THE INSTITUTE FOR CONNECTED COMMUNITIES

University of East London

PREVENTION AND PROMOTION FOR BETTER MENTAL HEALTH FUND: LONDON BOROUGH OF NEWHAM LOCAL EVALUATION REPORT

Learning from a rapid evaluation

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RESEARCHTHATMATTERS

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2. Executive summary

"Within the team there is a good awareness of local people, but they are only a small team and cannot represent every community. BMH Fund helped. It extended the team, increased capacity and helped thinking outside the box, exploring what the needs are. Staff have been engaging with the change enthusiastically and robustly." (Provider)

"It feels like I am back home because of how comfortable I have become with the service, and the importance of the service, which is now allowing me to become a volunteer." (Client)

2.1 Background information

This report provides evaluative evidence and insights into the strengths and weaknesses of the London Borough of Newham Council Better Mental Health (BMH) programme, which aims to help, uplift, and support at risk groups impacted by the pandemic to access community-based mental health and wellbeing services. In detail, the report looks at the achievements, challenges and lessons to scale the programme. The study evidences the programme's immediate positive impact in helping to strengthen partnership working in the borough and draws attention to the different ways community-based mental support services have improved outcomes in people by applying strategies and approaches that are sensitive to people's cultural identities and heritage. Arguably, this programme has reached and improved health outcomes for children and young people, members of the LGBTQ+ communities, Albanian refugees and migrants, Bajuni and Somali women and people recently bereaved – including individuals with intellectual challenges. At least 809 residents have directly benefited from this programme, all of whom have been traumatised or retraumatised because of the pandemic.

The decisions about the nature of the programme came out of the Newham Council Mental Wellbeing Impact Assessment (2020), which aimed to better understand the impact of the pandemic on the mental wellbeing of residents of Newham. The PHE (now OHID) Prevention and Promotion Fund for Better Mental Health provided London Borough of Newham with the financial resources to further fund several existing services, with the purpose of increasing service and community capacity and extending the service offer to residents, particularly those most adversely impacted by the Covid pandemic. The pandemic has had a deep but unequal impact on people, increasing existing and interconnected inequalities in health. Following a ranking exercise completed by professionals and community members, the Assessment placed importance on addressing residents' growing sense of fear and anxiety; isolation and loneliness; post-traumatic stress disorder; and poor physical health.

The Assessment is anchored in the 'Towards a Better Newham' strategy (2020), which sets out the Council's plan to support residents, communities and businesses to recover from the unprecedented impact of COVID-19. The Assessment recommends twelve actions. This programme covers ten out of the twelve actions (see Appendix 1). Essentially, the twelve recommendations seek to build on local work underway to tackle the complex set of circumstances experienced by residents, namely by building on the collaborative work with partners in the field of mental health and wellbeing, locally known as the Newham Mental Health Welling Partnership (i.e., involving NHS, Local Authority and Voluntary Sector partners and stakeholders). Strategically, this programme has enabled and facilitated the realisation of the plan to stimulate borough-wide thinking in how best to support underserved

and under-represented residents in the community at risk or with early signs of poor mental health. For that reason, the evaluation sought to answer:

- In what ways are deprived communities, at risk and vulnerable groups, and communities from different ethnic backgrounds being engaged with in the different services? What can be learned from these approaches?
- Which target population groups are not being reached and why?
- What are the perceived benefits and impacts of the services from the service user perspective?
- What are the perceived benefits and impacts of the services from the service delivery perspective, including the role of volunteers?
- What is the best model for delivering these services from the user group perspective?
- What evidence is there of needs being met that are not currently being met by other commissioned services?

2.2 The purpose of the research study

Over the last three years of isolation and being apart, residents want to connect or need help and assistance with their mental health recovery. Local befriending schemes and a bereavement service received additional funding from the Council to help and support residents to emerge from the pandemic and reconnect with the community. The Services are:

- Newham Bereavement Service, targeting the early bereaved across the borough, especially residents living with an intellectual disability where bereavement counselling was not available.
- Your Time, is a free, confidential and tailored programme, delivered collaboratively by HeadStart and School Health targeting children and young people with early signs of mental health and wellbeing problems in the community.
- Connect Newham an established telephone befriending service which focused the funding received on developing local community groups to develop their own befriending service via training and ongoing support. The three organisations supported were
    - Kulan Somali Organisation
    - Bajuni Women's Advocacy Group
    - Shpresa Programme

Generally, using a strengths-based approach (e.g., involving compassionate conversations and often delivered though a racially responsive service) the services have innovated and tested different ways to better reach and engage their target populations.

2.3 Method of data gathering and analysis

The programme ran from May 2021 to May 2022, and the evaluation was carried out between May and June 2022. The evaluation used both qualitative and quantitative data. The qualitative data collection consisted of telephone interviews, practitioner reflection logs

and online surveys with a range of participants, including clients, programme coordinators and frontline staff, as well as trainees/volunteers. The research team interviewed 22 participants using a semi-structured interview schedule (*N*=9 Newham Bereavement service, *N*=4 Your Time and *N*=11 Connect Newham, consisting of *N*=6 Shpresa Programme, *N*=4 Bajuni Women's Advocacy Group and *N*=1 Kulan Somali Organisation).

Thirteen interviews were conducted over the phone, eight on TEAMS and one interview with a service user was conducted by WhatsApp. All 22 interviews were transcribed by the research team and the findings are thematically analysed – along with the three practitioner reflection logs – and presented with anonymised quotations in the report. The quantitative data collection consisted of a review of programme monitoring data and clients' mental health and wellbeing measurement scores. Research ethics was obtained by the University of East London Research Ethics Committee (*No*. ETH2122-0174).

2.4 Overview of findings

The social value of the programme is explained through the number of residents successfully reached who would have otherwise not accessed any early help. In total, the programme had **809 unique direct beneficiaries**, 529 (65%) female and 238 (29%) males. Their ethnic groups were comprised of 143 (19.56%) white British, 86 (11.76%) white other, 79 (10.81%) black African, 77 (10.53%) mixed and 75 (10.26%) Bangladeshi. 38 (5.20%) participants fall within the Other ethnic category, which is above the borough percentage of 3.79%. 173 residents came from the 10% most deprived LSOAs in England.

An exploration of key measures associated with the mental health and wellbeing of the clients (*N*=529) suggests that the clients exposed to the programme benefited in building resilience and in their overall wellbeing. The Outcome Star (*N*=118) used as part of the Your Time programme shows improvements. For instance, *N*=118 Your Time clients were measured, all the boys and girls made progress in at least one Outcome Star area, while almost 1 in 4 clients made progress in at least three areas. The Short Warwick-Edinburgh Mental Well-Being Scale data, used as part of the Connect Newham programme, suggest that for *N*=53 clients their mean scores improved by 67% between pre and post assessments. The Coping with Bereavement and Grief scores were not obtainable. However, we do know that the Bereavement service completed an initial baseline questionnaire with 358 residents (77%) of the total number of 462 residents seen by the service, with 183 residents completing a final questionnaire (40%) of the total number of residents taking up the service.

Based on the primary data collected in the evaluation these outcomes have been achieved in part through the refocusing of the projects in how they reach and engage residents and provide age-appropriate and culturally sensitive individualised support. In practice, this has meant enhancements to their systems and processes, increasing the size of their workforce and providing staff training and often innovating the space and place in which to provide support that is sensitive to people's cultural identity or heritage. With these changes, the workforce has arguably been empowered and increased their confidence to become notably more targeted in their outreach approaches/techniques and more aware and responsive to the complex needs of residents.

Characteristics of "best model" of delivery

- Culturally competent services tailored or adapted for **minority groups** whose contextual needs, practices, values and beliefs are understood and reflected in an individualised plan.
- Services that offer **bilingual language support**, reflected in **staff that matches the target population.**
- Co-produced, tailored and flexible **support plans** that capture the clients' needs and serve to increase the agency and autonomy of clients.
- A range of **accessible** ways for clients to find out information and **blended** ways to engage with the services, whether in-person access (within walking distance), on the phone or online, allowing clients to decide what is most comfortable for them.
- Services provided in **community settings** that are not threatening or stigmatising for clients.
- **Outreach workplan** that engages local partners and builds cross-agency and public awareness of community-based mental health and support services.
- Whole system approach to **streamlining referral pathways** and making them less complicated for clients and providers to navigate and negotiate.

What is also borne out by the study is the positive way the Council have encouraged providers to co-produce services. In essence, they are commissioning co-production. The approach has served as a catalyst for action, rather than the Council serving as the central providers themselves. This action promoted mutuality, by offering community-based services a range of ways to engage, which encouraged them to work in reciprocal relationships with professionals and with each other. They established mutual responsibilities and expectations, demonstrated in a sharing of roles by removing tightly defined boundaries between professionals and recipients, and between producers and clients of services, by reconfiguring the way services are co-developed and co-delivered. Still, the Council could have done more in their facilitator's role in setting-up a learning network to coordinate collective action in the co-design and co-delivery of outreach approaches, allowing all parties to share learning and problem solve together in real time.

2.5 Recommendations

To move forward, each of the services share a set of challenges to embed their tested service enhancements and to become more sustainable, and so optimise on the gains achieved through this programme for residents. We have provided key recommendations to help build sustainability and to share best practice across the system. Fuller descriptions of the rationale for the recommendations is offered in Section 7.

Developing and delivering a strategic approach

1. Key strategic partners within London Borough of Newham across the Health and Social sector should continue to commission a mixed economy of services for residents which meet their mental wellbeing and health needs.

2. Key strategic partners within London Borough of Newham across the Health and Social sector should continue to commission blended delivery models incorporating online and in-person services to help reduce inequalities in access.

3. Key strategic partners within London Borough of Newham across the Health and Social sector should consider how best to innovate and test processes to simplify referral and other pathways between partners involved in delivering services for residents experiencing poor mental wellbeing and mental health.

4. Key strategic partners within London Borough of Newham across the Health and Social sector should consider how best to support VCS services to improve IT and data security systems to support new agile working, ensuring that security procedures and policies are in place to protect the information shared by residents.

Working with our community sector

5. Key strategic partners within London Borough of Newham across the Health and Social sector should continue to gather and amplify evidence to better understand how to effectively engage marginalized communities to increase uptake in community-based health and wellbeing services.

6. Through its Volunteering Strategy the Council should offer community-based services support to facilitate a coordinated approach in recruiting and training volunteers, and to target groups of residents who match residents' gender, ethnic, cultural and linguistic backgrounds.

7. Key strategic partners within London Borough of Newham across the Health and Social sector, including larger community-based organisations, should consider how best to identify and unlock social infrastructure and/or publicly owned assets to ensure partners can gain access to affordable and acceptable co-working space to accommodate the growing workforce and client group.

8. Key strategic partners within London Borough of Newham across the Health and Social sector should offer support to community-based services to access existing support and guidance on how to improve data storage systems to protect the privacy of residents and to better evidence outcomes.

Key skills and knowledge needed

9. Key strategic partners within London Borough of Newham across the Health and Social sector should build-on the promotion of services across the borough using culturally appropriate publicity materials targeted at residents and referral agencies. Publicity materials should be translated according to different ways of understanding in diverse communities.

10. Key strategic partners within London Borough of Newham across the Health and Social sector should assist VCS partners in the provision of specialist and refresher training to increase understanding of the full range of vulnerable and marginalised residents living in the borough for volunteers and paid members of the workforce.

11. Key strategic partners within London Borough of Newham across the Health and Social sector should work with VCS partners to think through a carefully facilitated process to strengthen the growth and development of racially inclusive services using a Community of Practice approach.

2.6 Limitations

There were limitations to the study that have influenced the results. We had a low completion rate of the practitioner reflection sheets, and even those completed were rushed, and often contained little to no information to enhance our understanding of each project.

The services collaborated with the evaluation team to varying levels, and therefore the interviews did not provide a similar level of information about each enhancement project. For example, we were only able to interview one person from one of the organisations, and therefore we were unable to assess whether there were differing views about the service.

We were unable to interview clients from two projects, and therefore our understanding of the service enhancements' impacts is limited in those cases. We could not obtain comparable pre- and post-intervention data. This was due to lack of, or limited access to, individual datasets from each provider. We were only able to use quantitative and secondary data as contextual information, rather than to assess the impact of the service enhancements.

3. Introduction

This report presents the summary of the key learning and impact that came out of the Newham Council's Better Mental Health (BMH) funded programme that ran from May 2021 to May 2022, which primary purpose was to improve mental wellbeing and health in residents affected adversely by Covid. The programme was aimed at children and young people, people experiencing social isolation, specifically Albanian refugees and migrants, Bajuni and Somalian women, and the recently bereaved, especially individuals with an intellectual disability. In practice, all the evaluated services have tested different ways to improve their outreach to target populations, implemented between July 2021 and May 2022, following an initial set-up phase.

The programme was co-developed and co-delivered at pace; therefore, the proposal made by the Council to PHE was focus on enhancements to existing services rather than to commission new provision. In total, 809 residents were direct beneficiaries of the enhanced services. The service enhancements have focused on correcting self-assessed defects in promoting their services to vulnerable groups and to onboard new clients, adding new service functions, and modifying functionality in response to the emerging mental health and wellbeing needs of residents due to the impact of the pandemic (see Newham Council Mental Wellbeing Impact Assessment, 2020). The report findings are based on evaluative evidence and insights collected by 22 research participants who are clients, providers and volunteers. The evidence consists of qualitative data collected through in-depth qualitative interviews and practitioner logs, supplemented by administrative data held on the 809 beneficiaries.

In the section below, the report considers the local context and how providers have gone about planning and implementing their service enhancements, before the report turns to look at the study design and present the key findings. The findings are organised around the central evaluation questions that look at the programme's effectiveness, and then moves to look at the themes which reveal the meaning and impact attributed to the programme from the perceptions of the beneficiaries and providers. The report then turns to look at the national picture of providing effective community-based mental health and wellbeing care,

before presenting the recommendations on how to sustain and embed best practice from the programme across the borough.

3.1 Background and context

The London Borough of Newham is made-up of 360,000 residents, who are 73% black, Asian and from minority ethnic group, 57% of residents do not have English as a first language, with a reported 200 languages spoken, and work is highly mobile, marginal and poorly paid (median income £28,000), with over-representation of 'gig economy' roles. It has one of the youngest populations in the UK, with over one third of residents aged under 25 (ONS, 2022). There are also an estimated 10,000 people with no recourse to public funds. While race and ethnicity play a part, Newham residents face many other realities which impact on their health, and which are seen in other places. Newham is within the most deprived 10% of local authorities in England. Up to 37% of all residents, and half of all children, live in poverty, and more children live in temporary accommodation than anywhere else in London (1 in 12) (Ministry of Housing, Communities and Local Government, 2019). Average rent represents 65% of average wages, compared to 30% across the UK (Newham Council, 2021). Newham has among the worst air quality in London, and the highest level of death attributable to air pollution of any London borough (Newham Council, 2022). Newham has had one of the worst standardised mortality rates in England, with upwards to 783 reported deaths with COVID-19. Many factors have contributed to Newham's high COVID-19 mortality rate, including factors linked to increased exposure and severity of outcomes.

As previously stated, this programme of work came out of the Mental Wellbeing Impact Assessment (2020) that aspired to better understand the impact of the COVID-19 pandemic on the mental wellbeing of residents of Newham. The evaluation findings support the recommendations that came out of the Mental Wellbeing Impact Assessment, justifying why it is important to look for ways to strengthen how the Council works with partners in the local provision of mental health and wellbeing support services.

The purpose of the Prevention and Promotion for Better Mental Health Fund call was to address the range of mental health difficulties that were aggravated by the COVID-19 pandemic, including loneliness and physical isolation, unemployment and financial difficulties, and racial discrimination and the impact of racial inequalities. The Better Mental Health Fund (BMHF) supported 40 local authorities in delivering community mental health services in the most deprived areas in England that responded to the emerging support needs during the pandemic and recovery (Centre for Mental Health, 2022). The BMHF was part of the government's Mental Health Recovery Action Plan 2021/22, which allocated £500 million to improve and expand mental health services, out of which approximately £15 million was allocated to the local authorities for community mental health support (Department of Health and Social Care, 2021).

Newham Council was successful in securing funding from the OHID Better Mental Health Fund, and provided additional funds to three previously commissioned suppliers to implement service enhancements throughout the funding period. They were:

- Newham Bereavement Service
- Your Time
- Connect Newham

This following section provides a summary of the three mental health and wellbeing community-based services funded by the Council to better reach and engage targeted residents impacted by COVID.

The first service is called Your Time. Your Time was developed rapidly at the height of the COVID-19 pandemic and was originally aimed at supporting vulnerable children and young people (5–18, and up to 25 for young people with SEND) in crisis by providing a regular weekly befriending catch-up delivered by the HeadStart Youth Practitioner Team. It supported the mental health and wellbeing of many vulnerable children during this time, including a significant number with complex mental health issues and safeguarding needs. It also led, in collaboration with CAMHS, on developing and coordinating a new Multi-Agency Collaborative (MAC) with the aim of reducing the impact on young people of waiting for a CAMHS service (or who do not meet the threshold) by providing not only the direct Your Time offer, but also coordinating a pathway to timely therapeutic support through interventions provided by 47 organisations across the borough. The OHID funding has supported a coordinator post for the MAC to continue this work.

The second service is called Connect Newham, which was established in 2020 to provide a medium-long-term telephone-based befriending offer for those who are socially isolated to improve their mental health and wellbeing. The service is delivered by a partnership of locally based VCFS (Voluntary, Community and Faith Sector) organisations, primarily delivered through volunteers drawn from the local community. OHID funding supports the expansion of the service into communities currently not being reached, such as the Roma, Somali and Albanian communities. This programme has funded three VCS providers named Kulan Somali Organisation, Bajuni Women's Advocacy Group and Shpresa Programme. In addition, the funding supports a consortium central hub and spoke model approach, placing an emphasis on training and capacity building to create a sustainable service provided by the community groups.

The third service is called Newham Community Bereavement Service (CBS). This service has been in place since August 2017 and is funded by London Borough of Newham. As a result of the impact of Covid additional capacity was funded by the Council, from August 2020 with the Better Mental Health Fund continuing this enhanced support for one year from May 2021. This increased funding was expanded to include early bereavement support for residents bereaved by COVID-19 or other sudden death, support for residents experiencing long-term trauma/PTSD, and specialist provision for residents with a learning disability/autism, as this group has been adversely impacted by COVID-19.

The following sections consider the national policy landscape in strengthening community-based mental health and wellbeing services, in which this programme is situated, as it relates to improving outcomes for children, young people and vulnerable adults.

Strengthening community-based child and adolescent mental health services and systems

The coronavirus pandemic has resulted in fundamental changes to the lives of children and young people. The Public Health England COVID-19 mental health and wellbeing surveillance report suggests that whilst some evidence shows that children and young people have generally coped well during the pandemic (March to September 2020), other evidence suggests that some children and young people, especially those with certain characteristics – such as those who are disadvantaged economically, females, and those

with pre-existing mental health needs – appear to have experienced greater negative impacts on their mental health and wellbeing.

In December 2021, the Government response to the Health and Social Care Committee report on children and young people's mental health stated that the government remains committed to the proposals set out in its response to *Transforming Children and Young People's Mental Health Provision*: *A green paper* for the importance of early intervention and community-based support, particularly related to funding (detailed later). To support recovery from the pandemic, in March 2021 the department announced an additional £79 million funding to significantly expand children and young people's mental health services. As set out in the NHS Long Term Plan (NHS LTP), by the financial year (FY) 2023 to 2024, at least an additional 345,000 children and young people aged 0 to 25 will be able to access support via NHS-funded mental health services and school- or college-based mental health support teams (MHSTs).

Before the pandemic, the national vision for children and young people's mental health was set out by NHS England and the Department of Health who offered a potential model for supporting the delivery of this national vision locally. The Children and Young People's Mental Health Taskforce, which convened in 2014 and whose findings and recommendations were set out in *Future in Mind* (Department of Health, 2015), identified a range of issues within the system, including **lack of access to support**, **fragmented local systems** and **a lack of early intervention**.

To address these challenges, *Future in Mind* called for local areas to "**simplify structures and improve access** by **dismantling artificial barriers between services**" and to **improve links between services so pathways are clearer** and there is a more **joined-up local approach**. Relatedly, the policy calls for **improved communication and referrals between services**, and **much greater involvement of the voluntary sector** in mental health pathways. *Transforming Children and Young People's Mental Health Provision: A green paper* (2017) promoted similar priorities through the proposal of introducing a **Designated Senior Lead for Mental Health in every school and college**. One of the specific responsibilities of this role is to **have knowledge of local services and referral processes**. The green paper also proposes the introduction of **Mental Health Support Teams** who will support Tier 1 services, as well as schools and colleges. The emphasis across national policy on more connected local systems, with input around mental health from a broader range of settings and improved navigation through the system by children and families, are ambitions that **social prescribing** could potentially support.

Social prescribing forms part of the Newham offer. Social prescribing as a means of supporting young people is a relatively new initiative, and there is very little in terms of research into this area (see Bertotti et al, 2020). While there is promising evidence emerging on the potential of social prescribing to improve mental wellbeing, most schemes to date have targeted the over 50s (Torjesen, 2016)). However, since a recent review of the literature suggests that up to half of all adult mental health disorders may begin in adolescence (Jones, 2013), social prescribing has great potential as a preventative intervention to improve outcomes for children and young people who do not meet the threshold for intervention from existing CAMHS services (NHS England, 2017). Although there are schemes across the country working with young people in a similar way to social prescribing, there is a need to identify what is working well to develop effective models to support individuals in different areas, build a pathway that systematically connects young

people to local voluntary sector services, and extend the range, access and timeliness of support available to young people.

An important aspect of social prescribing is its focus on a holistic, rather than specific, interaction with the client, where the client's multiple needs and aspirations are considered simultaneously, and their agency is central to the decision-making process. This approach could have important positive implications for young people's mental health pathways across the UK. The need to develop young people social prescribing models has been recognised by the national Social Prescribing Network (SPN), which represents over 1,300 members nationally and has a specialty group dedicated to social prescribing and young people.

There are now calls for a review and update to the strategies considering the pandemic. COVID-19 lockdown measures in the UK have disproportionately affected young people's aspirations, health and opportunities – both directly, through impacts on family life, school, work and training, and social isolation, and indirectly, through heightened economic hardship, threats of possible cuts to public spending, and the physical and emotional effects of the pandemic through rising unemployment and widespread loss and grief.

Strengthening community-based befriending services and systems to address loneliness and isolation

Coming out of the pandemic, the Government now needs to think about how best to reconnect communities. The pandemic has highlighted the need for social connection and so the need to think about the systems and services which enable that to happen is even more key and makes the work of OHID programme even more important. There is a wealth of evidence that demonstrates that loneliness and social isolation can have a detrimental effect on health and wellbeing. We know that loneliness can affect anyone – from teenagers and young adults to new parents, carers and the recently bereaved, from students starting at university and those with disabilities, from those moving to a new area of the country to refugees. Older people experience high levels of loneliness and isolation compared to most other age groups and are at risk because of a range of factors such as declining health and loss of close relationships or social networks. It is a growing problem with two million older people expected to be experiencing loneliness by 2023

Key to understanding loneliness and social isolation is the idea of **social relationships**. 'Social relationships' is an umbrella term that covers a wide variety of interactions, interconnections and exchanges between human beings and the physical and social environment. Therefore, it is not easy to cover its complexity through a **one-size-fits-all** definition. Evans (2015) suggests:

> *"Good social relationships and connections with people around us are vitally important to individual well-being. This is important to national well-being because the strength of these relationships helps generate social values such as trust in others and social cooperation between people and institutions within our communities*" (Evans 2015, p. 10–11).

In 2018, the Government response was the policy document, A *Connected Society: A strategy for tackling loneliness* (2018), which sets out the approach to tackling loneliness in England. It marks **a shift in the way we see and act on loneliness**, both within government and in society more broadly.

The Home Office has piloted schemes to help identify and support older people experiencing loneliness. For example, they trialled an **innovative digital solution** 'Safe and Connected'

to support lonely older people who live in the community, based on the successful Jersey-based project **'Call and Check'**. Working in conjunction with Royal Mail, private enterprise, local authorities and the local voluntary sector, the scheme saw postal workers calling on lonely older people who sign up to participate, as part of their usual delivery rounds. **Postal workers asked a standard set of questions to assess individual need, with responses captured via their standard hand-held work devices**. A professional from either the local authority or the local voluntary sector then analysed the results and signposted the individual as necessary to **friends, family, neighbours or local voluntary sector services**. This helped to reduce the risk of loneliness, as well as addressing other needs and issues.

Other examples include the Government's **Sporting Future strategy,** which places individual and social development as two of the five key outcomes that it aims to achieve through investment in sport and physical activity. Research shows that involvement in sports clubs is an effective activity to reduce loneliness in older people. Also, the Government's **Inclusive Transport Strategy** sets out how it will make the transport network inclusive and accessible for disabled and older people, enabling them to be more mobile and establish and maintain their own social connections.

The Government also aimed to tackle pre-existing inequalities and levels of poor population health **before the pandemic** as part of the NHS Long Term Plan. The **NHS Long Term Plan (2019)** set out a 10-year strategy for improving and reforming the NHS in England and forms the background context to the Primary Care Network (PCN). **GP practices, who typically cover 30–50,000 people**, are being funded to work together to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health and social care staff. As part of this work, **social prescribing the range of support available to people will widen, diversify and become accessible across the country**.

Link workers within primary care networks will work with people to **develop tailored plans** and connect patients to local groups and support services. Over 1,000 trained social prescribing link workers were put in place by the end of 2020/21, rising further by 2023/24, with the aim that over **900,000 people** can be referred to social prescribing schemes by then. Also, health and social care workforce, patients and volunteers should have benefited from well-designed and managed volunteering initiatives to improve satisfaction and wellbeing ratings for staff, as well as volunteers and patients. Local volunteering should allow **older people to stay physically active and connected to their communities.** However, the mental health needs of the programme's ageing target groups are unlikely to be met by key mainstream services in their current forms. For example, Social Prescribing services may only make contact with older people who have been referred to them or who are on a GP list because they are vulnerable.

Add to this the fact that the **overall picture of the NHS is of one of major delay, disruption and increased demands on services**. Previous national targets – such as for expanding access to mental health services – will need to be revised to account for greater need. COVID-19 has also exposed and widened existing inequalities in health and care in England. While **new partnership structures** have been developed to help local agencies improve care, the **pandemic has held back the broader process of redesigning care to improve health and reduce inequalities**. A more detailed framework for NHS agencies on tackling inequalities is now needed.

4. Study design

In March 2022, the Institute for Connected Communities, based at the University of East London, was commissioned by Newham Council to undertake an independent evaluation of the programme. This study brings together evaluative insight into the impact of the three Newham-based services in terms of reducing widening mental health inequalities by providing access to appropriate support services. In addition, the research findings help to identify what are the key aspects to include in ongoing support models. The local evaluation design used Pawson and Tilley's (1997) realist evaluation approach to investigate: what works for whom, in what circumstances, and in what respects, and how?, and May and Finch's (2009) Normalisation Process Theory, which serves as a conceptual framework for explaining what people do to implement a new practice. Questions covered through this research were:

- In what ways are deprived communities, at risk and vulnerable groups and communities from different ethnic backgrounds being engaged with in the different services? What can be learned from these approaches?
- Which target population groups are not being reached, and why?
- What are the perceived benefits and impacts of the services from the service user perspective?
- What are the perceived benefits and impacts of the services from the service delivery perspective, including the role of volunteers?
- What is the best model of delivering these services from the user group perspective?
- What evidence is there of needs being met that are not currently being met by other commissioned services?
- What does sustainability for the services look like going forward, including feasibility and design considerations?

4.1 Methods

This study adopts a qualitative approach, and data collection, collation and analysis were carried out between March and May 2022, consisting of interviews, practitioner logs and surveys with a range of people, including residents, programme partners, trainees and wider stakeholders.

These primary data will be supplemented with the analysis of administrative data captured by the programme partners and shared with Newham Council. The approach has been designed to rapidly gather insights into the implementation of the intervention, and to build understanding of the participants' experiences of the enhanced community-based mental health support services.

4.2 Participants and sample strategy

The sampling was purposive. An email invitation was sent to the three BMH project provider organisations' leads requesting them to fill in an interview schedule to nominate one manager and one coordinator for a 60-minute interview each, two frontline staff for

completing practitioners' logs, two volunteers and five clients for a 45–60-minute interview per organisation.

Table 1.1 Sampled research participants

Total number of BMH participants from 5 organisations	
Contacts received for interviews from all organisations	25
Participants with no contact number/needing coordinator support	3
Number of participants invited to an interview	22
Number of participants interviewed	22
Number of reschedules	7
Highest no. nominated/completed from a single organisation	9
Lowest no. nominated/completed from a single organisation	1

The names of 25 potential research participants were received from five organisations. Screening started in the first week of May. A research team coordinator contacted all the individual staff members nominated by the lead to offer and book an interview appointment, or to confirm an interview time booked by the lead in the case of one organisation.

Total flexibility for research participants to choose any day or time in the week was offered. Research participants had the option to have the interview over the phone or on Teams. The clients were offered an incentive of a £10 gift voucher for completing them. All 22 interviews were completed between 16 May and 10 June 2022. Three interviewees could not be reached for their interviews because of unsuccessful attempts by the project coordinator to book a time with the young clients.

Table 1.2. Research participants per service enhancement project

Organisations	Interviews completed with				No. of reschedules	No. completed
	Manager	Coordinator	Volunteers	Clients		
Mind - single organisation	1	1	2	5	2	9
Your Time/MAC- single organisation	1	3	N/A	0	3	4
Connect Newham organisation 1	1	1	2	2	0	6
Connect Newham organisation 2	N/A	1	1	2	1	4
Connect Newham organisation 3	N/A	1	0	0	0	1

4.3 Fieldwork

The fieldwork was carried out between May and June 2022, and consisted of telephone interviews, practitioner reflection logs and online surveys with a range of participants, including clients, programme coordinators and frontline staff, and trainees/volunteers. The research team interviewed 22 participants using a semi-structured interview schedule (*N*=9 from Mind, *N*=4 from Your Time and *N*=11 from Connect Newham, with *N*=6 for CN-Shpresa Programme, *N*=4 from CN-Bajuni Women's Advocacy Group and *N*=1 from CN-Kulan Somali). Thirteen interviews were conducted over the phone, eight on TEAMS and one interview with a service user was conducted by WhatsApp.

All 22 interviews were transcribed by research team members involved in the interview, and the findings were thematically analysed – along with the *N*=3 practitioner reflection logs –

and presented with anonymised quotations in the report. A few client interviews were conducted through translators, which might have affected how data were interpreted. These primary data were supplemented with the analysis of administrative data captured by the programme partners shared with Newham Council. The approach has been designed to rapidly gather insights into the implementation of the service enhancements, and to build better understanding into the participants' experiences of the three different community-based mental health support services.

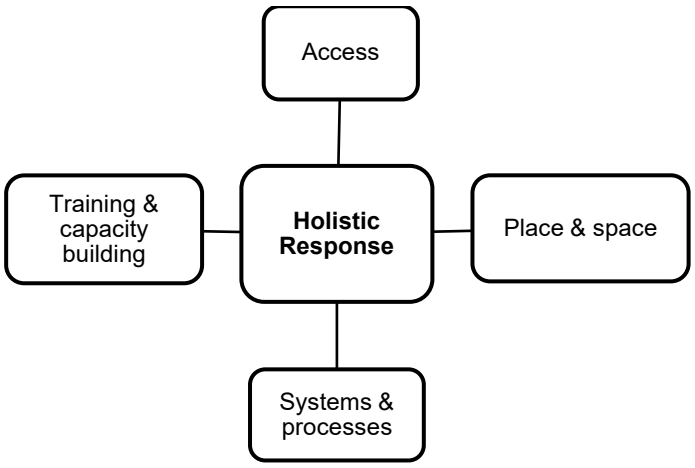
4.4 Analytical framework

The qualitative interview data were analysed using a thematic framework. The primary data were thematically organised around the core themes of 'trust' and 'compliance', and inductively coded using the NPT process evaluation normalisation framework (Murray et al., 2010) for linking process evaluation functions. The data were then thematically analysed (Aronson, 1995), looking for evidence pinpointing patterns and meaning attributed to the implementation of the model at a practice and population level. Descriptive and inferential statistics were used to analyse administrative data (e.g., booking forms) supplied by the Newham Council Public Health Team. Analysis to assess changes in outcomes is likely to be limited at this point, due to the small numbers of cases. The study obtained research ethics approval in April 2022 from the University of East London Research Ethics Committee (No. ETH2122-0174). To the degree to which it was possible, research participants who declined the service were included on the charts. In the following section, we look at the key findings based on the subjective accounts of the research participants. We have pseudonymised the names of the research participants to protect their identities.

5. Findings

This section presents the key evaluative findings collected from the fieldwork, which highlight the key areas in which the service enhancements have taken place and impacted the target groups of clients. See Figure 1.1 for an illustration of how each of the thematic concepts are grouped to optimise the reach and support provided to targeted residents.

Figure 1.1: Thematic conceptual framework



The thematic conceptual framework (i.e., holistic support, access, place and space, systems and processes, and finally, training and capacity building) draws on the research participants accounts of how they have experienced and/or contributed to the service enhancements. Research participants' stories of accessing or providing community-based mental health and wellbeing support services reflects both the strengths and challenges in the programme. We used ground deductive coding within NVivo to help us explore and build themes from the data, as well as manual appraisal and categorisation of the interview transcripts in whole research team meetings. This is a top-down approach where you start by developing a codebook with your initial set of codes**.** The research team triangulated the interview data alongside held data, firstly, against the stated evaluation questions, and, secondly, looking for new insights by methodically and systematically scrutinising the data. The research team also produced pseudonymised vignettes to highlight patterns of behaviour, attitudes and understanding of the benefits and challenges to accessing and engaging in the services from the clients' and practitioner's subjective perceptions.

5.1 Beneficiary wellbeing measures

This first vignette introduces you to a Bereavement Service client's set of circumstances and obstacles to accessing the right service, at the right time. Mary missed out on bereavement support in 2020, but later received counselling for agoraphobia in 2022.

Mary lost both of her parents during COVID-19, resulting in her heightened fear of catching COVID-19 and her grieving taking a greater toll on her mental health. Additionally, her anxiety surrounding the virus had caused her to become housebound with agoraphobia. She contacted her GP to get help to cope with the situation. She had tried to get bereavement support in 2020 when her father passed away but there was nothing available. She was referred to Talking Therapies but was told that CBT wouldn't be suitable for her. She managed to get support from the Sue Ryder charity in 2020, and again in 2021 after her mother passed away.

Mary received mental health support from Mind two months after the referral from her GP. After six over the phone counselling sessions, she was able to get out of the house, as well as gaining a new perspective on her relationship with her parents, which has allowed her to cope better with their passing. She gave the service a 4 out of 5 in terms of difference made to her health and wellbeing, stating that the six sessions were brief and that more sessions would have made the service even more helpful. She felt that the sessions had put her in the right direction towards achieving balance and better mental state. Mary rated the service's effect on her household 4 out of 5 as well, stating that it had allowed her to leave the house more, but also mentioned that there were external factors to this. After having COVID she felt less afraid about going out and catching it again. When rating the efforts to help her understand her health issues, listening to things that mattered to her most and assisting in her decisions for the future, Mary gave a 9 out of 9.

The counselling has helped her with her mental health and given her the confidence to get out of her home. She was able to make progress in her life as *sh*e no longer has a fear of panic attacks in public thanks to the support service, and it has definitely improved her quality of life. She managed to find a new job managing a catering supply chain's global hotel project, working remotely. Mary stated that the service helped her find a means of recognising the reasons behind her feelings, which helps her to refrain from having thoughts that may have recessive effects on her mental wellbeing. The sessions helped her with exploration of her relationship with her parents and the issues she may have been holding on to following their passing, and this exploration was important for the control of negative thoughts. Mary said it would have been more helpful if there were more sessions. She did not inquire about extra sessions, as she did not think it was possible.

Following the end of the service, she is now paying for a £50 weekly session with a private therapist to further help her cope with the passing of her parents. Mary said there is a need of joined up linking between GPs, talking therapies and other support services so people have all the information to get support when needed.

5.2 The programme clients' demographics

Table 2.1 below compares the number of projected beneficiaries, the number of unique beneficiaries, and the proportion of unique beneficiaries to projected beneficiaries for each of the services. **The bereavement service shows a higher number of clients than was projected for the service (116%), whereas Your Time shows a slightly lower number of clients than was projected for this service (93%)**.

Table 2.1. Comparison between projected beneficiaries and unique beneficiaries (1 July 2021 to 9 May 2022)

Enhancement projects	Projected beneficiaries	Unique beneficiaries	%
Connect Newham	67	67	100%
Bereavement Service	400	462	116%
Your Time	300	280	93%

Source: BMH Fund Monitoring Template

Table 2.2 summaries the number of unique beneficiaries between the Your Time, Newham Bereavement Service and Connect Newham services according to the age, disability status, gender and ethnicity of each client.

Table 2.2. Comparison between projected beneficiaries according to project

	Your Time		Newham Bereavement Service		Connect Newham	
	Frq	%	Frq	%	Frq	%
5 to 17	271	97%	0	0%	0	0%
18 to 25	9	3%	26	6%	14	21%
26 to 64		0%	377	82%	33	49%
65+		0%	34	7%	16	24%
Unknown		0%	25	5%	4	6%
Disabled		0%	81	18%	10	15%
Non-Disabled		0%	299	65%	53	79%
Unknown	280	100%	82	18%	4	6%
Female	140	50%	338	73%	51	76%
Male	138	49%	88	19%	12	18%
Other (Including unknown)	2	1%	36	8%	4	6%
Asian	87	31%	109	24%	8	12%
Indian	8	3%	29	6%	2	3%
Pakistani	17	6%	31	7%	1	1%
Bangladeshi	50	18%	23	5%	2	3%
Other Asian (Inc. Chinese)	12	4%	26	6%	3	4%
Black	62	22%	99	21%	22	33%
African	25	9%	36	8%	18	27%
Caribbean	17	6%	33	7%	2	3%
Other Black	20	7%	30	6%	2	3%
Mixed	30	11%	45	10%	2	3%
White	86	31%	115	25%	28	42%
White British	53	19%	84	18%	6	9%
White Other	33	12%	31	7%	22	33%
Other (Including unknown)	15	5%	94	20%	7	10%
Beneficiaries living in the most deprived 30% of LSOAS in England	140	50%	266	57%	46	68%
Beneficiaries living in the most deprived 10% of LSOAS in England	138	49%	120	26%	0	0
Total	280		462		67	

Source: BMH Fund Monitoring Template

To summarise, the demographic table illustrates which groups of clients accessed the three services and the real uptake, depending on the nature of the service. All the services apart from Your Time either reached or exceeded their target numbers by the end of the funded period. The slightly lower proportion reached by Your Time is most likely attributable to the length of time they work with clients (detailed later). The programme reached residents aged 5 to 65+, reflecting that the wellbeing at all ages was being addressed by the programme, and there was an uptake of Bangladeshi (Your Time), Pakistani (Bereavement Service) and African and white Other (Connect Newham) accessing early help for mental health and

wellbeing support. The following section looks in more detail at how the three services performed in developing and implementing their enhanced outreach strategies.

5.3 Insights into access: Bereavement Service

The total number of clients who have used the enhanced Bereavement Service was 462. The largest age group was that between 26 and 64 years old (82%), followed by clients aged 65+ years old (7%) and that of 18 to 25 years old (6%). Eighteen per cent of clients were disabled and 65% of clients were non-disabled. Eighteen per cent of clients were of an unknown disability status. Significantly, more women (73%) than men (19%) accessed the Bereavement Service. Eight per cent of clients declared their gender as “Other”; this includes clients who did not declare their gender. The largest ethnic group to access the service identified was white (25%) followed by Asian (24%) and then black (21%). The largest white ethnicity was white British (18% of all clients), whereas the largest Asian ethnicity was Pakistani (7% of all clients), and the largest black ethnicity was black African (8% of all clients). Clients of mixed race represented 10% of all clients and “Other” ethnicities, including clients who did not state their ethnic group, represented 20% (see Appendix 2).

The Bereavement Service used the Ability to Cope with Grief Measure to track the wellbeing of its clients. This measurement tool was used with up to 350 clients (77% out of 462). However, no results have been provided about this evaluation to the research team by the provider due to their inability to anonymise the privately held data.

We now turn to look at how clients accessed the Bereavement Service between May 2021 and March 2022. During this period, the Bereavement Service made significant changes to the way they work and how they promote the service. They reportedly updated all their information and leaflets, and their website. They also appointed a new Coordinator, and a lead counsellor for learning disability and autism. They have made improvements to their data management to improve the way that they collected information during the funded period. They also moved offices to ensure that they could be more accessible for the community and have improved space availability for the team.

Table 3.1 illustrates the most frequently used referral pathways used to access the Bereavement Service out of a sample of 134 recorded client cases (29% out of the 462 clients). Undoubtedly, the most efficient referral pathway has been through Newham Talking Therapies (46%), followed by self-referral (39%), Professional referral, such as a GP practice and Other Referral Pathways (5%) and Social Prescribers (4%).

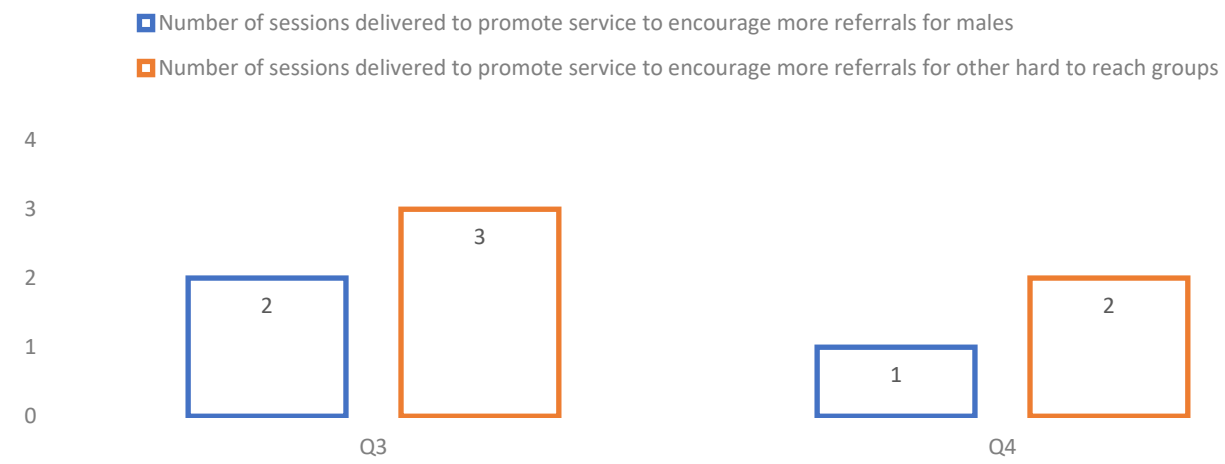
Table 3.1. Referral pathways in Q4. Source: Data provided by the Newham Bereavement Service quarterly report.

GP	Newham Talking Therapies	Self/NBS website	Professional	Social Prescriber	Other
1	62	52	7	5	7
1%	46%	39%	5%	4%	5%

Source: Data provided by the Newham Bereavement Service quarterly report.

The recruitment of men has been a priority, as **men are typically under-represented in this service**. As such, the NBS has set a minimum of two sessions delivered per quarter to men, as well as other hard to reach groups to promote the service. This minimum was reached in Quarter 3 for both men, but it was not reached for men in Quarter 4 (Figure 2.1).

Figure 2.1. Comparison between number of sessions delivered to promote service for different target groups in Q3 and Q4.



Source: Data provided by the Newham Bereavement Service quarterly report

The second vignette introduces you to a male client's experience of using bereavement support, and the motivation for him training to become a mental health first aider after receiving bereavement support.

Steve lost his father to COVID-19 in autumn 2021. He saw a flyer about the Newham Bereavement Service at Newham hospital and contacted Mind to get support. He was put on a waiting list. As he had used the mental health service five times in the last 15 years, he knew that there will be a bit of wait before he could get the support. When using mental health support in the past, he was able to get extra benefit, for example, double the number of counselling sessions, free reading materials, access to group sessions and low-cost counselling sessions.

Three months waiting for bereavement support was disappointing for him, but he was able to negotiate for six extra sessions. He only managed to get four extra sessions, as the system was not allowing for a break/holiday during the counselling. Technical issues were causing delays in sessions starting that led to a loss of up to ten minutes per session. He was unhappy that there was no option available for him to continue free counselling sessions or sessions at a discounted rate with the same counsellor. He said he would have paid in full to get more sessions with the same counsellor.

His aim was to speak to someone who is non-judgemental, and to get help with his thoughts about his father passing, which was met by the sessions. The counsellor was good. He gained a deeper understanding about how to recognise and manage his own feelings and emotions because of the support service. The conversation helped him in dealing with his difficult feelings. He has rated 3 out of 5 for the difference that the sessions made to his personal health and wellbeing, adding that he would have given 5/5 if there were more sessions offered. The quality of service received was 5 out of 5. He gave top marks for the counsellor's effort in listening to him and understanding what was important for him.

He said that the support service has enabled him to move on and make progress in his life.

Following starting the sessions, he had explored to become a mental health first aider himself, so he could support himself and others. His work is with deaf children in education, and he comes across a lot of people in complex situations, and by doing the mental health first aid training he wanted to become skilled to support other people, and to support himself:

"understand a little bit about myself because as you're learning about this stuff, you're also kind of working on yourself as well. But I want to be able to offer support to people that might be in difficulty, and often the people I work with have mental health issues."

"I think it's the conversation … I've had counselling before and sometimes, you know, you don't really make a connection but with this counsellor I found that she was very good. She was able to tell me stuff about myself that was quite accurate, which made me think about my behaviours and how things might be different in a more positive way. Some techniques, like how to break unhelpful thinking patterns and recognising certain things about myself."

Steve will continue to use the mental health and wellbeing support service. His next steps are to carry on working on some of the things for improving his own mental health. He is accessing SLEEP station, a free online service to help with sleep and relaxation.

5.4 Insights into mental health and wellbeing measures: Your Time

Children and young people have reportedly experienced fatigue and boredom from staying at home in tight confinement with their families and separated from their friends. In certain circumstances, this has exacerbated pre-existing mental health problems, or bought on low-level depression and increased social anxiety. Increased numbers of young people have accessed support services in order to better cope with lockdown. In total, 280 children and young people were supported through the Your Time service as part of this programme. The largest reported age category was between 5 and 17 years of age (97%), followed by young adults between the ages of 18 and 25 (3%). The number of clients who were disabled was unknown or otherwise not disclosed. The proportion of girls and boys was even, with slightly more girls (50%) than boys (49%) taking-up the service. One per cent of clients declared their gender as "Other"; this includes clients who did not declare their gender.

The largest ethnic categories to access the service was Asian (31%), followed by white (31%) and then black (22%). The largest Asian sub-category was **Bangladeshi (18% of all clients)**, whereas the largest white ethnic group was white British (19% of all participants), and the largest black ethnic group was **black African (9% of all clients)**. Mixed race clients represented 11% of the whole client group and "Other" ethnicities, including those who did not state their ethnicity, represented 5% (see Table 3.2, Appendix 3).

Your Time is an ongoing project that uses the Outcome Star[1] measure to co-produce a person-centred support plan, to track and evaluate the young person's journey through the support. The Outcome Star is used here as a proxy to provide insight into how clients have received structured person-centred support at an early stage to help them with mental health and wellbeing concerns developed during COVID. In practice, the Outcome Star is helping practitioners to track variations, identify emerging areas of need as well as improvements in the client's mental health and wellbeing.

In Newham, and other parts of the country young black men have faced challenges affecting their psychological wellbeing as a result of COVID (See Newham Council Relationship between Black Boys and the Borough Scrutiny Commission Interim Report, 2022). Research suggests that young black men (aged 16–25) are amongst the hardest hit by job losses and are more likely to report a fall in income because of lockdown in the UK. In addition to concerns about employment, young black boys also experienced significant inequalities in education. As a result, it should come as no surprise, that young black men were at high risk of mental distress during the pandemic compared to other groups of young people (Abdinasir & Carty, 2021) and lack trust in services, especially when they do not see people who resemble themselves.

The third vignette introduces you to a young black boy who has benefit in unexpected ways from his contact with Your Time service during COVID.

Damion is a 14-year-old boy of Black Caribbean and African background. He was finding it difficult to cope in lockdown. Damion was missing his friends and also beginning to question his mum on why he never gets to see his dad. Developmentally, Damion was at the age when he is questioning the world and beginning to understand that other people have different mind sets to his own. He was not looking forward to the

[1] The Star is a suite of tools comprising different versions tailored to the needs of different client groups. The data collected through the Star are ordinal. Star data are the outcomes data captured when any version of the Outcomes Star is completed with a service user by a frontline practitioner, or by a frontline practitioner or service user on their own.

summertime and not being able to contact his friends, which is causing him further angst. The Your Time practitioner worked with Damion on building his self-esteem and identifying his own goals. Initially they met virtual and focused on changes, which then progressed and ended with in-person meetings within a youth zone.

The practitioner reflected on his interaction with Damion. He recognised the impact of being a positive male role model. Mum highlighted to the practitioner that Damion did not have contact with his father and has been 'asking a lot of questions and felt a male role model would be significant for him. The practitioner shared how powerful an experience it was for him to support Damion in his progression, especially in learning about his interest and desire to get involved in an activity like parkour, and then completing the referral with him and speaking with the organiser to ensure his needs were met. Only to then see him attend and enjoy the sessions. Damion then went on to try several other physical activities in the borough.

Through supporting Damion, the practitioner recognised the importance of peer-to-peer support on Damion's wellbeing. Reflecting on his own practice, pivoting to online sessions during COVID has enhanced his skills and understanding in using visual aids and utilizing digital tools such as zoom for conversations as opposed to phone or text. He also learnt the power of autonomy, giving Damon the space and time to think for himself and plan what he wanted to say, how and to whom. He learnt the power of community support and working together to support engagement. Finally, the value of partnership working meant the practitioner could get Damion into the activity he was interested in within only a few weeks, which provided mum with respite.

In general, the guide of the clients' engagement and participation in the service is determined largely by the degree to which they have applied their co-produced support plan, that is, worked on the Outcome Star domain(s) jointly selected with their keyworker, and the degree to which the score has been kept stable along the three review points. (See Figure 3.6, Appendix 3) compares the different levels of progression made by clients in each of the Outcome Star domains. If the client's score has diminished, or if it is kept stable but at a low rate, then the clients are felt to not be making significant progression and further work and support is perhaps needed.

The domain of **"School, training and work"** is the outcome area at which most clients have made most significant progress; in contrast, "**Healthy lifestyle"** is the outcome area at which fewer clients have made progress. Whereas "**Where you live**" is the outcome area for which most clients have maintained a high score. "**Self-esteem"** and "**Healthy lifestyle**" are outcome areas at which we see most clients have dropped back down, whereas "**School, training and work**" is the outcome area where less clients have dropped back.

The mixed results tell us that the measured clients have been most engaged in their support plan when they can exercise greater control in that sphere of life. This report is not suggesting a lack of progression in the Outcome Star measure means a lack of motivation by the client and/or the service has failed the client in anyway. We have simply used the Outcome Star has a helpful proxy to identify what matters most to clients to build better mental health and wellbeing and where the service has made in-roads. As alluded to, a high number of clients have prioritised "**School, training and work[2]", 'Healthy lifestyles and 'self-esteems'** to work on, which clearly connects to three years of interrupted schooling and physical distancing but present mixed results in their improvement, particularly in the case of healthy lifestyles and self-esteem. Even so, the Your Time service was seemingly trusted enough by clients to have a go and work on these areas (see figure 3.5, Appendix 3).

[2] Note: The priority domains that matter most to clients have been determined by collapsing the categories of having a go, working on it and actively enjoying it to arrive individual score, which were then ranked to determine the top three domains. The only anomaly has been school, training and work, which seems a large volume split over education, training and work which features in both as a priority domain and unaddressed area.

A young person was referred to the programme due to concerns that they were at high risk of being excluded from school and had disengaged from learning and were getting into fights at school. A mistrust of professionals had prevented some support options. I used the Outcome Star to understand some of the strengths and difficulties in the young person's life.

We spent time building a relationship and engaging in confidence building activities. During one particular session, the young person spoke in depth about the challenges they faced with particular subjects in school and specific learning challenges. I was able to recognise some of the markers being described and from my own professional experience, suspected they may have a form of dyslexia. I initiated contact with school and liaised with staff to share my suspicions and suggest school arrange for dyslexia testing. They agreed and I worked alongside the young person to inform them of the importance of having any learning needs identified and the implications of having a diagnosis. I supported them to attend the test and stayed with them throughout.

They were confirmed to have dyslexia. This is an area of expertise for me, and I had already incorporated building dyslexia friendly tools and strategies into our sessions, which the young person found useful. I shared these resources with school and a learning plan was put into place.

The biggest impact for me was the shift in attitude from the young person. They were able to see that they were not unsuited to learning or to blame; they just needed to have support in place to learn in a way that was right for them. Some of the triggers for behaviour in school revolved around finding specific tasks too difficult. Raising understanding amongst staff and an individual work plan would ensure that learning could be adapted to build confidence and success for the young person

The fourth vignette outlines a Your Time practitioner's experience of effectively using the Outcome Star to work with and track a client's progression in treating their mental health and wellbeing concerns.

To summarise, the Outcome Star measure has provided a glimpse into what matters most to the Your Time clients and the effectiveness of the service in promoting better mental health and wellbeing in this target group.

5.5 Insights into holistic response: Connect Newham

The largest age group of clients that accessed the Connect Newham Service were aged between 26 and 64 years old (49%), followed by clients aged 65+ years old (24%) and then aged between 18 and 25 years old (21%). Fifteen per cent of clients were disabled and 79% of clients were non-disabled. Six per cent of clients were of an unknown disability status. Significantly more women (76%) than men (18%) used the Connect Newham services. Six per cent of clients declared their gender as "Other"; this includes clients who did not declare their gender.

The largest ethnic group was white (42%), followed by Asian (12%) and then black (4%). The largest white ethnicity was "Other" white (33% of all participants), whereas the largest Asian ethnicity sub-category was "Other "Asian (4% of all participants) and the largest black ethnicity was black African (27% of all participants). Mixed race clients represented 3% of all clients, and other ethnicities, including those who did not state their ethnicity, represented 10%.

The large proportion of "Other" white is perhaps misleading and needs further unpacking to identify key vulnerable groups within this category. This sub-category reflects the targeted Albanian residents who hold a unique position of being white and predominately secular Muslims. Shpresa Programme ('Hope' in Albanian) is a UK-based organisation that runs several complementary schools for Albanian-speaking children from refugee, asylum and migrant backgrounds. Shpresa Programme (Thorpe, 2020) is an active user-led organisation that advances the education and training of the Albanian-speaking people in the UK to enable them to take full and active roles in their communities. Shpresa Programme has been

working in collaboration with Connect Newham, targeting residents from the Albanian community, which would **represent no more than 33% of all the clients**, as reported by the BMH Monitoring Data (As "White Other")**.**

The level of engagement with this evaluation has been low, and not enough clients have been sufficiently motivated to participate. As a result, only four clients participated in a survey regarding their experience with Shpresa Programme (Table 4.1). Reaching populations from ethnic minority groups can be difficult due to a range of barriers, such as language, beliefs, stigma, religion and social network.

Table 4.1. Demographics of surveyed Shpresa clients.

	Gender	Ethnicity	Age
Service user 1	Female	White - Other	36 to 44
Service user 2	Female	White - Other	45 to 55
Service user 3	Female	White - Other	56 to 64
Service user 4	Male	White - Other	Over 65

Source: Data provided by user survey

The sixth vignette is about four client's exposures to Shpresa's clients and how the culturally responsive service has helped each of the clients in very different ways leading to improvements in their mental health and wellbeing.

All four clients were not only engaged but actively involved in the Shpresa programme. This is demonstrated in the reported support they have received and the range of activities they are deeply involved in. Sophia had struggled with her mental health during the pandemic. She got involved in a befriending programme and was referred to six months of group therapy. Annie and her children were attending English and Albanian classes respectively. Sarah and Oliver are part of the Walk-Talk-Watch group, in which they improved their social skills to feel more part of the community. All four participants reported their intentions to continue participating in Shpresa, as they all felt that the support received had made a positive impact to their lives.

It seems that each client has been supported in the areas they needed help in, and that effective approaches were used. Sophia reported improvements in her mental health and that she is now considering volunteering to support others. Annie took English classes, which would facilitate her ability to start a new course, and her children were happy to continue attending the Albanian classes. Sarah also improved her English and was enabled to get more involved in the community and to develop her social networks. She is now motivated to start her own business. Oliver's income became more financially secure through the help received with his pension application, and he now has the peace of mind to get more involved in activities, which has made him feel more part of the community.

Returning to Connect Newham, all leads described positive impacts for their clients linked to a holistic approach:

> "We know there's been a positive impact on our users. Our reports show this. Lots of people start out very low but when we establish what they need and refer them for support they're in a much better place. Some of them are volunteering or finding work. They're becoming part of the community and finding a positive value in life."

Common themes included more effective structure for their befriending activity…

> "Befriending was always there but it wasn't structured"

…and increased awareness and understanding:

> "This programme has raised the awareness of loneliness and isolation and we now understand the need for a service around this. We understand more and know when to refer to their GP for other issues…"

The Connect Newham befriending model was initially based on using phone contact as it was introduced during lockdown. The model is now moving towards more in-person befriending support. One lead reported initial difficulties with the lack of in-person contact, and some clients were keen to return to this:

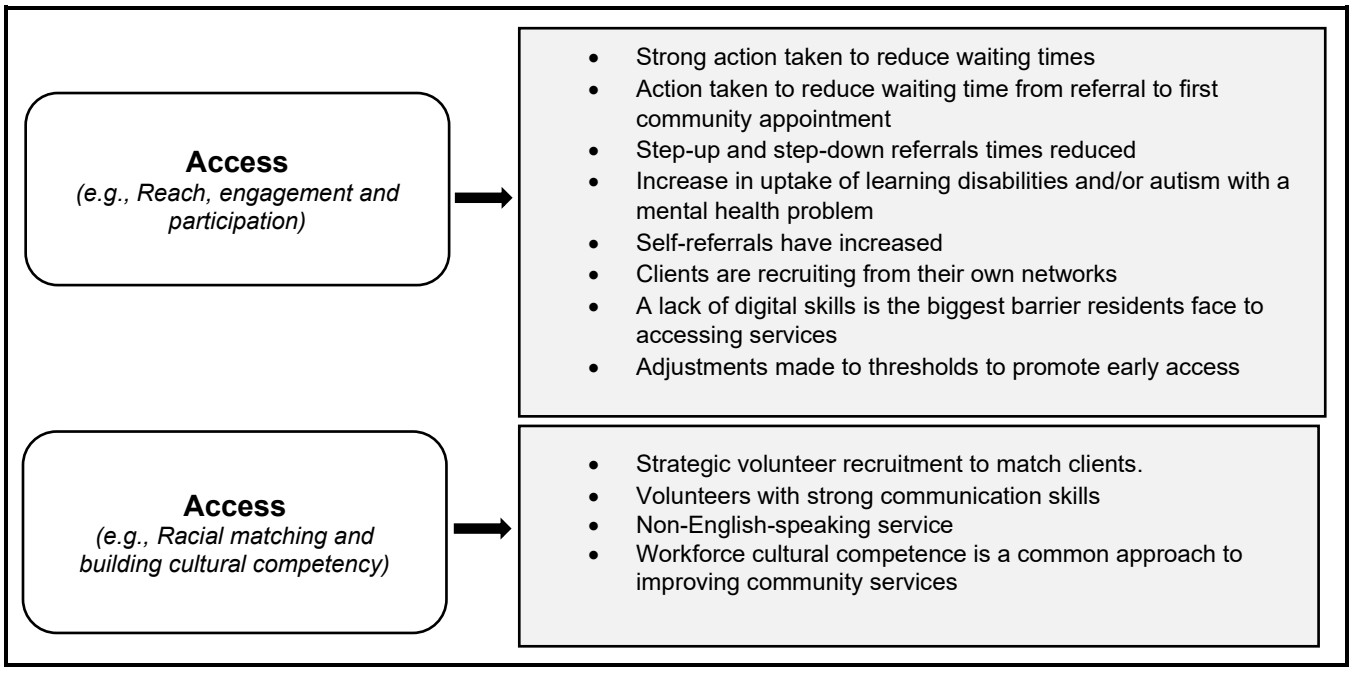
> "Originally members weren't happy that they had to use the phone and were reluctant to discuss issues, but once they saw some results, they became more confident. The very elderly was the most affected and needed help through this programme and were grateful but still want to get back to seeing each other."

Delivering befriending support in community languages is also central to its success:

> "It has been useful using our own volunteers as they can talk to our elderly members in their own language, they wouldn't get this without this project."

The different levels of evidence suggest a wide variety of cultural understanding in mental health support within the three services. The Bereavement Service and Your Time are professional services that explicitly focused on mental health support (among other areas), while the Connect Newham organisations offer an indirect mental health support element that is not always explicitly voiced – either due to cultural stigma around "mental health", or due to their focus on a holistic and often practical "neighbourhood" type support and delivery.

5.6 To what extent did the projects reach protected groups, and those most affected by COVID?



Research participants illustrate the benefits of adopting strategic volunteer recruitment to match clients. Racial matching is one way to ensure cultural competency is bolted down in the service, ensuring its effectiveness and acceptability for clients. Research participants comment:

"There has been an increase in reaching Asian communities (that was a problem before) through having counsellors speaking their mother tongue, but still could be improved."

(Project A staff)

"Diversity and inclusivity have changed. We get requests for gender and race specific workers for better interaction with clients."

(Project B staff)

A lack of digital skills is the biggest barrier residents face to accessing services:

"Language is the main problem for the user group, this extends to struggles with using the internet and teaching them the basics to use the online and web services. Volunteers may phone respondents to guide them through using online portals or accessing documents."

(Project C/2 staff)

"I haven't seen flyers in other languages, and doesn't know how the service is being promoted, but has come across a flyer about involving the Muslim community."

(Project A Volunteer)

Workforce cultural competency has been a common approach to improving the services, with volunteers with strong communication skills to provide a non-English-speaking service:

"We help to explain the service for clients. The lived experience of the staff helped the service to be culturally tailored, which benefits the clients."

(Project C/3 staff)

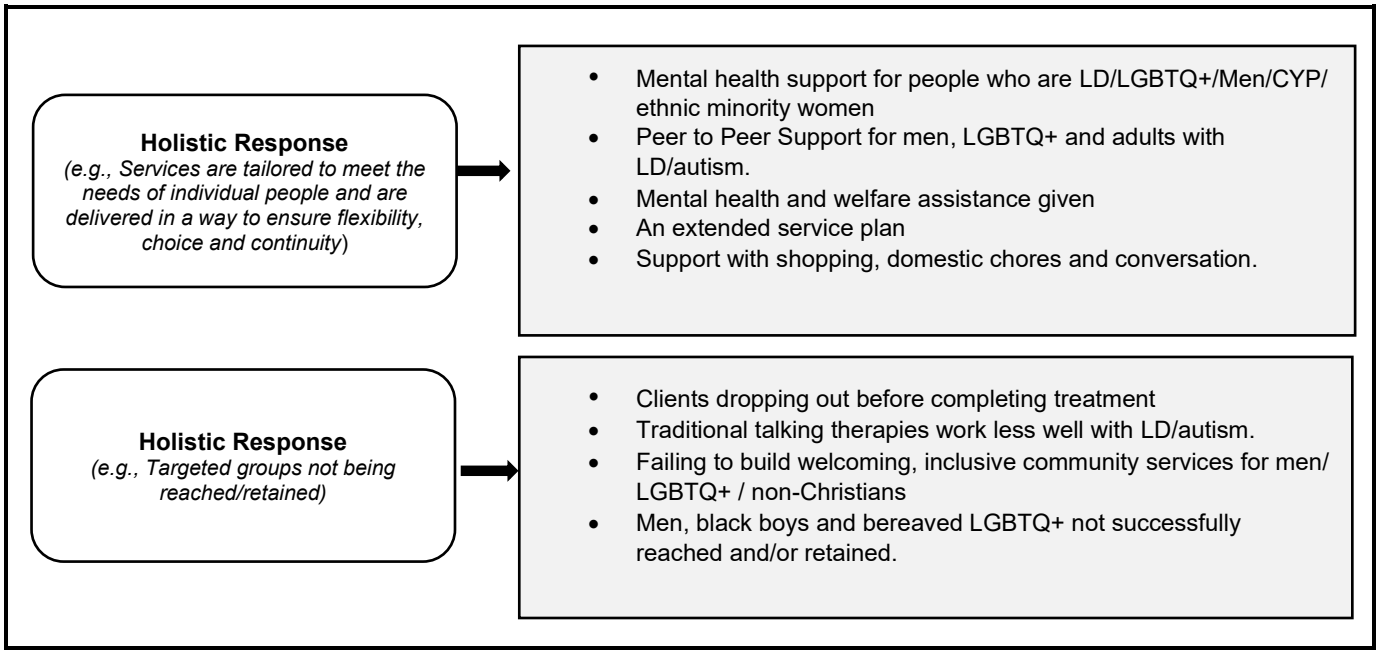
"People with desperate situations becoming volunteers after using service themselves, or volunteers turning to colleagues. They have lots of clients who are volunteering for the organisation, as they want to give back to the community."

(Project C/1 staff)

Connect Newham's Somali women's group identified that the clients' groups are not all comfortable using English, therefore bilingual volunteers are needed. Online platforms are limited due to the clients' level of digital literacy. Office and meeting space is urgently needed; however local libraries are not the most appropriate place to meet due to the intimidation of being highly literate. Space is simply needed to pray, talk and drink tea. The lack of sustained funding undermines the development of building trusting relationships.

5.7 Which target population groups are not being reached and why?

Areas for further work to sustain and develop the work carried out by the funded services were identified. Potential barriers to this work were also considered.



The extracts below describe the different ways that the services have gone about identifying and/or attracting targeted residents into their service.

> *"Generally, clients are mainly women, are generally open to counselling. Males are less open to counselling, especially those above 35 years. Women are more open about discussing what they are experiencing. Those born here are more articulate and willing to accessing the services."*
>
> *(Project A Volunteer)*

> *"We have been recognised as an organisation that delivers cultural competency for people from the BAME community. That was obviously very high because of the disproportionate impact COVID had on the BAME community, especially in Newham … We are really targeting some communities, as LGBTQ+, Muslim men and people with autism are still under-represented"*
>
> *(Project A staff)*

> *"The delivery of the service led to an increased number of young people. Used disaggregated data to work out what young people, where groups came from ethnically and demographically, and which groups were impacted and how, including young people with additional needs and across all other needs as well."*
>
> *(Project B staff)*

Several strategies were employed for reaching these groups, such as providing virtual and phone access, and engagement with external organisations or community groups:

"Access has been improved with online/Zoom/telephone counselling offered, as people couldn't come in due to COVID, or have time limit due to other responsibility, such as mothers with young children."

(Project A Volunteer)

"Once COVID started, everyone was at home and some people live alone, so everything changed. More people have become more depressed. Me and junior volunteers would call to talk to them, help them with shopping and trying to cheer them up. I would just pick up a phone and call whoever and just talk, general talk, make jokes and because they come from the same place, so they know each other quite well, so that at least makes them happier."

(Project C/2 Volunteer)

"We are supporting people with learning disabilities and autism to access the service because they seem to be not represented in ours or any other figures, in fact, so we have been doing a big piece of work with Learning Disability and Autism services this year as well."

(Project A staff)

A strong emphasis by services has been placed on the referral system both in and out of the service to balance need and demand.

"… three times as many referrals than in previous years, over 400 people were already seen this financial year, and they will exceed 530 targets by the end of the financial year."

(Project A staff)

"Bajuni also makes referrals to other services, identifies the needs of clients and refers them, makes them an appointment and someone accompanies them to support their needs. My duty, and that of the volunteers, are in identifying their problems based on their needs (e.g., housing or health, and then refers them on to other services in Newham)."

(Project C/2 staff)

"Quality of the work has improved and also to be confirmed, first cases to be finished and be checked. Go back to referrers and check on quality of service. What to do about the service and to help the referrals and quality."

(Project B staff)

"Individuals are referred to the organisation through different sources, such as the GP, police and other agencies. [Our clients are] refugees, victims of domestic violence, mental health services, victims of trafficking are our clients."

(Project C/1 staff)

Despite adjusting their own thresholds to promote early access, the experience of making referrals to support clients to step down and step up into other services has often been time-consuming and challenging to meet thresholds and navigate complicated referral pathways:

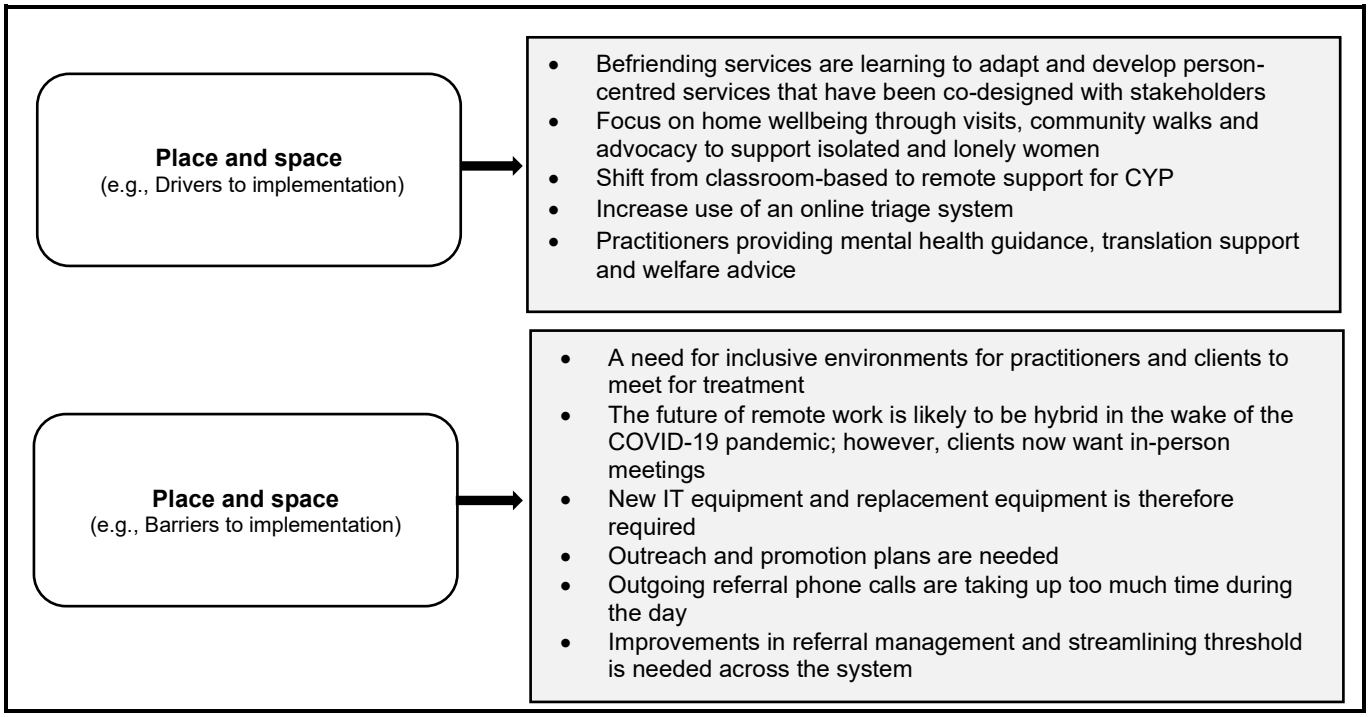
"Clients are not assisted for any referrals outside of the organisation. It is not within the organisation's volunteers or staff."

(Project C/1 Volunteer)

> *"It probably needs some investment from clinicians, as well that people talk about loss much earlier than the Bereavement Service. If people are held back from having good information, they cannot make choices [of accessing the Bereavement Service], there is a socio-political aspect before it comes to [the access of] Bereavement Services. I do think adults are treated in a childlike way sometime [in LD and Autism], and I do not think it is helpful for them."*
>
> *(Project A staff)*

The Bereavement Service project has a strong sense of coherency, and the service design is widened to reflect emerging needs of residents. **They have seen shorter waiting times, and tailored support being delivered for adults with SEN, and longer involvement for adults with complex bereavement needs, including the development of group-based sessions.** Newham is seeking to become a bereavement-aware borough at a strategic level; providing the right support at the right time has been a long-standing problem. The funding has allowed the service to increase its workforce and conduct training on building cultural competencies. The service has become more accessible than in the past. The service provides free or low-cost therapy, and an opportunity to make friends and build one's social support network. Challenges encountered include a lack of step-down provision in Newham, continuity of the counsellor, and digital problems that can be encountered over the six sessions. The workforce has had to deal with complex bereavement needs and a high volume of clients. This has been a strain on the workforce working remotely. Going forward, training is needed for the workforce in the specialist areas that they are being asked to focus on. Another challenge is providing in-person sessions when workers have been contracted to work remotely, and lack of space to accommodate everyone. They also need to improve data safety and streamline three data sources into one system. An improvement would be a whole system to manage the flow of referrals to and from GPs and Social Workers. They also need to train staff on working with special needs clients, and to develop a better understanding of communities. Most importantly, they need office space for the team to connect, learn and share support.

5.8 What were the barriers and facilitators to implementation?



Research participants shared accounts of the (imagined) benefits to enhance the principal service delivery models. The service enhancement allowed providers to structure, formalise and streamline their services to better respond to client needs. This included new ways of working with clients in one-to-one and group-based sessions, as well as in new community settings, offering out-of-hours and additional appointments. Particularly, befriending services are learning to adapt and develop person-centred services that have been co-designed with stakeholders. Research participants comment:

> *"The enhancement has helped structure and formalise this befriend services. This helps transcend culture, language barrier. Cultural barrier, language barriers should not be barriers."*
>
> *(Project C/3 staff)*

> *"[Needs] our service was not targeting before. Triage was based on risk. Group work, no one to one. Previously based in schools. Safety measures and lone measures, being in schools to group work, to Zoom, Teams, phone calls, and back to face to face. Engagement changed in deployment – one day in the office, but going out – out in the community, then going home. Achieving aims and objective better."*
>
> *(Project B staff)*

> *"The service is delivered outside office hours as counsellor is in full-time employment."*
>
> *(Project A Volunteer)*

> *"Six sessions are offered usually, but when the case is complex such as multiple deaths in the family (a client lost about 20 family members during Covid) or someone has lost a caregiver*

that sexually abused them, they would have a conversation to see if they would like additional sessions (6 extra/12 in total)."

(Project A staff)

"The service delivery worked with clients to understand their needs. Everyone was confined in their houses – by the door – and this impacted on people's lives. We oversee the volunteers driving to people's housing."

(Project C/2 staff)

Services have achieved increased capacity by strategic recruiting of paid/volunteers and providing additional training that allowed more tailored working with specific communities and/or stakeholders:

"Through the enhanced service, the team has learnt more about mental health issues, and had the opportunity to work with other organisations such as Hestia and Ikor."

(Project C/1 staff)

"We hired extra staff. Four paid therapists and a senior therapist doing the assessment, seven or eight volunteer counsellors as well. We deliver counselling both remotely and face-to-face, [now] that they are not in lockdown. Now able to offer assessment within 2–3 days from referral and can allocate appointment relatively quickly (2–3 weeks waiting time)."

(Project A staff)

Research participants' accounts detail how their services have pivoted in the pandemic, and how providing a balanced blended approach better meets the needs of clients:

"Because of the online sessions, a lot of people were able to access service during the lockdown. Opened for face to face now, and clients have the opportunity to come in, but many clients still prefer online sessions."

(Project A Volunteer)

"We provide resources, training online and in-person. Websites have information for clients on how to access resources, but trainings and support services are provided via Zoom or in-person."

(Project C/1 staff)

"Many have never heard of such a service before. There is a website, but most clients prefer face-to-face, Zoom or WhatsApp group. Most prefer WhatsApp group for information dissemination."

(Project C/3 staff)

"Prior to COVID, relatively small Bereavement Service offering common bereavement support to people following six months after bereavement offering 6–8 sessions. After COVID, this service was expanded allowing – through the BMH Fund. We were able to respond swiftly to COVID and move to remote access."

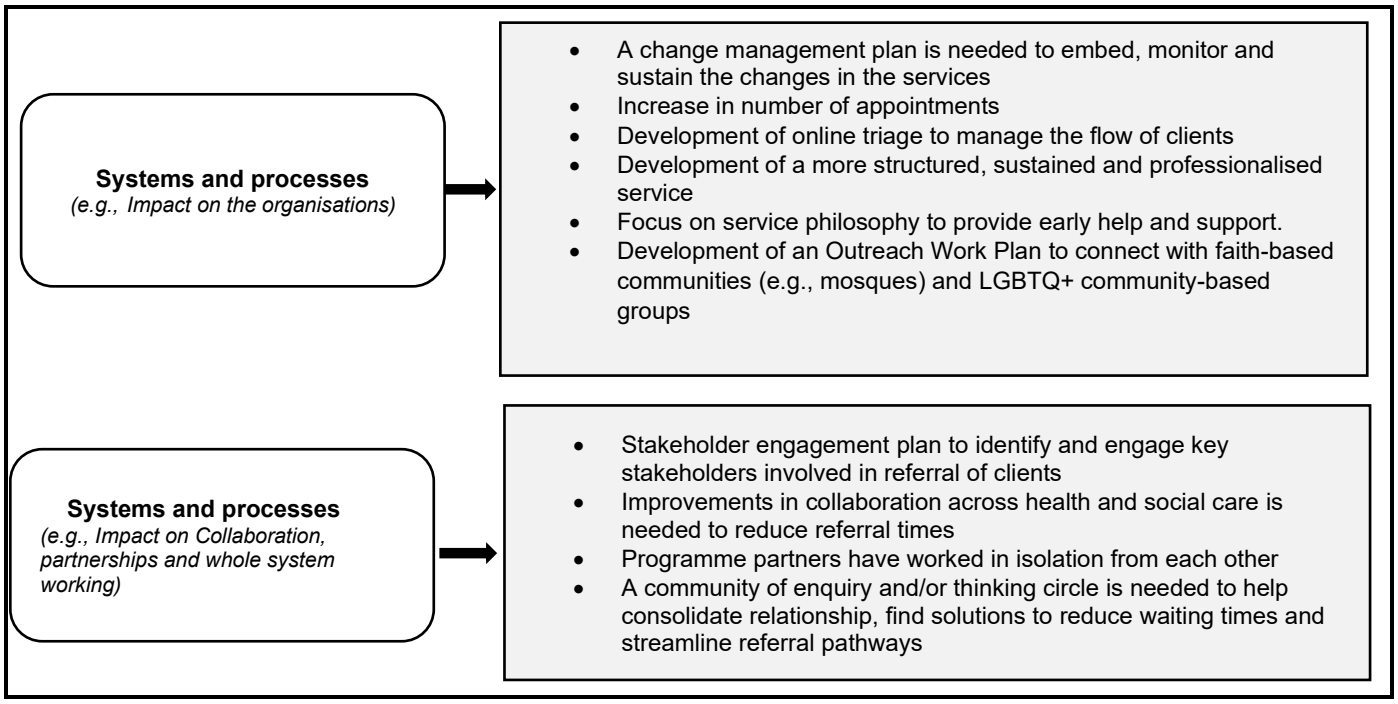
(Project A staff)

"The service speaks for itself, going for a walk and talking with volunteers, seeing the difference. We used to meet every week, twice a week now, for shopping etc. It's been a big

one to help them, anything we can change to support with language because they are afraid to talk."

(Project C/2 staff)

The impact on the organisations and other organisations (e.g., developing skills, developing partnerships)



Mind implemented several enhancements to their principal delivery model, including: early bereavement support; complex bereavement and increasing contact time to *N*=12 sessions; supporting people with learning disabilities and autism with bereavement and grief; developing a booklet that provides practical help with funeral planning during COVID and psychological needs; developing stepdown support offers; and recruiting additional staff (Including *N*=4 paid therapists and a senior therapist doing the assessment, and *N*=8 volunteer counsellors); and, finally, moving offices to be physically more accessible in the community and acquiring a bigger physical space to accommodate the growing workforce. Through these changes, Mind were able to reduce the time to assess referrals to two days from referral and offer a first appointment within two or three weeks.

Research participants give accounts about where enhancements in the mechanisms, structures and processes have been implemented, and give indications of their utilization and effectiveness for the services to better meet the needs of clients. The enhanced service often included elements of training on mental health awareness and awareness raising on alternative support pathways (e.g., financial, housing, welfare, bereavement):

"We delivered three extra services: early, complex and special bereavement support (part of the service specification). We even developed a booklet during COVID that is both practical (e.g., funeral advice, especially in COVID) and for psychological needs."

(Project A staff)

"The staff have helped shape it, from point of inception, programmes from school to home – they contributed the resources – head of service provided outcomes. Changed the spectrum

of needs, training and expertise of team including myself. Diversity and inclusivity have changed. … Better with partner services and improve other projects. We also do wellbeing roadshow."

(Project B staff)

"Clients are provided with information on mental health, housing, employment, immigration, benefits. Further support such as referral, hire a lawyer or campaign to inform policy change. Partner services are invited to their organisation to support clients, not clients just being referred."

(Project C/1 staff)

"Forms are given to them, to clients, and the data is recorded every week; how they have been at the start and beginning of the week which has been showing good responses. The forms allow users to be signposted or supported based on their needs, advice information, housing etc. or identities such as passport."

(Project C/2 staff)

Services that were previously delivered within the community and utilise local assets had the scope to promote partners' services and re-engage with grassroots originations, focused on reducing social isolation and promoting comfort in a familiar cultural milieu:

"The people who join may not speak and need help with translation with accessing GP, lawyers and so they are helped. The main aim is to support clients with companionship and reduce isolation feeling, improve their life in general."

(Project C/1 Volunteer)

"We are allowed to give volunteers some repayments for meetings, trainings and meet up with refreshment for clients. This is more structured than previously. It allows time to explain in detail what the service is, for clients to get maximum benefit."

(Project C/3 staff)

"The service speaks for itself, going for a walk and talking with volunteers, seeing the difference. We used to meet every week, twice a week now, for shopping etc. It's been a big one to help them, anything we can change to support with language because they are afraid to talk."

(Project C/2 staff)

Research participants describe in their accounts how collaborations, partnerships and whole system working served as both an enabler and barrier in the implementation of the service enhancements. Research participants comment:

"Some trainings are provided in Albanian, or with the help of an Albanian translator. The organisation is called ALTERNATIVES that is providing parenting skills training. The training is 6–8 weeks long. Free snacks, travel expenses are covered, and childcare provided."

(Project C/1 staff)

"We have been spending time to raise awareness of our work, and the necessity of bereavement support in general with local organisations/stakeholders and attend community events. We are also part of the end-of-life strategic group as well. Working to make

bereavement support a natural referral process, instead of an extra step clients must make while struggling. Overarching aim of the service is to move towards population health and wellbeing, which is very important – it makes any mental health issue less stigmatised, helps accessing services without shame."

(Project A staff)

"Talking therapies is not suitable for learning difficulty clients, so we are trying to liaise with some of the learning disabilities organisations in Newham. They're an independent service and aren't directly linked to the GP."

(Project A staff)

"Linking up other young people with community – if identified. Practitioners would refer such as pathfinders. We try to speak to other responsible people and fast track referrals, and we have CAMHs services in house. This reduced wait time for young people."

(Project B staff)

Connect Newham Bajuni Women's Group principal delivery model had no structure, and addressed loneliness and isolation. They recognise that additional funding is required to hire suitable community-based meeting space to run their core activities (i.e., focused on food, employability, health and wellbeing), which are all free. All the staff are volunteers, and they are not reimbursed for their expenses. The volunteers work as advocates to connect residents with GPs, help with shopping, and in their COVID recovery, and they promote health and wellbeing through community walks. Clients are usually recruited through friendship networks via word of mouth.

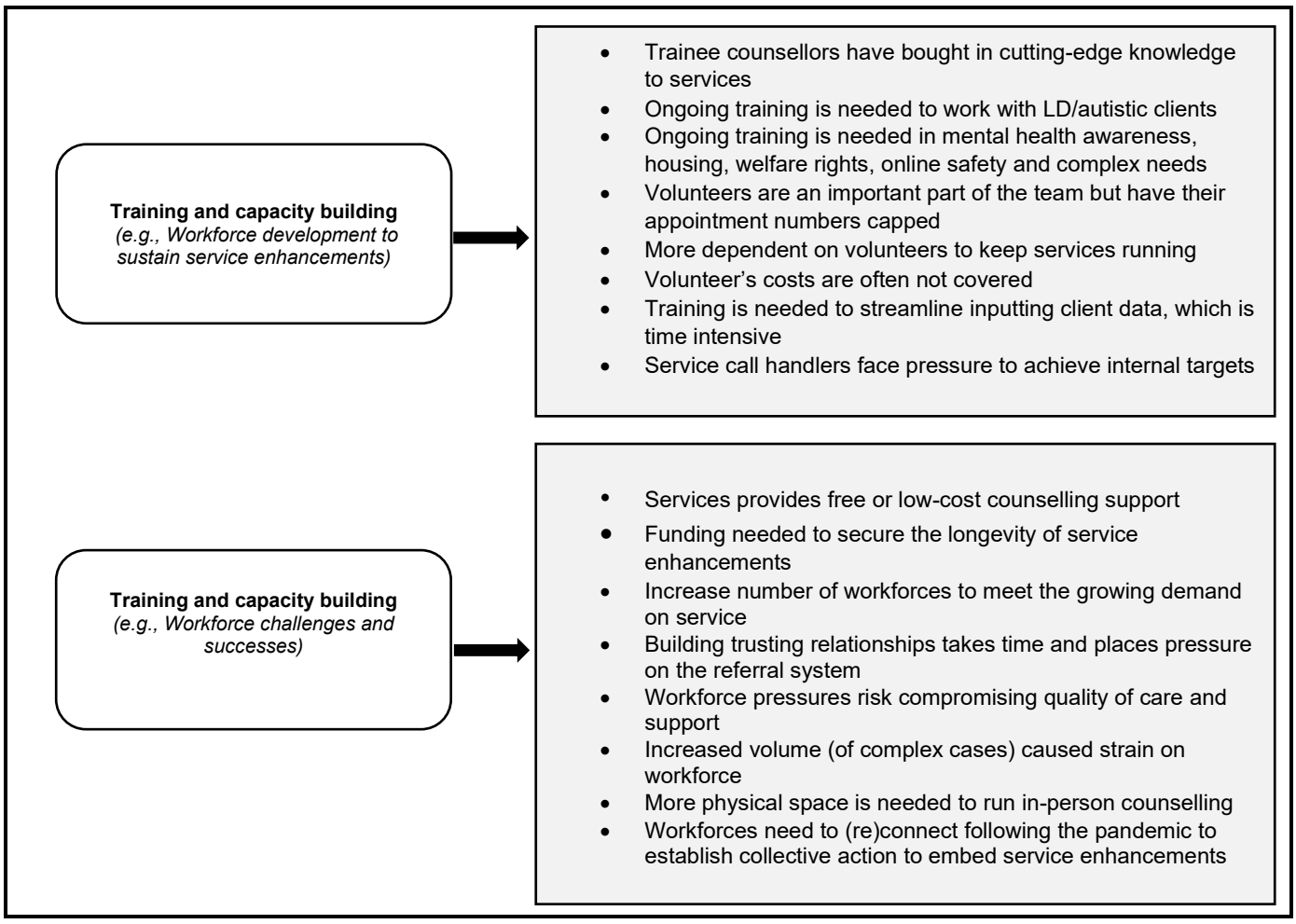
Bajuni Women's Group stress that raising awareness of such services should also be linked to finding ways of connecting to ethnic minorities and letting the population know that despite language, social networks, beliefs and many other barriers, they can still get the support they need. They also emphasise that in community events, organisers should implement strategies that shine a spotlight on how people can engage in local services, by perhaps promoting the approaches used in different areas of support (e.g., including bereavement), and how such support has improved the lives of members of the community.

Partnership working is highly valued, considering that small projects aim to reach ethnic minorities. They bring with them the deep understanding of cultures, religion and beliefs to be able to provide the appropriate support from which clients will benefit and keep engaged. Form partners they would welcome prevention programmes that are considered crucial to raise awareness and promote better mental health. Moreover, it can be beneficial to work alongside other organisations to complement each other's services and, in this way, provide wider, ongoing, more appropriate and more effective support to clients

What might organisations have done differently?

The evaluated services reflect different levels of professionalisation (e.g., typically determined by training) and workforce pressures that risk compromising quality of care and support. The services focus is very different in terms of workforce development, scale of reaching communities, their aims of supporting communities and how they envisage their role and responsibilities as part of whole-system approach. This has implications for the normalisation legacy of the service enhancements. In the small befriender services sustainability is not a core function because they simply lack capacity to get involved directly in partnerships and to continually communicate the value and benefits of their service. This

is where Connect Newham played an enormous value in their community organisation and advocacy role.



Research participants suggest areas for workforce development to help sustain achievements. These include training in specialised support areas (e.g., counselling LD and autistic clients and safeguarding training), and general counselling approaches (e.g., trauma-informed practices). Research participants remark:

> *"Trauma-informed (TI) session has been done long ago, 2007. They have been aware of these things, and this is not necessarily new. However, this training enhances this TI delivery. Every year, trainings are delivered to staff. Service entails 1-2-1 call with service user being referred. Not many challenges, word of mouth helped spread the word, and then grew bigger to form partnership."*
>
> *(Project C/1 Staff)*

> *"We are trained and fully aware of what is expected, go to another length, changed the way of work, we work more efficiently. For example, now we give them (the clients) the choice of the best time to call and what they want to do – ask them what they want – e.g., going go to the shop; things have changed for the better."*
>
> *(Project C/2 Staff)*

However, some services identified that there might be areas where skills could be improved, even when they were unsure what extra skills are needed to better deliver services. Others noted specific skill development needs. Research participants comment:

> *"Shpresa's staff have safeguarding skills, which is important. Generally, I feel that staff and volunteers have the basic skills to help clients, although I am unsure of the exact skill set required. However, having more English teachers would really help in Shpresa."*
>
> *(Project C/1 Volunteer)*

> *"Lack of appropriate clinical level training to deliver effective therapeutic benefits with specific groups, for example Learning Disabilities, LGBTQ+, trauma-informed therapy (e.g., EMDR).*
>
> *Much of the training offered is at an organisational awareness level, but not suitable for clinical delivery."*
>
> *(Project A Staff)*

> *"Cultural sensitivities are not always taken into consideration."*
>
> *(Project A Staff)*

The service enhancements often posed new challenges for staff, but also offered growth opportunities at the same time. Research participants comment:

> *"Within the team, there is a good awareness, but they are only a small team and cannot represent every community. BMH Fund helped. It extended the team, increased capacity and helped thinking outside the box, exploring what the needs are. Staff have been engaging with the change enthusiastically and robustly. They had to keep up with a lot: changing mental health services, BLM. There is a stress factor – they had to work harder but I think most of the staff enjoys making a difference – and this is a frequent discussion topic/mantra, how they are making a difference."*
>
> *(Project A Staff)*

> *"Most of the volunteers were keen with the service enhancements, because they saw the improvement, some were a bit anxious to go out and speak to people; to befriend them, but there is a great pool of clients who are coming out and getting involved more often."*
>
> *(Project C/2 Staff)*

> *"The training helped with delivering the services before supporting clients. The enhancement helped with the service delivery. COVID lockdown made loneliness worsen, talking to clients helped them gain hope, positive vibe to aim for their goals."*
>
> *(Project C/1 Volunteer)*

Research participants highlighted the need for continued financial support and investment in services to maintain all those aspects that were implemented during the service enhancement:

> *"We need a committed funding support – long term – take away support cannot be done. Support and scaffolds in place cannot be taken away. Need to invest money from research to know what's most likely to create sustainable change."*
>
> *(Project B Staff)*

"The need for continuity of care is important. There is a need to make this face to face to better support clients on a long time. There is a need to get paid part-time staff, as many of the clients speak non-English language, mainly Somali language. This allows clients to feel more comfortable, if they speak with someone that speak same language with them."

(Project C/3 Staff)

Several research participants highlighted the need for physical meeting spaces and face-to-face appointments as a key factor for sustainability:

"Since COVID, we lost our physical space, we cannot meet, and that impacted on their psychological wellbeing as we cannot talk as they used to. This causes social isolation. The coordinator is trying to do a lot for each member and support them and also to get a space, but it has not happened yet."

(Project C/2 Service User)

"More face-to-face appointments required. There are more people needing support, but not enough space to offer the service. This is needed to allow people feel heard. Especially, when you consider that many do not know how to access technology such as Zoom meetings."

(Project C/3 Staff)

6. Discussion

In this study, the research participants have shared accounts of how they have planned, delivered and/or experienced enhanced community-based mental health and wellbeing support services leading to several positive, albeit small, impacts coming out of the service enhancements. Such as strengthening partnerships, streamlining referral processes, identifying support priorities and starting to move towards whole system working. The purpose of the programme has been to improve mental wellbeing and health in residents affected adversely by Covid. We cannot truly know the full impact of exposure to the services, and whilst the measures employed in this programme suggest positive short-term outcomes more research is needed to better understand what changed from the client's perspective.

6.1 Overview of implementation learning

The underlying goal of the Better Mental Health programme in Newham, as perceived by the services, has been to enhance their services in order to widen access and increase uptake of underserved and underrepresented sections of the community whose mental health and wellbeing has been negatively impacted by the pandemic, and to provide them with tips for managing mental health through culturally appropriate care and support. These matters are not only applicable to issues of 'race' and ethnicity, but equally relevant to adultism/ageism experienced by children and young people, ableism faced by people with learning disabilities/autism, and homophobia faced by the LGBTQ+ communities in their access and experience of mental health support services. The presumption behind this programme is that fears - real or imagined - form a barrier to why certain sections of the community arguably do not access early help with mental health and wellbeing problems at a time when it can be straightforwardly treated.

The overarching strategy employed in this programme has in part addressed these fears. The **emergent themes of holistic support, access, place and space, systems and processes, training and capacity building** provide partial insight into what features of the service enhancements matter most to the staff and clients in providing and receiving a responsive service. Two independent research study reports are due for publication that will

look at the Connect Newham projects in more detail, and they should shed more light on the outcomes experienced by clients following exposed to the interventions. The first report is entitled *Lives on Hold Study,* led by Professor Stalford based at the University of Liverpool. The report will focus on how the Shpresa Programme has co-developed a trauma-informed approach to research; the mental health of clients; its educational work; the specific challenges confronting Albanians in the asylum system; and age assessment. The second study has been undertaken by Compost Newham and is peer-led research study exploring the Bajuni Women, Kulan Somali Association, and Shpresa services. This study will explore whether the Connect Newham befriending model has been effective and is transferable to the participants' communities/organisations, if the support provided by Connect Newham is effective in terms of developing capacity around befriending, and if the model was fit for purpose. Finally, the study will consider the wider impact on the three organisations, and if they are now more sustainable and if their communities have been better served.

This evaluation has identified several important implementation measures of the enhanced services that have:

- successfully engaged and supported deprived communities;
- engaged with at risk and vulnerable groups and communities from a wide range of ethnic backgrounds;
- met needs that were not met previously by other commissioned services; and
- had a positive impact from the service user and service provider perspective.

The analysis has drawn attention to the key characteristics of the service enhancements that should contribute to establishing the "best context-specific models" of community-based mental health support from the subjective perceptions of the providers and beneficiaries.

6.2 Supporting deprived communities, at risk and vulnerable groups and ethnic minorities

At risk and vulnerable groups were engaged in higher numbers, with a specific focus on children and young people with low level mental health needs (Your Time), lonely and isolated adults (Newham Connect) and residents at the early stages of bereavement (Bereavement Services), including those with complex bereavement needs and people who had learning disabilities. For instance, the Your Time service enhancements ensured that vulnerable children and young people could use self-referral pathways that provided a higher level of anonymity and a separation between school and personal life, thus avoiding the stigma of school-based interventions. Furthermore, the co-production of support plans with their counsellors helped to create a more tailored and reflexive support approach. The Bereavement Service increased its access numbers: (1) through a blended delivery approach (including appointments via phone or online), while also increasing capacity to see clients in person; (2) by matching clients with bilingual counsellors; (3) by changing its threshold and providing immediate support following bereavement; and (4) by offering tailored group and or extended sessions for those with complex bereavement and learning disabilities.

All three services were successful in reaching and engaging targeted ethnic minority groups. For example, Connect Newham's approach focused on prioritising the cultural needs of three small minority groups, by empowering volunteers to develop trusting social relationships with clients in their homes and out in the community, and were therefore able to reduce their social and cultural isolation. Your Time and the Bereavement Service successfully reached sections of the Asian community (e.g., Pakistani and Bangladeshi) and used culturally competent approaches to engage and work with clients (e.g., the Bereavement Service proactively increased cultural competencies by employing bilingual counsellors to match under-represented minority groups, and increased outreach work to

community and faith-based groups to build their understanding on what matters most to different cultural groups).

6.3 Further steps to engage with population groups currently not being reached

The evaluation drew attention to several minority groups that are still under-represented in the services, for example, in the Bereavement Services, they were keen to point out more outreach work needs to be done to reach Asian men, LGBTQ+ clients and people with learning disabilities. Research participants highlight a number of strategies to help close this gap, such as continuing to increase the diversity of the workforce to match the client groups; continuing their outreach work with community groups and voluntary sector organisations to raise awareness of the service and to build better understanding of the issues impacting the communities they hope to serve; providing different pathways to access services (e.g., phone, online, in-person spaces within walking distance), and finally, campaigning and education to tackle the cultural stigma surrounding mental health problems in targeted communities.

6.4 Meeting the needs that were not previously met by other services

Research participants accounts suggests that the service enhancements addressed gaps in cultural competencies, raised awareness of the relationship between mental health, wellbeing and stigma, and most importantly provided safe, trusting, non-judgemental spaces for clients to seek help and receive support with their mental health and wellbeing concerns. Research participants accounts illustrate how their mental health concerns had often been compounded by social problems resulting from COVID. In response, most, if not all, the services played an important role in providing basic financial, welfare and housing advice and information, and when needed signposted clients to other support services (e.g., statuary and voluntary) who could better address their needs.

All the services took action to learn and embed client's cultural normative practices and languages at the core of their services. In practice, this meant bilingual counselling sessions, co-designed support plans and facilitated peer-led groups within their own communities. The advantage for clients is seemingly a growth in trust, empathy, compassion, and understanding of their lives and cultural histories, which allows for openness to fully benefit from the service, especially in the case of Connect Newham.

6.5 Positive impacts from clients' and providers' perspectives

From the clients' standpoint, the programme has been effective on a number of different fronts, such as in increasing communities' health and bereavement awareness, reducing isolation and loneliness through established connections to their communities, and providing them with activities and new stimuli, adding variation to their daily routines and breaking inactivity.

Providers were able to offer services for a longer period, with reduced waiting times. They also increased their capacity and saw more clients, while providing more tailored services with co-produced support plans. The service enhancements allowed them to reduce work pressures and recruit new staff members/volunteers/trainees with up-to-date and specialised expertise. They also gained a better understanding of the communities they serve, and they were able to mobilise community assets, establish new stakeholder partnerships and aspire to move towards whole system working (Bereavement Service, Your Time).

As alluded to, this evaluation is unable to answer the degree to which the service enhancements have helped to mitigate the mental health impact of the pandemic on the targeted communities. The short-term nature and size of the programme limits a population level assessment. Such measures on health and wellbeing takes time and are often affected by other factors that are beyond the scope of this evaluation. However, evident in this study is an increase uptake of services by at risk groups that exceeded the predicted numbers at the start of the programme. Despite the fact the positive mental health outcomes of the

services might not be evident across the system, the increased engagement in early help suggests how the enhancements have effectively contributed to healthier behaviour and increased health literacy in the targeted communities. In this spirit, the following section brings together all the insights and key learning from the programme for parties interested in replicating or scaling this work.

6.5 Key learning

Bullet pointed below are the key aspects of three projects that reportedly had the greatest success in engaging and supporting underserved and under-represented groups in the community. The key learning:

- The recruitment of additional staff, trainees and volunteers increased the capacity of the workforce to match the growing demand placed on services.
- Matching the workforce with the user groups in terms of primary languages, gender and ethnicity developed trusting relationships to establish understanding of their mental health and wellbeing needs.
- Workforce training and meetings focused on the issues experienced by discrete sections of the community increased the workforce understanding of how best to reach, engage and support the participation of underserved and under-represented members of the community.
- Targeted and coordinated community engagement work was able to both promote the service and learn more about the emerging needs of underserved or under-represented members of the community (e.g., Muslims, older men, LGBTQ+ people and bereaved people living with a learning disability).
- The review and development of communication and promotional materials provided different community members with accessible information to access the service both online and offline.
- Pivoting and moving some services online/phone/community-based helped to triage cases (e.g., with the addition of easy-to-read self-help information) and helped with caseload management and access for vulnerable residents.
- Partnership working helped to streamline the referral systems, and indirectly, the increase in self-referral absorbed the demand which would be placed on stretched statutory services during the COVID-19 pandemic.
- Modes of service delivery were innovated and tailored around users' groups to optimise the service impact (e.g., from early help, additional sessions and group-based work in the case of the Bereavement Service; 1-2-1 community-based work, as opposed to school-based group work, in the case of Your Time; and shopping, calls and domestic cleaning in the case of Connect Newham).
- Back-office adaptations were made to improve caseload management systems and security following the exponential growth in caseloads, the resourcing of IT equipment to remote workers, and co-working and community-based meeting spaces.

Insights into what could have been done better to reach and engage underserved and under-represented clients are bulleted below. Key learning:

- GPs and Social Workers are best placed to make referrals to the service, but they lack awareness and understanding of community-based mental health and wellbeing services.

- There is an absence of a borough-wide referral system to help make referrals to step-up or step-down from the community-based mental health and wellbeing services.
- There is a challenge of applying eligibility criteria to support clients to move on to other services, which can be problematic when clients do not meet service thresholds (e.g., due to postcode)
- Better local data storage systems and equipment would facilitate remote working to maximise FaceTime with clients.
- There is a lack of a systematic and sustainable way to recruit and train appropriately matched volunteers.
- There is a need for high-quality, specialised, and timetabled training for new and established staff members and volunteers (e.g., trauma training, complex bereavement, such as the loss of a child, and bereavement counselling for people living with a learning disability).
- Access to co-working space would enable the increasingly remote workforce to come together to bond, share and learn as needed, and would help reduce work pressure and the feeling of isolation.
- Increased knowledge and understanding are needed of cutting-edge therapies, approaches and measurement tools to use with underserved and under-represented residents.

The perceived benefits and impact of the service enhancements from a client perspective are evidenced in the increased take-up of services, namely through a widening of the pathways to access services through self-referral (where it did not previously exist), and sustained engagement in (formalised and reviewed) co-produced support plans that focus on what matters most to the service user and, in turn, providing holistic support.

The perceived benefits and impact of the enhancements from the service providers' perspective include: the success of recruiting a critical mass of volunteers to help increase their capacity to match demand on the services; the new workforce better matches the ethnic and linguistic needs of the pre-existing and/or targeted client groups, thus ensuring that cultural sensitivities and ways of communication are addressed in order to get to the root of the problems; and the professionalisation of services is considered to be leading to more efficient and effective ways of working.

The best model(s) of delivering these services from the combined perspectives of clients and providers are community-based person-centred modes of delivery, with the caveats of having high levels of cultural competency in the workforce, and visibility of the service across the whole system, breaking down the barriers that might prevent engagement, such as language barriers, finance and accessibility, as well as referral routes. There is acknowledgement that mental health and wellbeing problems can seldom be resolved in the short term, and therefore sustainable statutory support for community-based mental health and wellbeing services is needed for them to continue supporting underserved and under-represented residents. This arguably involves continually training the workforce, adequately resourcing the workforce, and valuing and empowering the workforce, so that they can confidently support clients.

7. Conclusion and recommendations

There were limitations to the study that have influenced the result. Most notably, we had a low completion of practitioner reflections sheets, and even those completed were rushed, and often contained little to no information to enhance our understanding of each project. Nonetheless, the data collected has enabled insights into the challenges and success of the programme and enabled the development of a set of evidence-based recommendations to embed and extend the community-based mental health and wellbeing provisions.

7.1 Recommendations

To move forward, each of the services shared a set of challenges to embed their tested service enhancements and to become more sustainable, and so optimise on the gains achieved through this programme for residents. We have provided key recommendations to help build sustainability and to share best practice across the system:

Developing and delivering a strategic approach

1. **Key strategic partners within London Borough of Newham across the Health and Social sector should continue to commission a mixed economy of services for residents which meet their mental wellbeing and health needs.**

   This should include a range of community-based services and support organisations to achieve sustainable growth, preserve autonomy, scale and agility, whilst expanding the visibility, accessibility, capacity and efficacy of the community-based services.

   To take account of the mobile and marginalised communities living in the borough with changing needs a mixed economy of service provision is needed.

2. **Key strategic partners within London Borough of Newham across the Health and Social sector should continue to commission blended delivery models incorporating online and in-person services to help reduce inequalities in access.**

   A significant insight from the pandemic is the benefits of having multiple pathways available at the fingertips of residents to help reduce inequalities in access and empower residents to engage and participate in services.

3. **Key strategic partners within London Borough of Newham across the Health and Social sector should consider how best to innovate and test processes to simplify referral and other pathways between partners involved in delivering services for residents experiencing poor mental wellbeing and mental health.**

   To improve take-up of services at access points, understanding of thresholds and to speed up referral times between services, a common referral pathway framework is needed for the borough.

4. **Key strategic partners within London Borough of Newham across the Health and Social sector should consider how best to support VCS services to improve IT and data security systems to support new agile working, ensuring that security procedures and policies are in place to protect the information shared by residents.**

   Community-based services need to modernise and equip to better promote and protect residents' needs in the digital age. This may include considering the use of

capital investment, supporting community-based services to access existing external support and funding sources not available to public sector bodies.

Working with our community sector

5. **Key strategic partners within London Borough of Newham across the Health and Social sector should continue to gather and amplify evidence to better understand how to effectively engage marginalized communities to increase uptake in community-based health and wellbeing services.**

   Better understanding is needed to reverse the trend and ensure that boys and men take-up the right service, at the right time.

6. **Through its Volunteering Strategy the Council should offer community-based services support to facilitate a coordinated approach in recruiting and training volunteers, and to target groups of residents who match residents' gender, ethnic, cultural and linguistic backgrounds.**

   Building on the Council's Volunteering Strategy (2022), support should be afforded to partners to establish a pipeline of appropriately recruited and trained volunteers to help address current demands of services.

7. **Key strategic partners within London Borough of Newham across the Health and Social sector, including larger community-based organisations, should consider how best to identify and unlock social infrastructure and/or publicly owned assets to ensure partners can gain access to affordable and acceptable co-working space to accommodate the growing workforce and client group**.

8. A key focus of unlocking community assets will be to provide accessible, culturally acceptable and consistent meeting spaces in the community for residents, avoiding institutions/settings where stigma can easily arise

9. **Key strategic partners within London Borough of Newham across the Health and Social sector should offer support to community-based services to access existing support and guidance on how to improve data storage systems to protect the privacy of residents and to better evidence outcomes.**

   Guidance and support are needed for partners in the processing and protection of data, due in part to expanding teams, often working remotely.

Key skills and knowledge needed

10. **Key strategic partners within London Borough of Newham across the Health and Social sector should build-on the promotion of services across the borough using culturally appropriate publicity materials targeted at residents and referral agencies. Publicity materials should be translated according to different ways of understanding in diverse communities.**

    A focus should be placed on multiple and varied ways to effectively reach vulnerable and marginalised communities to make services known to residents where English is not the first language and/or where there is poor literacy in the first language.

11. **Key strategic partners within London Borough of Newham across the Health and Social sector should assist VCS partners in the provision of specialist and**

refresher training to increase understanding of the full range of vulnerable and marginalised residents living in the borough for volunteers and paid members of the workforce.

The paid and unpaid workforce should have the opportunity to take part in professional development to enhance their work on what matters to residents.

12. **Key strategic partners within London Borough of Newham across the Health and Social sector should work with VCS partners to think through a carefully facilitated process to strengthen the growth and development of racially inclusive services using a Community of Practice approach**.

A key focus should be on building understanding into residents' cultural idioms and idiosyncrasy. The forum should also provide a community of practice to help build skills in the workforce to support residents to access move-on services.

Appendix 1 – Recommendations of the Mental Wellbeing Impact Assessment (2020)

The 12 recommendations and supporting action plan will be used to ensure that we have the appropriate responses in place, and we will work alongside residents and communities to improve mental health and wellbeing in our borough. The recommendations are as follows:

1.Work to continue collaboration across the system and progress the Mental Health and Wellbeing Action Plan.

2.Ensure that we understand, reduce and tackle the inequalities of our diverse communities by having quality of access to mental health and wellbeing services.

3.Develop the role of social prescribing as an important approach to the self-management of mental health and wellbeing.

4.Develop an overarching organisation that offers befriending services. Set a long-term plan to continue Befriending, Your Time and Parent Befriending.

5.Increase awareness of existing mental health services. Explore opportunities to link more with community services and ensure frontline access points are able to signpost to mental health and wellbeing services.

6.Provide suicide training to increase awareness amongst colleagues and partners to be able to deal with and refer residents to services if experiencing distress, self-harm and suicidal thoughts.

7.Strengthen Mutual Aid Groups/Neighbourhood Groups/Community Cafes etc. Address limitations (e.g., cultural barriers to access).

8.Using Community Health Champions and other channels as conduits for sharing information by increasing awareness of existing services and building additional capacity in the community through training (e.g., Mental Health First Aid Training).

9.Link to the wider 5 ways to wellbeing (e.g., walking to improve health).

10.Provide universal bereavement training to key settings such as schools, colleges and children's centres, and invest more in community bereavement services across the borough.

11.Develop a whole system Trauma Informed approach across the organisation (health, education and community settings).

12.Improve access to appropriate services for those disproportionately affected.

Appendix 2 Newham Bereavement Service

Table 2.1. Comparison between data provided by BMH Monitoring Data for Newham Bereavement Service and data provided by the Newham Bereavement Service quarterly report for Q4.

	Newham Bereavement Service - Monitoring Data		Newham Bereavement Service - Quarterly Report	
	Frq	%	Frq	%
18 to 64	403	87%	147	77%
65+	34	7%	12	6%
Unknown	25	5%	33	17%
Female	338	73%	123	64%
Male	88	19%	27	14%
Unknown	36	8%	22	11%
Asian	109	24%	59	31%
Indian	29	6%	13	7%
Pakistani	31	7%	16	8%
Bangladeshi	23	5%	4	2%
Other Asian (Including Chinese)	26	6%	26	14%
Black	99	21%	20	10%
African	36	8%	7	4%
Caribbean	33	7%	6	3%
Other Black	30	6%	8	4%
Mixed	45	10%	26	14%
White	115	25%	45	23%
White British	84	18%	24	13%
White Other	31	7%	21	11%
Other (Including unknown)	94	20%	42	22%
Total	462		192	

Appendix 3 Your Time

Table 3.1. Comparison between data provided by BMH Monitoring Data for YourTime and data provided by HeadStart

	MAC/YourTime – Monitoring Data		HeadStart data	
	Frq	%	Frq	%
<5	0	0%	1	1%
5 to 17	271	97%	113	96%
18 to 25	9	3%	4	3%
Unknown		0%	10	8%
Female	140	50%	63	53%
Male	138	49%	45	38%
Other	2	1%	10	8%
Unknown		0%	10	8%
Asian	87	31%	25	21%
Indian	8	3%	1	1%
Pakistani	17	6%	7	6%
Bangladeshi	50	18%		0%
Other Asian (Including Chinese)	12	4%	17	14%
Black	62	22%	20	17%
African	25	9%	12	10%
Caribbean	17	6%	5	4%
Other Black	20	7%	3	3%
Mixed	30	11%	9	8%
White	86	31%	16	14%
White British	53	19%	10	8%
White Other	33	12%	6	5%
Other (Including unknown)	15	5%	48	41%
Total	280		118	

7 (6%) clients are in the process of completing Star 1, while 95 (81%) clients are in the process of completing Star 2 and none of the clients are in the process of completing Star 3; 22 (19%) clients are yet to complete Star 1, while 112 (95%) clients are yet to complete Star 3.

Figure 3.1. Percentage of participants that have completed, are completing or are yet to start their Star Outcome. Source: Data provided by HeadStart

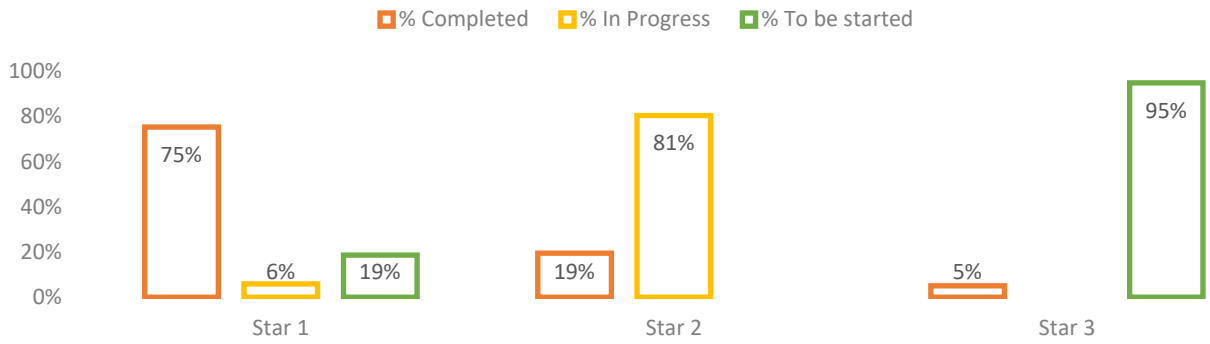


Figure 3.2 below shows the timeline of completed stars since the start of the project in May 2021 until April 2022. Completions seem to have been increasing, with observable decreases in September 2021 and December 2021, coinciding with the start of the academic year and the Christmas period respectively.

Most completed Star Outcomes, especially for Star 1, occurred during the last months of 2021 and early months of 2022, suggesting that **many clients are still on the early stages of the intervention**.

Figure 3.1 below shows a comparison between the percentage of clients who have completed the different stars to date and the percentage of clients that are still completing it, and the percentage of clients yet to start the star.

The Outcome Star measure was applied to 118 out of 280 beneficiaries (42%). Table 3.2 provides a broad overview of the profile of each of the clients who used the measure, according to their gender, age and ethnicity. The largest age category was **11 to 15 years old (53%)**, followed by 16 to 18 years old (27%) and 5 to 10 years old (9%). Gender distribution is more girls (53%) than boys (38%), and 8% of the clients were of an unknown or non-disclosed gender. **The largest ethnic group was Asian (21%), followed by black (17%) and white (14%)**. Within the Asian category, the largest ethnicity was that of Asians of any other group (68%). Within the black category, the largest ethnicity was black African (60%). Within the white group, largest ethnicity was white British (63%). **There is a noticeable absence of Bangladeshi clients, despite this grouping being highly represented in the service (see table 3.2).** We can see that the Outcome Star was either inconsistently applied and/or not processed in the case of all the Bangladeshi clients. We cannot fully explain why this was the case, but this does of mean that Bangladeshi clients were left behind and did not have an up-to-date support plan.

Of this sample of 118 clients, **80 (68%) declared not having any support or special needs**. Of the remaining 38 (32%) clients, the most cited support need was **learning disabilities, with 10 (8%) clients.** Combined autism and mental health amounted to 3 (2%) clients and Other Support Needs accounted for 4 (3%) service users.

Table 3.2. Demographic distribution of measured clients.

		N	% of Group	% of Total
Gender		118		100%
	Male	45	38%	
	Female	63	53%	
	Unknown	10	8%	
Age	<5	1	1%	
	5 to 10	11	9%	
	11 to 15	70	59%	
	16 to 18	32	27%	
	>18	4	3%	

Asian		25		21%
	Indian	1	4%	
	Pakistani	7	28%	
	Other Asian	17	68%	
Black		20		17%
	African	12	60%	
	Caribbean	5	25%	
	Other Black	3	15%	
Mixed		9		8%
	Other Mixed	1	11%	
	White and Asian	1	11%	
	White and Black African	1	11%	
	White and Black Caribbean	6	67%	
White		16		14%
	White British	10	63%	
	White Other	6	38%	
Arab		2		2%
Unknown		46		39%
Total		**118**		

Source: Data provided by HeadStart

Figure 3.2. Monthly changes in number of completed Outcome Stars. Source: Data provided by HeadStart

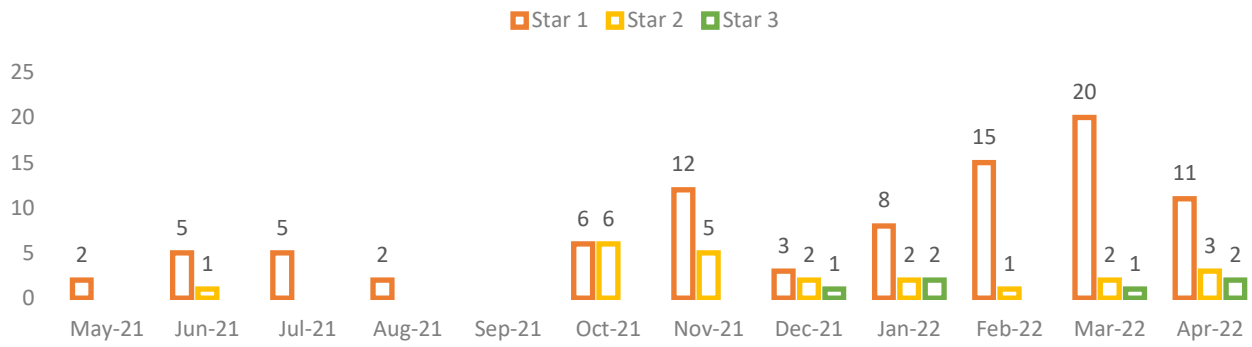


Figure 3.3 provides a comparison between newly completed stars (as presented in Figure 3) and recorded local COVID-19 cases over the same period. Completions seem to have been increasing, with **two different decreases in September 2021 and December 2021**, coinciding with the start of the academic year and the Christmas period respectively.

As such, completion of the first Outcome Star seems to follow the academic year in terms of monthly increase and decrease. Interestingly, increase in COVID cases around the Christmas period seems to be due to the nature of the holidays and might not be related to decreases in the completion of the first Outcome Star.

Figure 3.3. Monthly changes in number of completed Star 1 in comparison to new COVID-19 cases. Source: Data provided by HeadStart and UKHSA

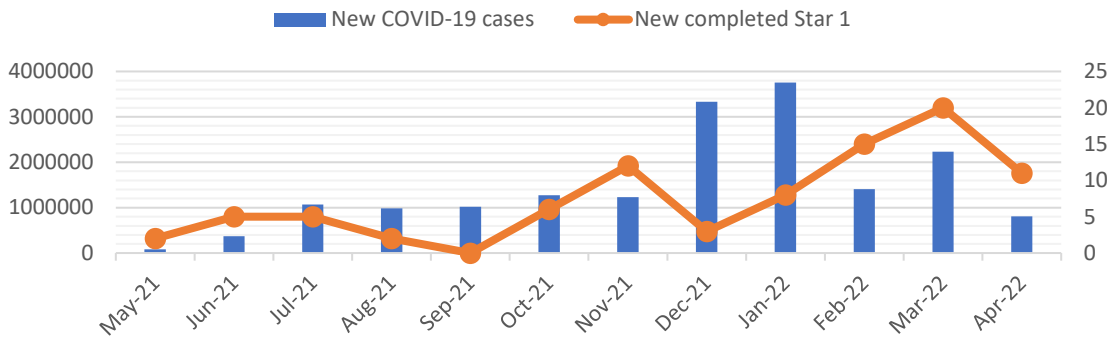
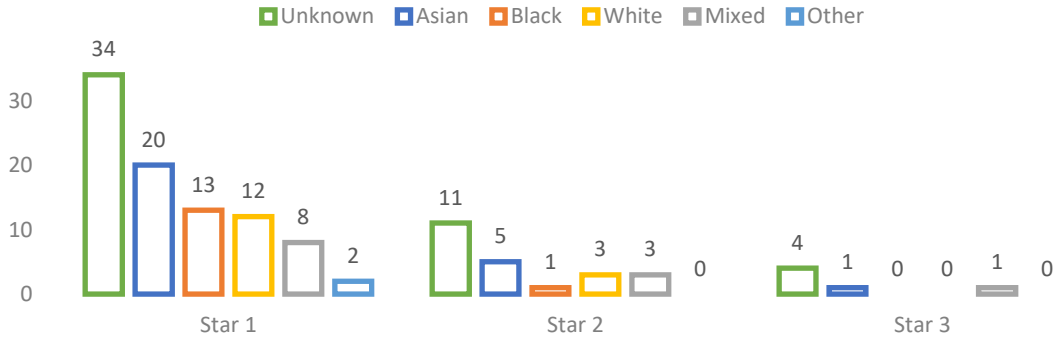


Figure 3.4 below provides a comparison between the ethnicity breakdown of clients at Star 1, Star 2 and Star 3 within the sample of 118 clients out of 280 beneficiaries (42%). The results should not be read literally as markers of success or failure of individual clients but shows trends in active engagement in support planning based on the client's ethnicity.

The recorded numbers for all ethnicities decline sharply from Star 1 into Star 2, but less so from Star 2 into Star 3. **From Star 1 into Star 2, sees an observable decline in black clients at 92%,** whereas white and Asian clients decline less sharply at a rate of 75%, clients of an unspecified ethnicity decline at 68% rate and mixed-race clients decline at a rate of 63%. Those who identified as "Other" declined at a 100% rate.

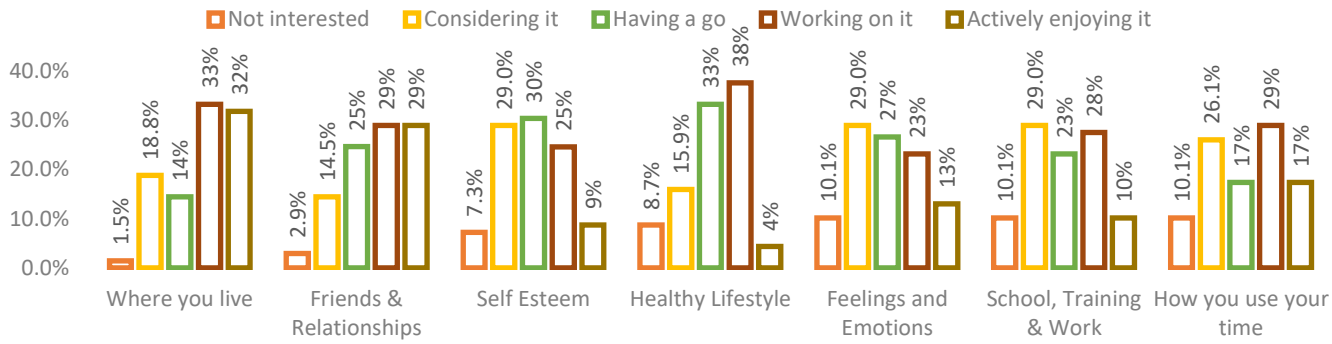
From Star 2 into Star 3, black and white clients both declined at a rate of 100%, whereas Asians declined at a rate of 80%, Mixed clients declined at a 67% rate and those of a non-specified ethnicity declined at a 64% rate. A contributing factor to the potential disengagement of black clients with Star 2 and 3 is the reported lack of black male mentors to match the number of black boys accessing the service.

Figure 3.4. Ethnic distribution of participants that have completed Outcome Stars.



Source: Data provided by HeadStart

Figure 3.5. Participants' identification of relevant outcome areas

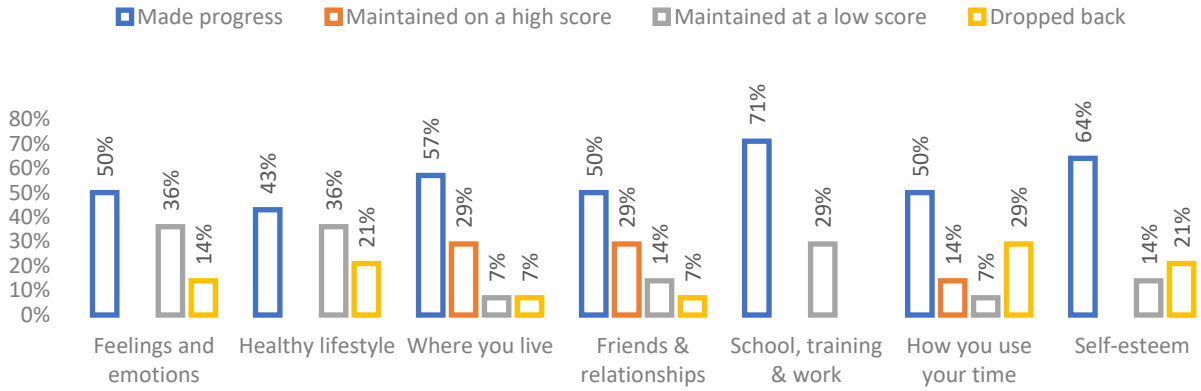


Source: Data provided by HeadStart

Figure 3.5 maps the different domains of the Outcome Star used with clients to co-produce their support plan. If the client is not interested, or if she or he is just considering it, then the client is likely not to have seen this domain has a contributing factor to their mental health and wellbeing problem. As such, "**Feelings and emotions"**, **"School, training and work**" and "**How you use your time**" were the outcome domains where a larger percentage of the clients decided not to address (10% each).

Table 3.3 below illustrates the percentage of clients making progress at one, two, or more than three outcome domains within a sample of 118 clients out of 280 beneficiaries (42%). **All clients have made progress in at least one outcome area**, while almost **1 in 4 clients have made progress in at least 3 areas**. The average number of areas in which a client is making progress is almost 4, more than half the available outcome areas.

Figure 3.6. Percentage of clients' progress at the different outcome areas.



Source: Data provided by HeadStart

Table below provides further information on how the outcome stars have been progressed with the recorded sample group. It illustrates the distance travelled and progression made by the clients.

Participants' progress at the different outcome stages	%
Percentage of people making progress in at least 1 outcome area	100
Percentage of people making progress in at least 2 outcome areas	93
Percentage of people making progress in at least 3 outcome area	71
Average number of outcome areas in which someone is making progress	3.9

The Outcome Star is usually reviewed at set interval (e.g., up to three months) by both the client and practitioner to review progress and set new targets, signifying active engagement in the service and a sense of agency and control over the support they receive. Within this sample of 118 clients, **89 (75%) clients have completed Star 1**, 23 (19%) clients have completed Star 2 and 6 (5%) clients have completed Star 3 (See Appendix).

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