Many reportedly tend to be low achievers in terms of educational qualifications, and a few have learning difficulties. In addition, they are overrepresented in experiencing custody, as well as poor mental health and financial wellbeing. Mentor trainees described care-leaving as 'daunting' and 'stressful'. Although there were attempts at recruiting both male and female sessional workers to be involved in mentor training, apart from one young man, only young women have responded. According to the Leaving Care assistant team manager, this could be explained by the gendered nature of the health and social care workforce, where women make up the majority. Nevertheless, the Leaving Care practice manager has explored avenues for including more young men through discussions with Andy's Man Club. She believes that while there are no ethnic minority young people involved at present, the recent national transfer scheme will see more young people being allocated to South Tyneside social work and care teams, including asylum-seeking children. While their

mentoring offer will be open to them, they foresee additional challenges such as barriers regarding communication. Transgender young people have attended the sessional groups where the mentorship scheme is open to them.

Building workforce capacity and resilience

The potential of the BMHF to help build and boost the mental health community workforce and resilience has been demonstrated in this evaluation. COVID impacted on staffing and volunteering levels, and the much-needed recovery was achieved through supporting volunteering pathways, for e.g., through one of the responsibilities of the MHC facilitator role. To illustrate, she gave the following example:

One person new to the area, felt really isolated. They joined the college by text messaging, had coffee, joined a group and drop-in, and then attended a course. By Christmas, they were volunteering for Crisis, which was a big step for them, and started volunteering in the Kind Mind Community. – ST05

With an improved volunteer base, paid staff could be better supported, and in the case of Age Concern, this contributed to staff retention. The programme lead had interviews with his staff (volunteer coordinator) and volunteers to discuss how they would use the additional capacity they had. Although they reacted with some degree of stress because of the change to working patterns and anxiety about what would happen after the funding ended, the ability to help more people, receive good feedback and gifts of appreciation from clients, made it worthwhile. Paid roles such as the MHC facilitator and the WHiST counsellor had developed from volunteer roles and were invaluable for post holders' personal and professional development within their role. In the case of the counsellor, her knowledge of suicidal ideation increased, and she obtained training to support women suffering from sexual violence. Her first client was a lady with a learning disability, and she was able to progress the case to teach emotional resilience and self-belief, with ongoing success. The women's advocate at WHiST was appreciative that she was able to fit her role flexibly around her parental responsibilities, which made for a good work-life balance not available in many other posts.

Shared experience is a key aspect of both adults and young people successfully employed with the funds from BMHF. Young people were employed as peers on part-time contracts because of the benefit that their shared experience brought especially in the case of mental health. The Loneliness project presently have three young persons' advisors who are paid five hours a week. They felt rewarded with fulfilment from the work they do, having the responsibility of liaising with other young people, getting their views known, producing a zine, and producing arts submissions and videos. The following account gives some idea of the positive impact of the programme.

Covid affected everyone, all of the young advisors. B01 was in the house for 4-6 months and felt very claustrophobic. He couldn't go out to meet his friends and felt isolated. He lost contact with people on social media, and drifted away from friends, because he was physically alone and lost interest in being social. He lost the motivation to contact people online, until school opened. To him, social media can be harmful because you can see people going out and having fun with a lot of friends, and this could make you feel worse about yourself because you are not having the same experience. B01 would like to go to university after sixth form. He thinks this whole experience of being a young advisor has helped him feel more competent and confident, especially in speaking and giving presentations, doing his own research, contacting people and networking, all of which will help him in his future. He hopes that after all these events, the school will be more alert to the needs of young people.

Similarly, the peer mentoring training provided by BMHF took the young beneficiaries through a ten-week course covering what it is to be a mentor, safeguarding, boundaries, relationship-building, values, group dynamics, one-to-one, counselling skills (at a basic level), communication skills, and self-reflection. The programme lead believes their young people were given the opportunity to exercise agency and control and describes the following dynamic being very valuable in the programme: a) making the decision to be a peer mentor, b) the foundation steps in the mentoring curriculum, leading to better opportunities in the career pathway, and c) the sense of identity of being a mentor and contributing to the wellbeing of others. One example quoted of the value of shared experience being able to contribute is where a young parent with anxieties about taking their child to a children's centre was linked up with a peer mentor who was also a parent. She was then able to help them access universal services.

In the group interview with peer mentor trainees, they described what benefits they envisaged would arise from their peer mentoring training.

B05 thought that it could lead her to other jobs, like counselling, as it is an added qualification. One could start their own mentoring business, but in her case, she wanted to stay in the Leaving Care team, or become a social worker, and peer mentoring added to her experience. For B04, the appeal was to be helping young people who were leaving care. B06 thought the same, just to be able to support somebody, but to have the added qualifications was a bonus. B04 mentioned that in the course, they talked about the benefits to both the mentor and the mentee, the personal growth for both sides, which she thought was important.

From the point of view of the Leaving Care Team, the funding opportunity stimulated the development of the idea of peer mentoring, which otherwise would not have arisen. The programme lead experienced professional development as she was helped by the PHMHS lead to put in the bid, which was a new venture to her. She made the case successfully in the application that the mentors would add value to the team since they would be helping to support young people with complex needs and chaos in their lives. Another staff member gained experience in project management, dealing with timescales and returns to the Office for Health Improvement and Disparities (OHID), which was all new to him.

The funding received justified to senior management the time and energy Leaving Care staff put into developing the programme. Similarly, but in more practical terms, the BMHF investment in the surf training of veterans paid for staff time and booking of equipment, including lifeguard services on the beach.

The following account from the interview with the young person's engagement worker speaks of the skills, experience and personal growth that has resulted.

ST13 loves what she is doing, learning what it takes to get new courses up and running, looking at funding, room allocation, and who the tutor is, materials needed, and timing. She signed up for training courses that are available through WHiST and learnt about networking, suicide prevention, domestic abuse, including 'A Better You' course, about weight management and healthy lifestyles, which could be offered at WHiST in future. She has attended a mental health course run by Mind, which will help her interactions in her role. Setting up meetings, managing her time well, are all very valuable skills that she has gained.

Additional, indirect, and unanticipated benefits

The thinking behind the BMHF was that the fund would eventually be able to incentivise investment in prevention and promotion interventions for better mental health. There was some hope expressed by programme leads that this would happen. As the Age Concern programme lead observed, the proven ability to reach more people would potentially make the organisation more attractive to funders. When it comes to training programmes, with more people attending, more evidence is gathered that the training works and serves a purpose. This would give training organisations like Mind an opportunity to bid for more funding to sustain the charity while at the same time sustaining community resilience. For example, with Washington Mind having had ten years of evidence built up from delivering their suicide prevention training 'A Life Worth Living', it was hoped that the sister course on grief 'The Stories We Tell and are Told' - about how grief is talked about - would generate more evidence for future funding. One unanticipated benefit reported from the training was that attendees had found it therapeutic for their own experiences with grief.

It was the view from the Leaving Care team that the money from the fund generated ideas, and action, igniting work to make changes, with the chance of testing something innovative. If proven successful, the programme of work is more likely to get agreement for it being run again, from another funding source or budget. The evidence is however dependent on the results of the national and local evaluation, but at the time of writing, there is limited evidence of the ability of organisations to generate long term funding from the seed-corn money from BMHF. Nevertheless, there appears to be a more systematic collection of evidence from organisations that has resulted. For example, the MHC facilitator has developed a new database of groups that have started up involving well over a hundred new people. There is a breakdown according to gender and other demographics, including reasons for them joining among which are mental health reasons, depression, financial difficulties, loneliness, wellbeing needs, and a large number are carers. Her marketing skills have enabled her to run data analytics on their social media presence, and design and collect feedback from service-users. However, of all the staff roles funded by BMHF, only hers has resulted in a permanent position in the organisation.

Additional benefits to the ones outlined in the previous sections are in need of mention here. Firstly, for some organisations, the relationship with the Public Health team at South Tyneside Council began to be established, and for others, improved, through the funding period, which built a foundation for future work. For Age Concern, it was the first time that they had received funded work from STC Public Health. For Tyneside Mind, the programme lead appreciated the introduction to the PHMHS lead, and the responsiveness, information and good conversations that arose from the funding relationship. She looked forward to future partnership working with them. Not only were there relationships built up between commissioner and fund recipients, but there were also those between recipients, for e.g., leading to staff and volunteers benefiting from each organisation's training and services and helping to publicise these because of what was gained. The WHiST women's advocate's holistic role was able to facilitate connections between organisations, of which she had contacts with up to twenty. Within the council, the Leaving Care team described the improved working relationship they now have with the Participation and Engagement team that helped them to deliver the programme. One unanticipated outcome they reported was the ability to strengthen the family and corporate parenting approach that had been adopted.

Challenges and recommendations

Limitations of time and money

Programme leads struggled with the immense time pressure to start programmes and produce results. While more established organisations were better placed for setup and delivery almost immediately, other smaller organisations took longer. They reflected on how much better it would have been if there was more time to develop work and deliver outcomes. For some, it was a lost opportunity where mental health work was concerned, especially considering the effects of the pandemic.

[BMHF's] a scratch in the surface of the iceberg rather than kind of making any genuine big impact. I think it will take a couple of years of this kind of intervention to start breaking, to getting those older people who've locked themselves away for two years and are still worried now - ST02

With more time, the youth worker for the Loneliness project felt that they could have extended the project to include a wider cross-section of young people, such as young mums. Thus, the potential of the funding was not fully exploited. This was also the opinion of WHiST where they expressed regret that the funding was not for a longer time, else they would have had a greater impact.

To those delivering training for mental health, short term funding is not the way forward according to one trainer, because mental health training is about shifting mindsets and cultures, which takes time. There is also the issue about participants' availability, where they usually give at least six weeks' notice for diary space, affecting their ability to meet their BMHF targets. She regretted that she was only told in January about the chance to take advantage of the funding, which did not leave a lot of time for delivery. Another mental health charity reflected on the fact that the short time scales could possibly lead to demoralization as services were not able to meet demand.

Because the Leaving Care team did not have enough time and funds to employ a dedicated person to run the programme, it had to come from the existing staff resources. So, while staff were incentivised to find the time, and to be creative so that the outcomes were met for the young people, one staff member who coordinated and chaired meetings and brokered relationships faced challenges in getting routine business done, affecting staff performance and service delivery. The short turnaround also meant that all the staff had to manage with additional roles to their day-to-day jobs. But they admitted this was what they often had to deal with as a service. Ideally, they would have liked to have a full-time coordinator to realistically deliver the whole programme, which might have led to them recruiting and retaining more mentors.

The PHMHS lead recognised that even though there were benefits reaped, running the risk that those who had received the benefit of services would no longer receive them could be detrimental to beneficiaries and organisations in the longer term. From his experience, most mental health programmes take 2-3 years to become established and even one year was not the amount of time that most programme leads had. Programmes started in October/November only had seven months, while those starting new projects had even less. There was agreement among programme leads starting innovative work that the turnaround times were particularly unrealistic. Time had to be spent in recruitment, induction, training, preparation, and outreach, before work could properly start. As a result, the number of beneficiaries reached often did not meet target expectations for good reasons.

The Loneliness project had only two months to recruit and to arrange interviews for young advisors in December. Because of the Christmas break they could only start in January to gain access to schools. The veterans surfing project could only start when the weather permitted, although the time before that was utilised in preparing the groundwork. The PHMHS lead felt that any fund in future should be a minimum of 18-months, giving service providers more time to develop and deliver the work. With less pressure, the quality of the work would be improved. However, he reported that OHID were flexible where they could be and generally very helpful.

COVID-19 effects

The fund was launched at quite short notice at a time when public health staff were stretched in their response to Covid-19. The public health team was also engaged in developing funding proposals for other national calls, including drugs and alcohol, obesity, and domestic abuse. It was also felt that some of the processes could have been streamlined to help assist with the implementation of the programme considering the demands faced by local teams. The pandemic also affected the smooth delivery of services e.g., when staff were suddenly taken ill with COVID. The number of residents reached and supported by the Age Concern link worker to access services was reported not to have reached their target because of the Omicron variant affecting services and service-users. The feedback from service providers highlighted the need to understand the effect of COVID-19 on people locally, those on the frontline, those who have lost colleagues and relatives, and 'how the world has completely changed' (ST09). This affected engagement with older people for e.g., who were nervous and unwilling to get out and about and involved in groups.

Mental health training was affected by COVID-19 in several ways. Because of restrictions, training materials that had been developed during non-Covid times had to be adapted for use online. This took time and effort. For one trainer leading on training frontline staff, it was quite problematic to deliver the training because of the context of organisations catching up on a backlog of work, so that staff were not able to be released to attend training. With staff illness due to COVID-19, staff were needed to cover colleagues' shifts because of sickness absences. The PHMHS lead believed the challenge was that while people were interested in training, post COVID recovery led to a lot of pressure on people's time to deliver their service, and not enough for their professional development. At the same time, with the mental health risks arising COVID and the importance of training, training providers in recent months have had to compete to deliver training where workers were needing to be upskilled for post-Covid recovery.

With respect to other problems faced by mental health trainers, the following training manager reflected on what she faced conducting online training during COVID-19:

During the pandemic, when the training courses were online, attendance could be a problem. Attendees needed to be reminded that once the course is gone, it's gone, and this was all public money. Problems such as last-minute cancellations, disturbances during the course, like knocks on doors, presented an interesting dynamic. ST03 preferred face to face because some attendees may switch off their cameras, and the non-verbal is lost. They are exploring hybrid provision as a solution. There are cost implications regarding travel and time, as in-person courses can take up to three quarters of a day. Managing male trainees when you are a female trainer can be challenging. In the past, they have tried to facilitate male involvement by providing lunch, doing training in a forest etc. The training environment is part of the journey, but BMHF can't fund or mitigate for this. Caregivers

need special attention because they tend to forget about their own needs, and need an immersive learning environment, where it is all about them, but online training doesn't provide this.

There were other challenges of online training reported, such the safety of participants. One training manager would ask participants for a name and contact number of a supportive person, so if they were concerned about an attendee's well-being, or if they 'disappeared' from the screen and they were concerned, a training colleague would phone him or her.

Barriers to outreach and retention

While there had been significant efforts by the different teams to reach a wide range of beneficiaries, the nature of the client group meant that there were hurdles that took time to overcome. Care leavers for e.g., are generally not an easy group to work with because of trust issues when leaving care. Younger people face many challenges such as educational pressures, part-time work, and the journey into adulthood with its new responsibilities. This presented different issues to navigate including new personal relationships, parenting, and various demands on their time. This partly explained the reason that fewer than expected young people who were trained in mentoring went on to work as peer mentors, preferring to take on other jobs. The mentor-trainees shared the following thoughts on this topic:

B06 reflected on the fact that if she got the mentoring job now, and she is only 22, so in a year or so, she might have completely changed what she wanted to be doing and might find another opportunity to do something else. This was because people 'keep growing and learning'. B05 observed that mentoring isn't a permanent job but part of the sessional work. There wasn't a full-time job with a full diary, so she thinks people would prefer a fulltime job, and then they would leave their mentoring role. B04 felt that something like mentoring would be difficult to fit in, and depending on the timing, it could be hard to find the time to do it on top of a fulltime job.

The young women's engagement programme was new and struggled with getting the numbers, because of the difficulties of trying to work with the demographic of white working-class women, and ethnic minorities who generally struggle to engage with services. While the worker made contact with several young women, many had commitments, whether because of college, work, or childcare. There were some young mums' groups that she visited, but a creche at WHiST was not yet available to enable them to join activities. She described the other barriers she encountered:

Working around other people's schedules, with professionals or referrals, and appointments getting cancelled, can be frustrating. There are also no-shows from quite a lot of women for 'meet and greet' which can be disheartening. For instance, one woman came but because she suffers from anxiety, she couldn't cope with the new environment and people she doesn't know. Several women have mental health difficulties, which present barriers, but ST13 has had to persist, e.g., by sending out reminders to women on the day of the meeting.

Her task was also to change the perception that WHiST was only for older women and those in need of specific help rather than general health and wellbeing. Changing such views takes time and effort. The National Trust staff member was also facing difficulties engaging with veterans, because 'there are a lot of things going on with these men that we cannot mitigate for' (ST12). This included post traumatic stresses and the fear of being judged. Likewise with older people, they needed the confidence to engage socially, especially after long periods of isolation and loneliness. Mobility issues that arise from not having been out and about in the community also affect confidence, with frailty and falls on the increase.

Outcome measures

Programme leads were required to produce returns for the national evaluation on staffing, the number of service beneficiaries, including their demographics such as ethnicity, age, attendance profiles, indices of deprivation, to evidence whether their targets had been achieved. In addition, wellbeing outcome measures were to be selected from a recommended list and for some, the spreadsheet for all these returns was described as 'cumbersome'. The wellbeing outcome measure used by most organisations, i.e., Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), is different to what many programme leads use for their own monitoring work for their organisation. It was seen as an additional burden, particularly when some of their staff were unfamiliar with it. Organizations however understood the need for OHID to require nationally recognised tools for consistency when evaluating value for money. Therefore, some organisations like WHiST included these assessments for their own end evaluation and there was anecdotal evidence that the measures could be of some benefit. For e.g., one counselee saw how many points she had moved along on the wellbeing score, from a low average to an above average, and felt very encouraged.

Age Concern reported doing quarterly returns of the SWEMWBS, 13 weeks after interventions, rather than the recommended 6 weeks. The explanation given was that changes in mood vary as people's circumstances change, only getting resolved over time. For example, a client might have received a £60 uplift in their benefit, felt good about it, but then used up all the money, and felt terrible afterwards. Or someone might offload to a support worker and felt relief, only to uncover deeper issues needing to be dealt with. Nevertheless, the outcome measures have shown improvements in their clients' wellbeing.

For programme leads starting innovative work, providing returns on the number of beneficiaries was a challenge in the early stages. They would have found it more helpful if there was space for reflection and thinking and they were ambivalent about the usefulness of the outcome measures. One training provider felt that the outcome measures were not appropriate for training programmes and could be ethically and morally unsafe, for e.g., when exposing work/employment issues. The PHMHS lead acknowledged the problems trainers faced and advised them to use bespoke local measures for training and adapt the SWEMWBS for their purposes.

Young people are generally used to filling in forms, but those leaving care or have been institutionalised in some way, have experienced a lot of formal processes, paperwork, and documentation. Care-experienced young people have shown reluctance in the pathway-planning processes that they have to undergo after leaving care, so the Leaving Care team were reluctant to subject their young people to a lot of feedback. However, outcome measures collected after the residential trip involving mentors were very encouraging.

Another view from one of the training providers was that qualitative feedback such as beneficiaries' confidence, knowledge, opportunities to talk, was more valuable. It was important to her that people could be frank about the possibilities of suicide, and that the fear of speaking about mental health risks is removed. Service-providers need to be involved and part of the conversation, not just the beneficiaries. Anecdotal evidence before and after interventions would reveal beneficiaries' expectations and whether they had been fulfilled. From her experience, getting feedback online is difficult, even though all that was required was a click on a link. The programme lead for WHiST also felt that without case studies and anecdotal evidence, data can feel false and tokenistic. To support the statistics, the MHC facilitator added written feedback e.g.,

to show how students have improved, with constructive comments from students about courses run by MHC. But full narratives were not required by OHID.

The PHMHS lead recognised that estimating beneficiary numbers when organisations applied for funding, could be challenging especially for new programmes. A template was developed to help the organisations plan for the numbers. The was a sense that nationally, due to the constraints of COVID-19 and time, more flexibility would have been appreciated at a national level.

Limitations

The fieldwork for this evaluation was conducted midway through the funding period and the analysis was completed before all the returns were sent to OHID. The anonymised cumulative datasets for the National Evaluation are summarised in Appendix C, and contain the following information to complement the findings of this report:

1. Number and type of projects funded
2. Number of Full Time Equivalent (FTE) staff employed
3. Number of beneficiaries (including by target group, protected characteristic and proportion living in the most deprived areas)
4. Projected number of total beneficiaries by the end of the programme
5. Number of partner organisations engaged
6. A summary of key learning, innovation, and wider system change
7. Measures of mental wellbeing of participants at baseline and on project completion.

Therefore, this report does not claim to represent the full picture of the outcomes of the different programmes of work that were set up from the BMHF funding. Instead, a detailed account of the processes involved in implementing the programmes of different activities was provided. The narratives collected from interviews are weighted towards the service-providers for reason of time constraints in recruiting beneficiaries. Follow-up interviews to capture progress especially for those programmes that started late unfortunately could not be carried out as planned. Nevertheless, there were rich insights from the in-depth interviews that were conducted, some lasting more than an hour.

Discussion and conclusions

The themes arising from the analysis speak firstly of the way in which programmes of work were included in the application for the BMHF funding, and how collaborative discussions with selected service providers in the community paved the way to the bid being successful. Each programme had different delivery starting times, depending on whether they were new projects, building on previous work, or increasing existing capacity. The possibilities for sustainability for the different programmes depended on how well they were embedded in existing services and funding streams, and the evidence collected on service outcomes being able to incentivise further investment. The areas of work are described in terms of impact on firstly, vulnerable adults through training and facilitation, secondly, specific groups of vulnerable adults i.e., vulnerable women, veterans, and older people, and thirdly, two groups of young people. A major area of investment was made in mental health training courses for key workers, with a community approach to training that sought to target individuals who tended not to access training, some perhaps because of cost implications. But there were challenges to the training offer that were complicated by COVID-19 recovery, pressures on key worker time,

and online delivery. The benefit of administrative support was highlighted when the employment of a full-time facilitator led to great strides in engagement, and service delivery. The success in her performance led to her post being made permanent in the organisation. Meeting unmet need among vulnerable adults was another area of commendable work, where not only were gaps in services filled, but opportunities provided. These included joined up working between colleagues, including between organisations in receipt of the funding. There was evidence of service providers accessing and recommending the training and services provided through the BMHF funding. This could be described as a ripple-effect of a community of service-providers formed from the common experience of being fund recipients, brought together by the public health lead for mental health. All this led to opportunities for capacity building in mental health resilience, but this could also be precarious because of the funding being limited only to one year.

The benefits of the fund in enabling services to fill the gaps in mental health support services, extend their reach in the community, and thus widen their impact were clear to see. These benefits were delivered in many cases despite the limitations of time and money and having to navigate the effects of the pandemic. Barriers to outreach and retention need to be taken into consideration by funders, and ways to accommodate such challenges provided. One clear lesson from this regards the need for lower expectations being applied to new projects, where recruitment of junior workers is involved. And yet the benefit of involving them in community mental health should be seen as a steppingstone to further work and good outcomes. It is particularly in these cases that beneficiary returns do not tell the whole story of the benefit of this seed-corn funding, because they cannot capture the full potential of capacity building in mental health resilience that was uncovered at the heart of these endeavors.

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Appendices

Appendix A: Interview topic guide – provider organisations

Introductory information

1. Can you tell me something about yourself and your role in your organisation?
2. How did you find out about the BMHF and what do you know about it?
3. Can you briefly describe the project or programme of activities that the funding enabled your organisation to run?
4. Why was there a need for such a project or programme of activities?

Details about the project/programme

5. Would you have information on the numbers of staff, service-users, referrals, or hours of support provided? Any breakdown of the composition of the participants in the project/programme and their frequency of use/attendance? Or case studies that you can quote?
6. Can you tell me about the course or timeline of the programme, from initiation to finalization?
7. Would you be able to comment on any feedback from service deliverers or recipients along the way?

Support for the project/programme

8. Was your organisation supported in any other way, by the council or external agencies? Were there any collaborations with other service-providers e.g., the NHS?
9. Within your organisation, were you personally supported to run the programme and its activities? If so, how?

Challenges and recommendations

10. Were there barriers to engaging participants in the programme, and if so, what were they?
11. Did the programme deliver according to plan with anticipated risks, or were there unexpected obstacles or unintended consequences?
12. What is your personal estimation of the programme and its activities?
13. What recommendations would you give for the program's continuation or future development?

Final comments on funding

14. What difference has the BMHF made to service delivery in your organisation and service users/recipients? Has access to the BMHF helped to facilitate or make improvements which otherwise would have been difficult to achieve?
15. On reflection, could funding processes have been better managed by those administering the fund?
16. Is there any feedback you would like to give regarding the commissioning of Mental Health services in South Tyneside?

Appendix B: Focus group and interview topic guide – beneficiaries

Opening:

- Introductions
- Complete and collect consent forms and reply slips; emphasise that all information will be stored securely and reported anonymously
- Reminder that there are no right or wrong answers
- Any questions before we start?
- Start audio-recorder

Questions

1. How did you find out about [insert name of BMHF project/activity]?
2. Why did you decide to join?
3. Can you tell us about the activity or support that you received from the project?
4. What did you enjoy or gain from this activity/project?
5. How could the activity/project be improved?
6. Would you recommend the project to other people like yourself? Why/why not?
7. Are there any other activities, services, etc, that you think would help to improve mental health in South Tyneside?

Closing:

- Anything to add?
- Any questions for us?
- Reminder of what happens next, i.e. how findings will be used
- Offer debrief sheets
- Thank them for their time

Appendix C: Summary sheet from BMHF anonymised dataset for National Evaluation

Beneficiaries by Project	Number of beneficiaries
Age Concern Tyneside South Debt and Advice	579
Age Concern Link Worker	851
Age Concern Wellbeing Calls	522
Leaving Care Service - Peer Mentoring and Engagement project	31
Washington Mind - S8046 Tackling Loneliness in Young People	420
Washington Mind S8047 Developing Community Resilience In Front Line Key Workers	226
Mental Health Concern - Community Kind Mind	153
WHiST Support for Women	44
WHiST Advocate Programme	79
WHiST Engagement Programme for Vulnerable Young Women 16-25	35
Tyneside and Northumberland Mind - Suicide Prevention Training	51
Sea Company - Surf Intervention	137

Beneficiaries by Gender	Number of beneficiaries	%
Female	1644	53%
Male	1303	42%
Other	27	1%
Unknown	154	5%

Beneficiaries by Age	Number of beneficiaries	%
0-4 Years	0	0%
5-17 Years	415	13%
18-25 Years	119	4%
26-64 Years	1074	34%
65+ Years	1308	42%
Unknown	212	7%

Beneficiaries by Ethnicity	Number of beneficiaries	%
White British & Irish	2224	71%
White Other	185	6%
Mixed	65	2%
Indian	40	1%
Pakistani	70	2%
Bangladeshi	59	2%
Chinese	10	0%
Other Asian	34	1%
Black African	30	1%
Black Caribbean	21	1%
Other Black	7	0%
Other Ethnic	30	1%
Unknown	353	11%

Beneficiaries by disability status	Number of beneficiaries	%
Persons with a disability	1503	48.0%
Persons without a disability	897	28.7%
Unknown	728	23.3%

Benificiaries by deprivation	Number of beneficiaries	%
Beneficiaries living in one of the most deprived 30% of LSOAs in England	1769	56.6%
Beneficiaries living in one of the most deprived 10% of LSOAs in England	1003	32.1%
Other	981	31.4%
Unknown	378	12.1%