REPORT

Centre for Mental Health

A lifeline for London

How mental health services in the voluntary sector worked during the pandemic

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Contents

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Executive summary

In 2018, the Mayor of London set out the ambition for "all Londoners [to] share in a city with the best mental health in the world" (GLA, 2018). Three years on, this ambition is both more urgent and more challenging.

During the Covid-19 pandemic, the voluntary and community sector (VCS) played a critical role in supporting mental health within communities and lessening the strain on the NHS (CQC, 2020). It did this not only by providing extra capacity, but also by providing skills and expertise that were complementary to and distinct from those of statutory services. These included:

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

Although the initial crisis has passed, demand for mental health services is forecast to rise (Royal College of Psychiatrists, 2020; GLA, 2021; Nottingham Trent University *et al.*, 2021c; ONS, 2021). It is predicted that up to 10 million people in England, including 2 million Londoners, will need either new or additional mental health support as a result of the pandemic (O'Shea, 2021; Thrive LDN, 2021).

The Greater London Authority (GLA) commissioned Centre for Mental Health to engage with VCS organisations and statutory bodies in London who provide or signpost to mental health support. The purpose of the exercise was to explore how they responded to the initial stages of the Covid-19 pandemic, how they worked collaboratively, what challenges they faced and what lessons they learnt.

Between February and July 2021, Centre for Mental Health reviewed the existing literature on this subject, carried out interviews and surveys with services working in London, and held a roundtable discussion. The themes that emerged from the research are listed below.

Demand for services

During the earlier stages of the pandemic, VCS organisations saw a rise in demand for their mental health services and people presenting with more complex mental health needs. As well as creating and exacerbating mental health needs, the pandemic highlighted the inequalities that divide our society. The VCS played an important role in supporting people during the pandemic, especially those who were less likely to engage with statutory services.

New ways of providing support

When lockdown restrictions were in place, a key way in which the VCS was able to deliver support was by moving services online. For some service users, remote support worked well; for others, it was better than nothing at a time when other options were unavailable.

But it wasn't suitable for everyone: some service users were unable or unwilling to access support remotely. When we spoke to VCS organisations about how they would be delivering services when lockdown restrictions were lifted, most were planning to resume in-person services, to prevent digital exclusion; but they also planned to continue offering online and telephone options to provide greater choice and flexibility for those who preferred to engage remotely.

Staffing and staff wellbeing

Adapting to these new ways of working while navigating the challenges of the pandemic hasn't been easy. One source of stress – enforced home-working – has ended for many. But another – heavy caseloads and high demand for services – continues. Coping with the pandemic has taken a toll on the VCS, as it has on other sectors, and there are warnings of burnout, if staff are expected to continue working at their current pace.

Funding and relationships with other sectors and organisations

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

Concerns for the recovery phase and beyond

Yet some VCS services have seen the extra support they received during the pandemic start to recede. Emergency funding is being phased out; and, in some places, there has been a return to shorter-term contracts and more competitive bidding processes. At the same time, demand for services is rising, and the energy and morale of many staff are flagging. The VCS will also be affected by changes in the wider system, as mental health services transition to Integrated Care Systems and work to deliver the Community Mental Health Transformation programme within a tight timeline. If these trends continue, the distinctive skills and expertise of the VCS, which have made its mental health services a lifeline for many over the last 18 months, could be compromised.

To ensure we build on the positives that the pandemic response facilitated, and recognise the full potential of the VCS, we make the following recommendations.

Recommendations

1. Local government and NHS commissioners should work collaboratively with the VCS when planning services. This should include enabling VCS organisations to advocate on behalf of their communities without undermining their financial position.
2. Commissioners should offer funding models that support the stability, sustainability and diversity of the VCS – options may include long-term contracts, core and unrestricted funding, and grants.
3. Commissioners should create contracts for VCS organisations that enable them to work flexibly to meet requirements. This would enable organisations to make swift changes to their ways of working in future emergencies without putting their contractual position under threat.
4. Commissioners should work with VCS organisations to develop more appropriate monitoring and evaluation protocols. This may include greater use of qualitative data, peer research, and narrative approaches to understanding impact and managing performance.
5. Integrated Care Systems should embed mechanisms to include VCS organisations in their governance and decision-making processes. This must be at 'place' as well as 'system' level, to ensure the voices of VCS organisations are heard at every level of the new health and care system. VCS organisations working with communities that have not had equity in access to appropriate mental health services need to be prioritised in this regard.
6. Integrated Care Partnerships should include members from a range of VCS organisations representing communities and groups that experience the most significant health inequalities.
7. The Government should extend the remit of the CQC to inspect and review commissioning practices, to hold Integrated Care Boards to account for the extent to which they identify and address health and care inequalities in their decision-making and resource allocation.
8. Health and Wellbeing Boards should work closely with the VCS when carrying out Joint Strategic Needs Assessments.
9. Charitable funders and larger VCS organisations should build partnerships with smaller community- and user-led organisations to amplify their voices and create a more level playing field for groups that have been marginalised or disadvantaged.
10. Thrive LDN should explore ways of supporting VCS organisations across the capital to share intelligence, resources and innovations which can build capacity and resilience within the sector.

Introduction

In 2018, the Mayor of London set out the ambition for "all Londoners [to] share in a city with the best mental health in the world" (GLA, 2018). Three years on, this ambition is both more urgent and more challenging. As Londoners continue to deal with the repercussions of Covid-19, the city is seeing widening health inequalities and rising demand for mental health services (GLA, 2021; Thrive LDN, 2021).

Delivering an effective, responsive and truly inclusive mental health offer is only possible when statutory services work in partnership with the voluntary and community sector (VCS). The VCS has expertise and skills that are distinct from and complementary to those of the NHS and local authorities. Before the pandemic, there was growing recognition of the crucial role played by VCS organisations in supporting mental health within communities, and this was put beyond all doubt by their response to Covid-19 (CQC, 2020).

The pandemic presented an unprecedented and rapidly evolving situation that put exceptional strain on the NHS. VCS organisations brought invaluable skills and expertise to the crisis. They demonstrated their ability to respond quickly and flexibly, finding creative ways to support vulnerable people and easing the demand on statutory services. They did this while facing significant challenges of their own, especially in terms of financial security and staff wellbeing. And their hard work continues: demand for mental health services is forecast to rise as access to emergency funding falls (Royal College of Psychiatrists, 2020; GLA, 2021; Nottingham Trent University *et al.*, 2021c; ONS, 2021, O'Shea, 2021).

The London Recovery Board has set out a vision to "build back better" from Covid-19, and supporting the mental health and wellbeing of all Londoners is one of the 'missions' at the centre of this ambition (GLA, 2020). We know this will not be possible without a flourishing VCS.

Definition of terms: Voluntary and community sector

The term 'voluntary and community sector' covers a broad range of organisations. While acknowledging the difficulties of finding an adequate definition, the NCVO Civil Society Almanac sets out six criteria that characterise VCS organisations:

1. Formality: They are formalised and institutionalised to some extent, with a recognisable structure, and a constitution or a formal set of rules.
2. Independence: They are separate from the state and the private sector.
3. Non-profit distributing: They do not distribute profits to owners or directors but reinvest them in the organisation or use them for the benefit of the community.
4. Self-governance: They are truly independent in determining their own course.
5. Voluntarism: They involve a meaningful degree of voluntary participation through having, for example, a trustee board, volunteers, and donations.
6. Public benefit: They have social objectives and work to benefit the community.

(NCVO, 2020)

The purpose of this report is to learn from the experiences of the pandemic to enable London's VCS organisations to thrive in the recovery phase and beyond. What have been the effects of Covid-19 on mental health services in the VCS? What lessons have been learnt from new ways of working during the pandemic, both in terms of what helps and what hinders service delivery? How well is the relationship between the VCS and statutory services working, and is there room for improvement? What new challenges and opportunities are on the horizon?

This report begins with a more detailed discussion of the role of the VCS in delivering mental health services and the impact of Covid-19. It then outlines the research – an engagement exercise with statutory services and VCS organisations in London – and presents the findings. In the closing section, it considers the implications of these findings for the recovery phase and beyond, with recommendations for how London can enable organisations in the VCS to work to their full potential.

The role of the VCS in delivering mental health services

At the outset, it is important to acknowledge that the VCS and statutory services are large and diverse sectors. This report will discuss the sectors in general terms, while noting that the points it makes will not be equally true for all organisations at all times.

Strengths of the VCS

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

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

Addressing the social determinants of mental health, and working across traditional clinical and disciplinary boundaries

There is a growing awareness of the social determinants of mental health, an awareness that "many of the causes and triggers of mental disorder lie in social, economic, and political spheres – in the conditions of daily life" (WHO, 2014). This means people who are labouring under burdens of oppression, discrimination and marginalisation are also at higher risk of mental health problems (Centre for Mental Health, 2020a). The London Health Inequalities Strategy recognises the complexity of this relationship, stating that "poor mental health is both a consequence of inequality and disadvantage and a cause of it" (GLA, 2018).

A broader understanding of the causes of poor mental health goes hand in glove with a broader understanding of how mental health problems can be prevented and treated. Clinical interventions when things go wrong are only one part of a bigger picture. It is a matter of addressing not only people's symptoms, but also their social, economic and environmental circumstances; and of stepping in *before* people become unwell, working preventatively to help people maintain wellbeing, as well as treating difficulties when they arise (Allen *et al.*, 2014). This is reflected in the London Health and Care Vision's ambition to "adopt a more holistic and positive approach to mental health, tackling the stresses that cause people to get ill – like poverty and violence – as well as the symptoms" (Healthy London Partnership, 2019).

These approaches are well established in the VCS, where organisations have a long history of working across traditional clinical and disciplinary boundaries. In a review of the Mental Health Act, the Government noted the valuable contribution made by the VCS, not only in terms of support for people in crisis, but also in terms of prevention for those at risk, by helping them address issues such as debt, difficult relationships and poor housing (HM Govt, 2018). Similarly, a report by the Institute of Health Equity (2017) notes that: "The voluntary sector makes significant impacts on the social determinants of health, improving health and reducing health inequalities – even those charities whose primary purpose and remit may not be directly health-related."

In comparison to statutory services, VCS organisations often:

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

These characteristics mean that, compared to statutory services, it is often easier for VCS services to wrap around the needs of their service users, working holistically to address not only the symptoms of mental ill health, but also many of its root causes.

Advancing equality, diversity and inclusion

We know there are certain groups who are less likely to access statutory services than others. These include people from racialised communities, older adults, and asylum seekers and refugees (Goward *et al.*, 2006; Asthana *et al.*, 2016; Balaam *et al.*, 2016; Codjoe *et al.*, 2021). There is much overlap between those who are less likely to access statutory services and those who experience marginalisation, discrimination and oppression (Priebe *et al.*, 2013; Nazroo *et al.*, 2020).

The reasons for lack of engagement include:

- Mistrust of statutory services
- Linguistic and cultural barriers
- Services which are not culturally informed
- Greater likelihood of experiencing traumatic pathways into statutory services (e.g. via the police)
- Greater likelihood of traumatic experiences within statutory services (e.g. restriction of freedoms by compulsory admission)
- Evidence of structural racism within statutory services
- Stigma within communities around accessing mental health services (Memon *et al.*, 2016; NICE, 2017; Satinsky *et al.*, 2019; BMA, 2021; Codjoe *et al.*, 2021; Harwood *et al.*, 2021).

People who are unwilling or unable to engage with statutory services may be more accepting of support from VCS organisations. VCS organisations are often particularly successful at:

- Building trusting, respectful relationships with service users
- Offering flexible services that wrap around the needs of the people they are intended for
- Empowering service users to take active roles within the organisation (e.g. as peer supporters or as members of an interview panel)
- Taking a strengths-based approach
- Working in ways that are appropriate to a person's cultural background (Flanagan & Hancock, 2010; Centre for Mental Health/ Association of Mental Health Providers, 2019).

As a result, as Newbigging and colleagues (2020) have noted, VCS organisations play an important role "in advancing equality by facilitating access to support to people from disadvantaged groups who may be reluctant to access public sector services".

Offering choice, consulting with service users and adapting to changes

People have different needs and preferences when it comes to mental health support and these can change over time. One way to increase the probability that an individual will find appropriate support is to have a wide range of services available. Mental health services need to be as diverse as the people they serve and the circumstances they operate in.

The VCS makes a significant contribution to the diversity of the mental health system. Statutory services specialise in medication and talking therapies delivered in settings that are often formal and clinical. These forms of support are appropriate for some, but not for all. The VCS expands this offer to cover different forms of support (e.g. nature-based therapies), different contexts for engaging with people (e.g. at their places of worship), and different organisational structures (e.g. more peer-led services and co-produced services).

Another way to ensure individuals can find a form of support suited to their needs and preferences is to give them a voice in service design. Coproduction results in services that are closely aligned with the needs of the people who will be using them. Its other benefits include:

- An improved sense of belonging to local groups and networks
- Reduced stigma
- Reduced inequalities in care
- Improved access to care
- Increased skills and employability
- Reduced need for emergency health care
- Improved physical and mental wellbeing (New Economics Foundation, 2013; NCCMH, 2019a).

While statutory services are beginning to recognise the value of coproduction (see for example NCCMH, 2019a), the VCS has a long history of listening to the voices of the people who access its services and of collaborating with them in service design (NPC, 2016).

Coproduction is not a one-off activity but a continuous process. There is an ongoing dialogue between organisations and their service users. Organisations that work in this way must learn to be open to change, and able to respond to feedback and unexpected developments.

Greater responsiveness and flexibility have been identified as strengths of the VCS, in comparison to statutory services. The VCS has a strong reputation for innovation and for adapting to changing circumstances (Hogg & Baines, 2011). This has been an asset in emergencies such as the Grenfell disaster where VCS organisations were able to mount a quick and pragmatic response (Muslim Aid, 2018).

Definition of terms: Coproduction

"The term coproduction refers to a way of working where service providers and users work together to reach a collective outcome. The approach is value-driven and built on the principle that those who are affected by a service are best placed to help design it."

(Involve, n.d.)

Overview: The strengths of the VCS

In general and in comparison to the statutory sector, VCS services are often:

- More open to new approaches
- More flexible, able to respond quickly and creatively to changes
- More holistic, able to work across traditional clinical and disciplinary boundaries
- More successful at engaging people seldom seen by statutory services
- More effective at building trusting, empowering and equitable relationships with their service users
- Better able to offer ongoing, less formal support with fewer barriers to access
- Better placed to tackle the social determinants of mental health.

(NPC, 2016; Centre for Mental Health/Association of Mental Health Providers, 2019; Cresswell-Smith *et al.*, 2021; Newbigging *et al.*, 2020)

The relationship between the VCS and statutory services

The VCS has a long history of providing public services (Hogg & Baines, 2011; The King's Fund, 2017). Yet, despite the increasingly important role it has played in the health and social care system, the relationship between VCS organisations and statutory services has not always run smoothly.

Traditionally, the relationship has been one of 'command and control' (with the statutory services doing the commanding and controlling) (Addicott, 2013). Some commissioners have viewed the VCS in terms of the money it could save them, rather than the value it could add. As a result, the strengths of the VCS have sometimes been overlooked. In 2016, the New Philanthropic Council wrote of "worrying signs [...] that the full potential of the VCS is yet to be tapped" (NPC, 2016).

Changes in the policy context

The 2010s saw changes in the policy context that were conducive to developing the strengths of the VCS in the mental health system (The King's Fund, 2017; Newbigging *et al.*, 2020). There has been a growing recognition of the social determinants of mental health and the importance of addressing inequalities: for example, the NHS has set out an Advancing Mental Health Equalities Strategy, and the Long Term Plan has committed more resources to social prescribing (NHS, 2019 & 2020). There has also been greater emphasis on asset-based community development approaches, with the NHS Long Term Plan setting out an ambition for VCS organisations to play a more significant role in health care provision and for more care to be delivered closer to people's homes (NHS, 2019).

This has been backed by new policies, new funding and structural changes. For example, the National Collaborating Centre for Mental Health (NCCMH) has published a Community Mental Health Framework, outlining how this ambition will be realised in practice (NCCMH, 2019b). The Long Term Plan has pledged to bring £2.3 billion of extra funding to mental health services in England to facilitate the move to community-based mental health care (NHS England, 2021). And the introduction of Integrated Care Systems (ICSs) is intended to break down some of the barriers between the NHS, local authorities and the VCS, and between health and social care.

More locally, the London Health and Care Vision has stated an ambition to improve collaboration between different sectors "to ensure people receive coordinated support" (Healthy London Partnership, 2019). Thrive LDN brings together health and care leaders, residents, businesses and community and voluntary organisations to improve mental health and wellbeing in the capital (Healthy London Partnership, n.d.). And, as part of London's Health Inequalities Strategy's objective to empower Londoners to improve their health and wellbeing, "the Mayor would like to see both the public and private sectors making their facilities, resources and networks more available to help community and voluntary sector organisations" (GLA, 2018).

Thrive LDN

Thrive LDN is a citywide movement to ensure all Londoners have an equal opportunity for good mental health and wellbeing. At its core, Thrive LDN is a participation-driven partnership that engages with and responds to the needs and insights of Londoners. Thrive LDN is supported by the Mayor of London and led by the London Health Board.

Therefore, going into the pandemic, an ambition for greater collaboration between statutory services and the VCS was in place, as was some of the infrastructure necessary to make this a reality. However, new policies and strategies can take time to have an impact on practice. At the end of the decade, in 2019, mental health services were beginning to see signs of change, but authentic partnership-working across the sectors often remained more of an aspiration than a reality.

Covid-19

If, in the 2010s, improved system-working was an aspiration, in the 2020s it became a necessity. At the turn of the decade, NHS services were stretched to their limits and, during the pandemic, they were at risk of being overwhelmed (BMA, 2020). The pandemic added urgency to the need for the different sectors in the mental health system to work in a more integrated way.

The VCS played a critical role in supporting mental health within communities and lessening the strain on the NHS (CQC, 2020). It did this not only by providing extra capacity, but also by providing skills and expertise that were particularly necessary in responding to the challenges posed by the pandemic.

First, the pandemic has been, and continues to be, a rapidly evolving situation. Many VCS organisations responded quickly and creatively, finding ways to continue providing support in changing circumstances, using their knowledge of, and relationships with, local communities to help identify people in need of support (The King's Fund, 2020). Second, there is evidence that informal, community-based services, including peer support schemes, telephone check-ins and befriending, were of the most help in supporting the psychological wellbeing of Londoners during the pandemic (Thrive LDN, 2021). Third, the pandemic exposed and amplified the underlying inequalities in our society (Marmot *et al.*, 2020). It disproportionately affected marginalised groups, for example people from racialised communities, people with disabilities, and people with pre-existing mental health conditions (Centre for Mental Health, 2020b; IFS, 2020; Mind, 2020; Nazroo *et al.*, 2020; Thrive LDN, 2021). It also had a significant impact on many of the social determinants of mental health (e.g. people lost their jobs, went into debt and were unable to pay their rent or buy food) – determinants that, as discussed above, the VCS is often well-placed to address.

And many of these challenges are far from over. It is forecast that up to 10 million people in England, including almost 2 million Londoners, will need either new or additional mental health support as a result of the pandemic (O'Shea, 2021; Thrive LDN, 2021). The success with which the mental health system meets this demand will, to no small extent, depend on the health of the VCS.

Methodology

Rationale for the research

A flourishing VCS will play an essential role in London's recovery from the pandemic. Yet Covid-19 has taken a toll on the sector. The Greater London Authority (GLA) commissioned Centre for Mental Health to engage with VCS organisations and statutory bodies who provide or signpost to mental health support. The purpose of the exercise was to explore how they responded to the initial stages of the Covid-19 pandemic, how they worked collaboratively, what challenges they faced and what lessons they learnt. The research was carried out between February and July 2021, a period that covered part of the third national lockdown and a gradual easing of restrictions.

Approach to the research

Literature review

Information was gathered from published academic and professional literature, and from grey literature, including online information, practice guidance, government documents, evaluations and reports. Greater weight was given to literature published in 2021, when information relating to the pandemic's impact was less speculative; and greater weight was given to literature focusing on London.

Interviews

An opportunity sample was recruited through social media and the networks of the GLA, Centre for Mental Health, Healthy London Partnership and Mind in London. The inclusion criteria was working for a London-based service delivering frontline or ancillary mental health support. We conducted seven interviews with VCS organisations and two interviews with statutory services. Six of the VCS interviewees were CEOs of local branches of large, well-established national charities, and one was the CEO of a small, relatively new charity. The statutory service interviewees were involved in managing and commissioning mental health services.

Surveys

Survey recruitment followed the same lines as interview recruitment (see above) and the same inclusion criteria was used. The VCS survey received 30 responses, a majority of which (70%) were from CEOs or service directors. The size of the organisations is summarised in Table 1.

Table 1. The size of the VCS organisations that responded to the survey

Organisation size (Annual income)	Number (%)
Micro (‹£10k)	3 (10%)
Small (£10k-£100k)	3 (10%)
Medium (£100k-£1m)	14 (47%)
Large (£1m-£10m)	8 (27%)
Don't know	2 (7%)

The type of services provided by the organisations included talking therapies, helplines, befriending, advocacy, housing and employment support, welfare and benefits advice, safeguarding, meditation, and mental health education. Examples of the groups supported by the organisations included racialised communities, new parents and parents to-be, vulnerable/socially isolated adults, carers, people with autism, and women with a history of trauma/domestic violence.

The statutory services survey received two responses: one from a clinical psychologist at a mental health and wellbeing service, and one from a senior commissioning manager at a clinical commissioning group (CCG) who was also a member of an ICS.

Roundtable discussion

A roundtable event was held online after the research had been conducted to 'sense check' the findings and to explore the emerging themes in greater detail. There were 18 participants representing NHS organisations, local councils, grant-making trusts, voluntary sector services and umbrella bodies.

Findings

This section summarises the themes that emerged from the different strands of the research. These were:

- Demand for services
- Inequalities
- Workforce issues and staff wellbeing
- New ways of working
- Financial health and funding
- Relationships between VCS organisations and key stakeholders
- Relationships between VCS organisations.

Demand for services

In general, the organisations that took part in the research had seen increasing numbers of people seeking mental health support over the course of the pandemic and an increase in the complexity of people's presenting issues. VCS survey responses showed that:

- 90% agreed or strongly agreed that their organisation had seen an increase in the number of people seeking help for their mental health over the course of the pandemic
- 87% strongly agreed or agreed that their organisation had seen an increase in the complexity of mental health needs of people presenting to their service.

Services expressed concern about capacity and the ability of the system to safely support vulnerable people when services were overwhelmed. One VCS organisation told us, "Demand for [our] safeguarding work has also risen sharply, with more cases of concern and more pressure from statutory services to take on more. Demand has risen from 2-3 cases a week to several complex cases per day."

There have also been changes in the issues for which people are seeking support. For example, some organisations have seen an increase in demand for bereavement support; and, as a result of the pandemic's impact on job security and income, more people seeking help with employment, with benefits and with food poverty.

The trend seen by the people we spoke to was towards greater demand for mental health services during the later months of the pandemic. Organisations anticipated an even sharper rise in demand when in-person services resumed and people who had been unable or unwilling to engage online or by telephone began to seek support. This trend is in line with the findings of the London Community Response Survey: this weekly (later fortnightly) survey asked a cohort of civil society organisations about changes in demand for support with specific issues over the course of the pandemic. In 2021, the issue most consistently reported by the highest proportion of respondents was mental health (GLA, 2021).

Inequalities

We asked participants which groups among their service users had been more affected by the pandemic. Answers included:

- People from racialised communities
- People with severe and enduring mental health problems
- The digitally excluded
- The street homeless (especially young women in danger of exploitation)
- Older adults
- Carers
- People who were already isolated.

Where services already had targeted support in place for these groups, this was stepped up.

The people we spoke to from statutory services felt that VCS organisations had been able to reach people who might not otherwise have accessed support. They also reported that VCS organisations had played a significant role in providing practical support for issues that disproportionately affected people from

marginalised groups, such as social and housing services, and help with food insecurity. However, despite this good work, lockdown restrictions presented considerable challenges to supporting vulnerable people. Some of the VCS organisations we spoke to said that their outreach and advocacy work had been harder to carry out during the pandemic; and digital exclusion was a pressing concern when a majority of services were being delivered remotely.

Case study: Supporting the Black community – IRIE Mind

IRIE Mind spoke to us about their work during the pandemic supporting the mental health of the Black community in the Hackney area:

The African Caribbean Service launched in 2019. In 2020 came lockdown, everything changed overnight. We provided a wellbeing kit to give people things to read and do – stress balls, puzzles, tips on cost-effective healthy eating and looking after yourself. We were the first team in our organisation to go online providing our counselling service. Our cooking group went online – people joined in from home. We have a women's group for trauma, a counselling service, an IAPT service, most interventions are culturally specific. Our entire team is Black. We have seen about 200 clients.

During the lockdown Hackney Council gave us a lot of referrals – anyone who was struggling, they would say "Speak to IRIE Mind".

We have created a 'This girl can' group for young women aged 16-25. It supports positive body image and the support is co-produced by two young women aged 19 and 22. They produced kits for the girls with sponsorship from Dove and Lush, which both provided items to include along with positive affirmations for young women to read and internalise for themselves.

We returned to the Centre in June. In the meantime a significant number of older Black men aged 50+ had been admitted to psychiatric wards because their community support had stopped during lockdown. We have been working so hard to link people in with help and support, and to help people install Zoom on their phones so they can receive the support.

The pandemic has generally affected the Black community much more than our white counterparts. I have had many more people that I know pass away than white friends.

While IRIE Mind has been available throughout, some people have been totally isolated because they were afraid of getting Covid and would not go out at all. At first we saw a lot of resistance to the vaccine but thankfully most have now had it. We helped with this; we organised the Hackney Public Health Director to come and speak. Many people did not know that she is a Black woman and GP, with experience of how diabetes affects the Black community. People were happy to listen and accept her explanations because she is Black.

We realise that people need more information online and we are developing a website for all mental health services across the Borough, with SWIM (Support Where It Matters) for older Black men and clients with drug and alcohol problems. We have support for the website from the CCG and African & Caribbean services. We know it's important to support each other as Black services.

We offer a hybrid service, we will continue with online. We plan to go back to face to face gradually over the summer, opening one day a week at first, holding the women's group on Fridays and restricting the numbers inside the building.

Workforce issues and staff wellbeing

Some of the greatest challenges faced by the organisations we spoke to related to staffing and staff wellbeing. On a practical level, there were challenges in securing enough trained staff to deliver services. Several organisations reported a reduction in staff capacity, owing to reasons related to the pandemic (e.g. self-isolation, child care issues, bereavement). At the same time, many have needed to increase capacity to meet rising demand and to implement new modes of delivery. Existing staff have had to quickly become competent in new ways of working and many have seen their caseloads increase. And, where services have recruited new employees or volunteers to help expand their capacity, they have had to be trained from scratch.

Moreover, this took place at a time when some of the usual safeguards against staff burnout were less available. Working from home made it more difficult to maintain a sense of team spirit. It also made it more difficult for staff to have boundaries around their work, especially when they were supporting people with high levels of need. Participants spoke of feeling like there was "never enough time in the day to meet everyone's needs," and how, "when you are working from home and you know people need you, it can be hard to take a break." Finding new ways to support staff wellbeing and maintain team spirit was a priority for many of the organisations who participated in the research.

However, the pressures of the pandemic have taken a toll on services and, in many cases, the reserves of energy and morale that enabled organisations to respond so quickly at the start of Covid-19 are now running low. Headlines in VCS-related publications have included: "Half of charity leaders consider quitting amid mental health crisis" and "Nine in ten charity workers have felt stress, overwhelm or burnout over the past year, survey shows" (Ecclesiastical, 2021; Third Sector, 2021). And more in-depth studies have expressed concern about the levels of anxiety and stress among VCS leaders and staff (ACEVO/MHFA, 2020; Clinks, 2020; NPC, 2020, GLA, 2021).

New ways of providing support

The biggest change for the organisations we spoke to was the transition from in-person to remote service delivery. Three themes clearly emerged from the interviews and the surveys: first, remote services have been a welcome addition to the working practices of many organisations. Second, the gain of remote services has not offset the loss of in-person services. Third, when restrictions ease, most organisations plan to adopt a 'blended' approach, retaining remote services and reintroducing in-person services.

First, the introduction of remote services. At the start of the lockdown, organisations acted quickly to adapt to the restrictions. 100% of the respondents to our VCS survey moved services online, and 80% also offered services by telephone. For most organisations, the initial transition from in-person to remote service delivery had been challenging and required a significant investment of resources: financial resources to purchase equipment and adapt work spaces, and human resources to train staff and to create digital safeguarding and data protection procedures, etc. However, once they had navigated the transition, many of the organisations found that remote service delivery opened up new possibilities.

The main advantage discussed by our participants was the potential to interact with service users in a wider range of ways, not only by video calls and telephone calls, but by WhatsApp groups and YouTube channels. In some cases, organisations had been using these platforms before the pandemic but only in an ad hoc way. Lockdown changed this, leading to a fuller and more systematic use of diverse apps and technologies. And, as a result, organisations developed new relationships, and improved existing ones, with people who preferred to interact with services digitally instead of face-to-face (e.g. new mothers for whom travel to and from services was often inconvenient).

Case study: Guidance on providing remote mental health support – Bromley, Lewisham and Greenwich Mind

In the early stages of the pandemic, when it became clear that in-person services would have to be suspended, Bromley, Lewisham and Greenwich Mind developed guidance on providing remote mental health support. The guidance was delivered in two interactive Zoom sessions. The training was designed to provide participants with the fundamental skills and knowledge they would need to safely and competently navigate the transition from in-person support to working remotely. By the end of the training, the intention was for participants to be able to:

- Recognise the similarities and differences between face to face and remote support
- Understand the different dynamics at play when using alternative forms of communication
- Effectively manage boundaries when delivering support remotely
- Manage risk and safeguarding when providing remote support
- Manage people's distress when providing remote support
- Make effective use of supervision and support in a remote context
- Effectively and safely facilitate online group support.

However, the gains of remote services did not offset the loss of in-person services during lockdown. Some services couldn't be delivered online – for example, advocacy services for people detained on mental health wards – and had to be suspended while social distancing measures were in place. Other services could be delivered online but at the cost of excluding some service users. For some, this was because they preferred in-person services. For others, it was because they were unable to access or use the technology needed to connect to services remotely. VCS organisations tried to overcome digital exclusion by, for example, buying laptops for service users and holding groups outdoors. But the organisations we spoke to were aware that vulnerable groups – for example, people living in poverty who were unable to afford digital devices, older adults who were unfamiliar with how to use the technology, people living in overcrowded accommodation who didn't have access to a private space for an online therapy session – were the ones who were most likely to miss out when services were delivered online.

"We desperately hope that we will be able to continue with in-person therapy because so much of our work cannot be delivered online."

(VCS survey)

Similar themes emerged from Mind's research into remote mental health services during the pandemic (Mind, 2021). Mind found that mental health services had acted quickly to move their support online. For some service users, such as those who had difficulties travelling, remote support had worked better than in-person services. For others, although remote support wasn't their preference, they felt it was better than nothing. And for others, remote support was unsuitable, owing to problems with technology, concerns about privacy and confidentiality, and greater difficulty communicating and forming a therapeutic relationship. Mind's report concludes: "People with mental health problems want to be able to choose whether they have appointments face to face, by phone, online or a mixture of these. This isn't a decision that they will make once and follow forever. Choice needs to be accompanied with flexibility."

And the organisations we spoke to reached a similar conclusion based on their own experience. One interviewee, speaking about the lessons her organisation had learnt from new ways of working, said, "The experience of the pandemic has influenced service design, especially understanding that there are a variety of ways to meet different needs, and the need to make the offer open to diverse communities." Although adapting to new ways of working was challenging and resource-intensive, now they have made the transition, few organisations are planning to abandon their remote services. A majority (77%) of VCS survey respondents said they would adopt a blended approach once Covid-19 restrictions were lifted, retaining remote services while also reintroducing in-person services, taking advantage of the best of both worlds and providing greater choice to their service users.

Financial health and funding

The picture that emerged from our research showed a split between the financial health of the VCS during the pandemic and its financial health in the longer term.

The main sources of funding of the VCS organisations we spoke to were charitable trusts and grants, contracts with NHS commissioning bodies, and contracts with local authorities. A majority of respondents to the VCS survey (70%) agreed or strongly agreed that their organisation had been able to access the funding they needed to deliver services, and a majority (83%) were confident that their organisation would still be able to operate in six months' time. Talking in more detail about their financial health during the pandemic, they reported that many funders had taken a more flexible, pragmatic and supportive approach, providing extra funds, loosening targets and extending contracts. Several organisations had also been able to access emergency funding made available by the Government. This eased the financial pressures on some VCS organisations during the early stages of the pandemic, allowing them to focus on delivering services.

The importance of these changes to funding has been reported by other research. According to Nottingham Trent University and colleagues (2021a), "The responses of funders have been a key feature of the Covid-19 pandemic response for [VCSs]. Many organisations recognise the creative and rapid responses funders made by providing emergency grants to help organisations through some of the early stages of the pandemic."

However, there were concerns about financial health in the longer term, especially as emergency funding was phased out. A common theme in the literature was the fear that the VCS was heading towards a "cliff edge in funding" (Clinks, 2020; NPC, 2020; Nottingham Trent University *et al.*, 2021a). And this was echoed by our research: when asked about their biggest concern for the coming year, almost half of the VCS organisations said funding. The people we spoke to anticipated a scenario in which demand for mental health services continued to rise but the funding and support for VCS services dropped off.

Some had already seen a return to shorter-term contracts and more competitive bidding processes. One interviewee said: "some commissioners have put [our VCS organisation] under pressure to tender for services which we are already delivering, which have worked well and don't need to be tendered. This level of competitive environment has not been helpful when trying to get back to a more 'normal' service experience for clients. Some commissioners are also asking 'what is new' in tenders when the 'new' element is simply getting back into the office."

Another noted that short-term funding (i.e. 12-18 month contracts) and last minute funding decisions are especially problematic when it comes to retaining staff. People who are recruited into posts with uncertain funding must be given appropriate redundancy notice before funding expires; and, by the time a decision is made to extend or repeat the funding, many of the best workers have already found new jobs elsewhere. There were also concerns among participants that, when funds are tight

in statutory services (as they are currently), the VCS is seen as an optional extra and statutory providers "eat up" all the contracts, only bringing the VCS in afterwards. A similar point is made by Newbigging and colleagues (2020): "There is [...] a sense that resources are being spread very thin and that often the [VCS] is seen as an afterthought or receives only the 'crumbs'."

Furthermore, there are signs that the challenges experienced by our sample of mainly medium and large organisations were even greater for smaller organisations. As one survey respondent said, "responding quickly to funding opportunities is resource intensive," and, as a result, at times when capacity is tighter than usual, smaller organisations may find it especially difficult to divert their resources into bid writing – a trade-off that larger organisations with dedicated business development teams do not necessarily face. A report by Clinks (2020) looking into the impact of Covid-19 on VCS services in the criminal justice system also suggests that smaller organisations have faced additional challenges to securing funding; and Newbigging and colleagues (2020) found indications that the likelihood of a VCS organisation obtaining grants goes up as the size of the organisation increases.

Relationships between VCS and key stakeholders

Before Covid-19

A large majority of the participants in our research were already working with organisations from the other sector – VCS with statutory services and vice versa – before the pandemic began. Many said they had seen signs of change in these cross-sector relationships in the late 2010s as new policies, strategies and system designs were introduced. But the organisations we spoke to noted that, before Covid-19, these changes were generally in their early stages and moving slowly.

During Covid-19

The pandemic accelerated changes in both the quantity and the quality of the relationships between VCS and statutory services. Our findings indicate that the factors driving this change included:

1. Statutory services being under great strain and, as a result, in greater need of extra capacity provided by the VCS
2. Some of the barriers to communication and collaboration between sectors being removed
3. A virtuous circle in which the more statutory services worked with the VCS, the more opportunities VCS organisations had to demonstrate their competence and expertise and, as a result, the more statutory services turned to the VCS as a trusted partner.

"Another helpful dynamic is the increasing recognition from 'health' (NHS Trust) that they aren't able to meet all the need themselves, and that they need to work with third sector and [local authorities] to develop the most effective services."

(VCS survey)

Almost all the organisations we spoke to had increased their involvement with the other sector during lockdown. The involvement took the form of more referrals: for example, 77% of the VCS organisations we surveyed agreed or strongly agreed that their organisation had seen an increase in the number of people referred to them by statutory services. The involvement also took the form of more communication, with widespread adoption of online meetings. Simply being around the same (virtual) table more often and engaging in more dialogue was, according to the people we spoke to, one of the biggest drivers of improvement in cross-sector relationships during the pandemic.

And improvement, not deterioration, was what many organisations reported. VCS survey responses to a question about their relationship to their funders included: "More communication, genuine concern and different offers of support in addition to funding." "Funders have been more supportive, not just give the fund and get on with it. They have kept in touch, kept us going with kind words and support."

Overview: Improved relationships between the VCS and key stakeholders during Covid-19 – what helped?

- More dialogue (facilitated by virtual meetings and more regular cross-sector communication)
- More trust (statutory services granting VCS organisations greater autonomy in decisions about service delivery)
- More equality (shared decision-making)
- More flexibility (adapting key performance indicators to reflect changing priorities)
- More support (a sense of common purpose)
- Less pressure (extended contracts)
- Less bureaucracy (relaxation of data requirements).

What contributed to these improvements? As discussed, greater dialogue was crucial, but so too were changes in contracts and in the dynamics of relationships. A majority of respondents to the VCS survey (60%) reported that their organisation's funders had relaxed or changed contractual arrangements during the pandemic. Going into more detail about the contractual changes, the two strongest themes were less pressure (e.g. more time to meet targets, extension of contracts) and more trust (e.g. fewer data requirements, being granted more autonomy in deciding the best way to respond to need).

Organisations also reported positive changes in terms of greater equality and collaboration. One VCS survey respondent said, "We were able to respond to the significant increase in needs. That has demonstrated our ability to adapt, respond and be trusted with developing new ideas. This has led to an increase in opportunities in co-developing further new ideas." Another spoke of "much more equity, thinking together about pathways, thinking about who's best to lead on particular approaches" and "an increase in partnership development of service models". And a roundtable participant said, "My experience locally in [my London borough] with the VCS during the last year or so has been a really positive one and it's been a real collective effort between the council and charities and the voluntary sector and businesses as well."

"Another helpful dynamic is the increasing recognition from 'health' (NHS Trust) that they aren't able to meet all the need themselves, and that they need to work with third sector and [local authorities] to develop the most effective services."

(VCS survey)

However, while there had been many positive developments, these were not seen by everyone or in all aspects of their cross-sector relationships. The people we spoke to told us that the balance of power, although shifting, was still heavily weighted towards statutory services – even where things had improved, there was still a "payer/provider" model and a "commissioning mentality". This often left organisations feeling like they were "being thrown bits of the system rather than being seen as a central part of the system".

In relation to this, a concern that was voiced repeatedly was lack of involvement of the VCS at the level of strategy and planning. Although some organisations had seen a move towards greater coproduction, this was the exception, not the rule. Few of the VCS organisations we spoke to felt that they had meaningful opportunities to influence decision making around mental health services at the early stages.

This mixed picture of cross-sector relationships during Covid-19, with improvements in some areas and ongoing challenges in others, is consistent with the findings of other research. The Association of Mental Health Practitioners, an organisation representing the VCS, reported cases of positive engagement with commissioners but also cases of cross-sector relationships fraught with difficulty (AMHP, 2020). And research by Nottingham Trent University and colleagues (2021b) found regional variation: "Whilst some [VCS] organisations have struggled to engage with the local authority, in other places [VCS] organisations and local authorities have collaborated in new ways to deal with the pandemic."

After Covid-19

Looking ahead to recovery from Covid-19 and beyond, a participant at the roundtable said, "I think effective working is looking at the practices we all achieved during this pandemic and trying to sustain those and the good relationships we've all formed with one another." Among the people we spoke to from statutory services, there was an appetite for ongoing collaboration. However, there was also an awareness of the challenges that need to be overcome – challenges that have been caused by, and that predate, the pandemic.

"I think there is a real risk, post-pandemic, that we go back to somewhere like where we were before with relationships."

(Roundtable discussion)

Before Covid-19, the transition to Integrated Care Systems (ICSs) was underway. The VCS organisations we spoke to viewed this change as a mixed blessing. On paper, the idea of breaking down the barriers between different mental health care sectors and of providing more care in the community is welcome. In practice, there are concerns about the large size of ICSs and the tight deadlines for delivering the Community Mental Health Transformation programme. These factors pose obstacles to genuine partnership working and coproduction with the VCS, and could exacerbate the power imbalance between the sectors, giving statutory providers even greater influence over where money flows in the mental health system. Also, change – even change for the better – comes at a cost. For example, VCS participants spoke of how new people and new roles were constantly emerging, and this made it hard to establish relationships and to keep track of the right person to talk to.

VCS organisations felt that the potential for ICSs to bring positive change is greatly dependent on two conditions. First, whether the transition to ICSs was backed by sufficient resources to enable statutory providers to build a good understanding of, and good relationships with, a range of providers in the VCS; and, second, whether this understanding and these relationships could be retained by the system for longer than it takes commissioners to change roles. If these conditions aren't met, it is unclear how ICSs will deliver meaningful improvements.

From the other side, statutory services spoke about the challenges they faced in collaborating with the VCS. Foremost among these was the fact that they are working within the constraints of limited time, tight budgets and exacting levels of accountability. While these constraints have grown, in part, out of the important aim of ensuring public money is spent responsibly and only invested in services that can be trusted, they create difficulties for statutory providers looking to work more collaboratively with the VCS.

"An online launch [of our VCS crisis recovery space] was a slow start, not because of demand but because of the lead-in time for statutory service teams to recognise that an additional resource was there. [We] did a lot of engagement work with NHS teams to boost awareness."

(VCS survey)

First, the VCS comprises a large number of disparate organisations. It can be difficult, given the competing demands on their time, for statutory providers to keep track of all the services available in their catchment area, and even more difficult to establish meaningful relationships with each of these services. Second, even when this knowledge and these relationships are in place, integrating them into coherent care pathways requires expertise in systems thinking – yet such expertise is not always available (McNab *et al.*, 2020). Third, limited time and high levels of accountability combine to create a risk-averse environment. Commissioners can end up favouring a narrow range of VCS providers that they know and trust – providers that are disproportionately likely to be larger, more well-established organisations that are closely aligned with the values of statutory services (RSA/NCVO, 2021; Nottingham Trent University *et al.*, 2021d). This can lead to smaller, newer, more diverse services being overlooked. As a result, greater collaboration with the VCS can come to mean deeper involvement with the same 'tried and tested' providers, rather than more involvement with the sector as a whole. Fourth, commissioners are tasked with delivering value for money. Owing to lack of data on return on investment (i.e. savings across the system generated by improved outcomes for service users), value for money is often equated with cheapness of tender (Centre for Mental Health, 2021). This can make it hard for commissioners to recognise and prioritise the complex and diverse ways in which VCS organisations add value to the mental health system – ways that cannot be captured by such simplistic metrics.

As a result, even where there is a wish among statutory providers to work more closely and equitably with the VCS (and our research indicates that there is such a wish), there are obstacles to be overcome.

Relationships between VCS organisations

We also heard about the impact Covid-19 has had on inter-sector relationships. Overall, the picture was one of greater collaboration between VCS organisations. This took different forms: some organisations came together to form an influencing body, in order to amplify the VCS 'voice' in cross-sector conversations; and some larger organisations took on a 'sector development' role, sharing funds and skills with smaller VCS organisations. For example, one participant said, "[We] trained up other organisations to deliver support. Those organisations can then contact [our organisation] to bring in professional support for more complex issues."

"I guess the big lesson that we've learnt is that collaboration is vital."

(Roundtable discussion)

The motivation for inter-sector relationships also varied. For some, as discussed above, the purpose was to have more influence in cross-sector relationships. But, for others, they represented a way to be more independent from statutory services. One organisation spoke about the importance of being true to its values, saying that if they were unable to work coproductively with statutory services, with value being given to lived experience, they would choose not to work with them at all. Another participant said that, because many of their service users mistrusted local authorities and government, "it's important that we are seen as independent rather than a subsidiary of a large organisation".

The costs of close working relationships between the statutory services and the VCS is discussed at length in the literature, with Neville (2010) referring to it as a "double-edged sword". On the one hand, cross-sector relationships can open up income streams for VCS organisations, as well as raising their profile within the mental health system and, potentially, creating opportunities for them to influence strategic decision-making. On the other hand, cross-sector relationships can:

- Erode the distinctive characteristics of VCS organisations
- Result in them being perceived as a branch of the 'establishment' (hence affecting their trusting relationships with service users)
- Limit their freedom to speak critically of statutory services
- Compromise their value base
- Limit their capacity to innovate and adapt
- Place greater burdens on staff and volunteers, in terms of data collection and target monitoring
- Lead to short-term goals being prioritised (Osborne *et al.*, 2008; Hogg & Baines, 2011; Morris *et al.*, 2015; Centre for Mental Health/Association of Mental Health Providers, 2019).

These costs and benefits, and the various trade-offs they suggest, demonstrate there is no single optimal 'distance' between VCS organisations and statutory services. Some VCS organisations work extremely closely with statutory services, others are entirely independent, and the mental health system benefits from this diversity.

Discussion and recommendations

"There's been a lot, helpfully, thrown up in the air, and a cultural shift that must be sustained."

(VCS service provider)

The skills and expertise of VCS providers have long been valued by the communities they serve. However, their potential has not always been harnessed by the wider mental health system. This changed during the first 18 months of the Covid-19 pandemic. Many VCS organisations in London were able to react quickly and flexibly to the changing situation, consulting with their service users to come up with creative solutions to difficult circumstances. They not only provided extra capacity to an over-burdened NHS, but also a wealth of experience and knowledge in areas that were particularly necessary in responding to the challenges posed by the pandemic, such as supporting marginalised communities and addressing the social determinants of mental health. In many cases their ability to provide this support was facilitated by new ways of working with key stakeholders. Our research showed how crucial the changes in these relationships were to enabling VCS organisations in London to work to their full potential.

Looking ahead to the recovery phase of the pandemic and beyond, the need for the skills and expertise held by the VCS will be no less urgent. The toll of Covid-19 on people's mental health is forecast to continue to rise. And pre-pandemic targets to deliver more holistic and community-based mental health services remain in place. Fulfilling these needs and ambitions requires a flourishing VCS. Yet many of the organisations we spoke to were facing challenges, and some had seen signs that their key stakeholders were returning to pre-pandemic ways of working. At this vital juncture, how can London ensure that the learning from the last 18 months is retained, and that the VCS is recognised in its role as an integral part of the mental health system?

Commissioning, funding and evaluating services

During the pandemic, many of the organisations we spoke to had experienced more supportive and collaborative relationships with their key stakeholders. The forms this took included: improved dialogue; greater flexibility around contracts and data reporting; more autonomy to make decisions about service delivery; increased and extended funding with fewer restrictions; and a greater sense of working together as trusted partners with a common purpose. These changes gave VCS providers more freedom and stability which, in turn, enabled them to be more responsive to the changing needs of their service users.

Recommendations

1. Local government and NHS commissioners should work collaboratively with the VCS when planning services. This should include enabling VCS organisations to advocate on behalf of their communities without undermining their financial position.
2. Commissioners should offer funding models that support the stability, sustainability and diversity of the VCS – options may include long-term contracts, core and unrestricted funding, and grants.
3. Commissioners should create contracts for VCS organisations that enable them to work flexibly to meet requirements. This would enable organisations to make swift changes to their ways of working in future emergencies without putting their contractual position under threat.
4. Commissioners should work with VCS organisations to develop more appropriate monitoring and evaluation protocols. This may include greater use of qualitative data, peer research, and narrative approaches to understanding impact and managing performance.

Addressing equality, diversity and inclusion within the mental health system

The pandemic has exposed and amplified the underlying inequalities in our society. During what Nottingham Trent University and colleagues (2021d) have called "the summer of diversity and inclusion awareness", many organisations reflected on their own roles in racism and discrimination. VCS organisations were among them (ACEVO/Centre for Mental Health, 2019; ACEVO, 2020). Although some have work to do, other – especially smaller, grassroots organisations – have the potential to be leading lights in addressing inequalities, and giving a voice to those who experience marginalisation, oppression and discrimination.

It is therefore concerning that the VCS providers we spoke to reported few opportunities to influence decision-making in the health and care system. If this is the case for our sample of mainly large- and medium-sized organisations, it is likely to be worse for small- and micro-sized organisations. Moreover, the transition to ICSs could exacerbate this situation. The tight deadlines ICSs are working to for delivering the Community Mental Health Transformation programme, combined with their large size, may pose obstacles to genuine partnership working and coproduction. It is crucial that they are able to overcome these obstacles and work, not with the easiest partners in the VCS (large, 'tried and tested' providers who are culturally similar to statutory services), but the *right* partners (those who truly reflect the diversity of the communities they serve).

Recommendations

5. Integrated Care Systems should embed mechanisms to include VCS organisations in their governance and decision-making processes. This must be at 'place' as well as 'system' level, to ensure the voices of VCS organisations are heard at every level of the new health and care system. VCS organisations working with communities that have not had equity in access to appropriate mental health services need to be prioritised in this regard.
6. Integrated Care Partnerships should include members from a range of VCS organisations representing communities and groups that experience the most significant health inequalities.
7. The Government should extend the remit of the CQC to inspect and review commissioning practices, to hold Integrated Care Boards to account for the extent to which they identify and address health and care inequalities in their decision-making and resource allocation.
8. Health and Wellbeing Boards should work closely with the VCS when carrying out Joint Strategic Needs Assessments.

Amplifying the voice of the VCS and strengthening the sector

Finally, the organisations we spoke to emphasised the importance of relationships within the sector. As noted above, the large size of ICSs may make it increasingly hard for VCS organisations – especially those that are small – to have their voices heard in conversations about the mental health system. There are also concerns that, as the VCS works more closely with statutory services, its distinctive characteristics may be eroded. To counter this, some of the larger VCS providers we spoke to had been sharing skills and commissioning services from smaller, more diverse organisations. And other VCS organisations had come together to form influencing bodies to amplify the voice of the VCS in cross-sector conversations. In these ways, they were working to strengthen the sector from within.

Recommendations

9. Charitable funders and larger VCS organisations should build partnerships with smaller community- and user-led organisations that amplify their voices and create a more level playing field for groups that have been marginalised or disadvantaged.
10. Thrive LDN should explore ways of supporting VCS organisations across the capital to share intelligence, resources and innovations which build capacity and resilience within the sector.

Strengths and limitations of the research

The period when this research was carried out overlapped with the third national lockdown and its aftermath. Many organisations were overstretched and unable to spare the time to be interviewed or to complete a survey. Those that did participate may have been facing fewer challenges (and had more time to spare), and/or they may have had stronger feelings about the subject of the research (and been more motivated to participate). Those that did participate were disproportionately likely to be large or medium in size compared to the UK sector as a whole (74% of our sample compared to 18% of the sector (NCVO, 2020)).

To mitigate the effects of these biases, the report situates our data in the context of findings from other research. (Although, where data were available, most were, like ours, obtained from relatively small self-selected samples.) We also held a roundtable event to 'sense-check' the themes that emerged from the surveys and the interviews. That these themes were frequently in accord with the data and the experiences of others gives cause for confidence in their robustness. Nevertheless, this was a small-scale study, and further research is needed to more firmly establish the validity of our findings.

Special care needs to be taken when applying these findings to smaller VCS organisations, which were underrepresented in our sample. Research indicates that the challenges faced by small and micro organisations during the pandemic were different from, and greater than, those faced by larger organisations, including difficulties resourcing remote working, obtaining funding, and building relationships with statutory services (AMHP, 2020; Nottingham Trent University *et al.*, 2021b; RSA/NCVO, 2021). They may also make a contribution to the mental health system distinct from that of larger organisations (Hogg & Baines, 2011; IPPR, 2016; The King's Fund, 2021).

Finally, the focus of this report has been on the way mental health services in London worked during the pandemic. Covid-19 has been a major force driving changes and innovation in the mental health sector over the last 18 months, but it has not been the only one. The pandemic has taken place against the backdrop of the transition to ICSs which, in turn, have emerged from wider ambitions to deliver mental health support closer to people's homes, and to break down some of the traditional barriers between different sectors of the mental health system. Different areas within London are at different stages in this journey, with many success stories as well as places where there is room for improvement. There has not been space to discuss this wider context in detail here. However, what is lost in complexity is made up for in clarity. By having a narrow focus on the pandemic, this report has been able to identify lessons that can be carried forwards to the recovery period and beyond.

Conclusion

This report began with the Mayor of London's ambition in 2018 for "all Londoners [to] share in a city with the best mental health in the world". Three years on, it is forecast that almost 2 million Londoners will need either new or additional mental health support as a result of the pandemic. For some this will mean formal interventions delivered in a clinical setting directly addressing the symptoms of mental ill health. But for others the most relevant and effective forms of support will look very different. For these Londoners – among them, those who experience the greatest social disadvantages and health inequalities – VCS mental health services are a lifeline, providing support that is community-based, culturally appropriate, holistic, empowering and embedded in trusting relationships.

If London is to deliver a responsive, effective and truly inclusive mental health offer, it is clear that the VCS has a key role to play. The good news is that the skills and expertise are already in place: the city is rich in dynamic and capable VCS organisations with deep roots in the communities they serve. It is now a question of tapping their potential, supporting them to continue to deliver services in the ways they know best, and ensuring their voice is heard at every level of the mental health system, from service delivery to strategic planning. The last 18 months have pointed to ways in which this can be achieved. Can we maintain this momentum and "build back better"?

References

ACEVO (2020) *Home truths: Undoing racism and delivering real diversity in the charity sector.* [pdf] ACEVO. Available from: **https://www.acevo.org.uk/wp-content/uploads/2020/06/ACEVO_Voice4Change_home_truths_report_v1.pdf** (accessed 21 August, 2021).

ACEVO/Centre for Mental Health (2019) *In plain sight: Workplace bullying in charities and the implications for leadership. [*pdf] Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/plain-sight** (accessed 21 August, 2021).

ACEVO/MHFA (2020) *Workforce wellbeing in charities.* [pdf] ACEVO. Available from: **https://www.acevo.org.uk/wp-content/uploads/2020/12/Workforce-wellbeing-in-charities.pdf** (accessed 13 July, 2021).

Addicott, R. (2013) *Working together to deliver the Mandate: Strengthening partnerships between the NHS and the voluntary sector.* [pdf] The King's Fund. Available from: **https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/working-together-to-deliver-the-mandate-jul13.pdf** (accessed 30 June, 2021).

Allen, J., Balfour, R., Bell, R. and Marmot, M. (2014) Social determinants of mental health. *International review of psychiatry*, **26**(4), 392-407.

AMHP (2020) *Covid-19 and the VCSE mental health sector: Briefing paper.* [pdf] AMHP. Available from: **https://amhp.org.uk/app/uploads/2020/04/Covid-19-and-VCSE-MH-Sector-Briefing-Final.pdf** (accessed 14 August, 2021).

Asthana, S., Gibson, A., Bailey, T., Moon, G., Hewson, P. and Dibben, C. (2016) Equity of utilisation of cardiovascular care and mental health services in England: a cohort-based cross-sectional study using small-area estimation. *Health Service Delivery Research* **4**(14).

Balaam, M.C., Kingdon, C., Thomson, G., Finlayson, K. and Downe, S. (2016) 'We make them feel special': the experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood. *Midwifery*, 34, 133-140.

BMA (2020) *Measuring progress: Commitments to support and expand the mental health workforce in England.* [pdf] BMA. Available from: **https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-health-workforce-jan-2020.pdf** (accessed 16 August, 2021).

BMA (2021) *A missed opportunity: BMA response to the race report.* [pdf] BMA. Available from: **https://www.bma.org.uk/media/4276/bma-analysis-of-the-race-report-from-the-commission-on-race-and-ethnic-disparities-june-2021.pdf** (accessed 11 August, 2021).

Centre for Mental Health (2020a). *Mental health for all? The final report of the Commission for Equality in Mental Health.* [pdf] Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/mental-health-for-all** (accessed 17 October, 2021).

Centre for Mental Health (2020b). *Covid-19: Understanding inequalities in mental health during the pandemic.* [pdf] Centre for Mental Health. Available at: **https://www.centreformentalhealth.org.uk/publications/covid-19-understanding-inequalities-mental-health-during-pandemic** (accessed 17 October, 2021.

Centre for Mental Health (2021) *Now or never: A systemic investment review of mental health care in England.* [pdf] Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/now-or-never** (accessed 15 August, 2021).

Centre for Mental Health/Association of Mental Health Providers (2019) *Arm in arm: The relationships between statutory and voluntary sector mental health organisations.* [pdf] Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/arm-arm** (accessed 16 July, 2021).

Clinks (2020) *The impact of Covid-19 on the voluntary sector in criminal justice.* [pdf] Clinks. Available from: **https://www.clinks.org/sites/default/files/2020-12/The%20impact%20of%20Covid-19%20on%20the%20voluntary%20sector%20in%20criminal%20justice_0.pdf** (accessed 09 July, 2021).

Codjoe, L., Barber, S., Ahuja, S., Thornicroft, G., Henderson, C., Lempp, H. and N'Danga-Koroma, J. (2021) Evidence for interventions to promote mental health and reduce stigma in Black faith communities: systematic review. *Social psychiatry and psychiatric epidemiology*, 1-17.

CQC (2020) The state of health care and adult social care in England 2019/20. [pdf] CQC. Available from: **https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf** (accessed 02 August, 2021).

Cresswell-Smith, J., Macintyre, A.K. and Wahlbeck, K. (2021) Untapped potential? Action by non-governmental organisations on the social determinants of mental health in high-income countries: an integrative review. Voluntary Sector Review.

Ecclesiastical (2021) *Half of charity leaders consider quitting amid mental health crisis.* [online] Ecclesiastical. Available from: **https://www.ecclesiastical.com/media-centre/charity-leaders-consider-quitting/** (accessed 13 August, 2021).

Flanagan, S.M. and Hancock, B. (2010) Reaching the hard to reach - lessons learned from the VCS (Voluntary and Community Sector). A qualitative study. *BMC health services research*, **10**(1), 1-9.

GLA (2018) *The London Health Inequalities Strategy.* [pdf] GLA. Available from: **https://www.london.gov.uk/sites/default/files/health_strategy_2018_low_res_fa1.pdf** (accessed 12 July, 2021).

GLA (2020) *London Recovery Programme: Overview paper.* [pdf] GLA. Available from: **https://www.london.gov.uk/sites/default/files/recovery_programme_overview.pdf** (accessed 14 July, 2021).

GLA (2021) *London Community Response Survey.* [online] GLA. Available from: **https://data.london.gov.uk/dataset/london-community-response-survey** (accessed 09 July, 2021).

Goward, P., Repper, J., Appleton, L. and Hagan, T. (2006) Crossing boundaries. Identifying and meeting the mental health needs of Gypsies and Travellers. *Journal of mental health*, **15**(3), 315-327.

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall, J., MacCrimmon, S., Rimes, K.A., Woodhead, C. and Hatch, S.L. (2021) Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, 1-12.

Healthy London Partnership (n.d.) *Thrive LDN.* [online] Healthy London Partnership. Available from: **https://www.healthylondon.org/our-work/thrive/** (accessed 04 October, 2021).

Healthy London Partnership (2019) *Our vision for London: The next steps on our journey to becoming the healthiest global city.* [pdf] NHS England. Available from: **https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/10/London-Vision-2019-FULL-VERSION-1.pdf** (accessed 12 July, 2021).

HM Govt (2018) *Modernising the Mental Health Act: Increasing choice, reducing compulsion.* [pdf] HM Govt. Available from: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf** (accessed 01 July, 2021).

Hogg, E. and Baines, S. (2011) Changing responsibilities and roles of the voluntary and community sector in the welfare mix: a review. *Social Policy and Society*, **10**(3), 341-352.

IFS (2020) *The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK*. [online] Institute of Fiscal Studies. Available from: **https://ifs.org.uk/publications/14874** (accessed 02 July, 2021).

Institute of Health Equity (2017) *Voluntary sector action on the social determinants of health*. [pdf] Institute of Health Equity. Available from: **https://www.instituteofhealthequity.org/resources-reports/voluntary-sector-action-on-the-social-determinants-of-health/voluntary-sector-action-on-the-sdoh-evidence-review.pdf** (accessed 23 July, 2021).

Involve (n.d) *Co-production*. [online] Involve. Available from: **https://www.involve.org.uk/resources/methods/co-production** (accessed 11 September, 2021).

IPPR (2016) *Too small to fail: How small and medium-sized charities are adapting to change and challenges*. [pdf] IPPR. Available from: **https://www.ippr.org/files/publications/pdf/too-small-to-fail_Feb-2015.pdf** (accessed 18 August, 2021).

McNab, D., McKay, J., Shorrock, S., Luty, S. and Bowie, P. (2020) Development and application of 'systems thinking' principles for quality improvement. *BMJ open quality*, **9**(1), p.e000714.

Marmot, M., Allen, J., Goldblatt, P., Herd, E. and Morrison, J. (2020) *Build back fairer: The COVID-19 Marmot review*. [pdf] The Health Foundation. Available from: **https://www.health.org.uk/sites/default/files/2020-12/Build-back-fairer--Exec-summary.pdf** (accessed 16 August, 2021).

Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T. and de Visser, R. (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open*, **6**(11), e012337.

Mind (2020) *Existing inequalities have made mental health of BAME groups worse during pandemic, says Mind*. [online] Mind. Available from: **https://www.mind.org.uk/news-campaigns/news/existing-inequalities-have-made-mental-health-of-bame-groups-worse-during-pandemic-says-mind/** (accessed 30 June, 2021).

Mind (2021) *Trying to connect: The importance of choice in remote mental health services*. [pdf] Mind. Available from: **https://www.mind.org.uk/media/7592/mind-20582-trying-to-connect-report-low-res.pdf** (accessed 30 July, 2021).

Morris, R., Kirk, S., Kennedy, A., Vassilev, I., Mathieson, A., Jeffries, M., Blickem, C., Brooks, H., Sanders, C. and Rogers, A. (2015) Connecting local support: a qualitative study exploring the role of voluntary organisations in long-term condition management. *Chronic illness*, **11**(2), 140-155.

Muslim Aid (2018) *Mind the gap: A review of the voluntary sector response to the Grenfell tragedy*. [pdf] London Emergencies Trust. Available from: **https://londonemergenciestrust.org.uk/sites/default/files/uploads/Mind%20the%20Gap%20Report_Muslim%20Aid.pdf** (accessed 17 August, 2021).

Nazroo, J., Murray, K., Taylor, H., Bécares, L., Field, Y., Kapadia, D. and Rolston, Y. (2020). *Rapid Evidence Review: Inequalities in relation to COVID-19 and their effects on London*. University of Manchester, The Ubele Initiative, University of Sussex.

NCCMH (2019a) *Working well together: Evidence and tools to enable co-production in mental health commissioning*. [pdf] Royal College of Psychiatrists. Available from: **https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/working-well-together/working-well-together---evidence-and-tools-to-enable-co-production-in-mental-health-commissioning.pdf?sfvrsn=4e2924c1_2** (accessed 16 August, 2021).

NCCMH (2019b) *The community mental health framework for adults and older adults*. [pdf] NHS England. Available from: **https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf** (accessed 17 August, 2021).

NCVO (2020) *UK Civil Society Almanac*. [pdf] NCVO. Available from: **https://ncvo-app-wagtail-mediaa721a567-uwkfinin077j.s3.amazonaws.com/documents/ncvo-uk-civil-society-almanac-2020.pdf** (accessed 15 July, 2020).

Nevile, A. (2010) Drifting or holding firm? Public funding and the values of third sector organisations. *Policy & Politics*, **38**(4), 531-546.

New Economics Foundation (2013) *Co-production in mental health: A literature review*. [pdf] New Economics Foundation. Available from: **https://b.3cdn.net/nefoundation/ca0975b7cd88125c3e_ywm6bp3l1.pdf** (accessed 09 August, 2021).

Newbigging, K., Rees, J., Ince, R., Mohan, J., Joseph, D., Ashman, M., Norden, B., Dare, C., Bourke, S. and Costello, B. (2020) The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. *Health Services and Delivery Research*, **8**(29), 1-200.

NHS (2019) *The NHS Long Term Plan*. [pdf] NHS. Available from: **https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf** (accessed 12 August, 2021).

NHS (2020) *Advancing mental health equality strategy*. [pdf] NHS England. Available from: **https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf** (accessed 12 August, 2021).

NHS England (2021) *NHS England and NHS Improvement Board meetings held in common: Update on mental health services*. [pdf] NHS England. Available from: **https://www.england.nhs.uk/wp-content/uploads/2021/06/240621-board-meeting-item-6-update-on-mental-health-services.pdf** (accessed 13 September, 2021).

NICE (2017) *Innovative ways of engaging with Black and Minority Ethnic (BME) communities to improve access to psychological therapies*. [online] NICE. Available from: **https://www.nice.org.uk/sharedlearning/innovative-ways-of-engaging-with-black-and-minority-ethnic-bme-communities-to-improve-access-to-psychological-therapies** (accessed 17 July, 2021).

Nottingham Trent University, Sheffield Hallam University and NCVO (2021a) *Respond, recover, reset: The voluntary sector and COVID-19, March 2021*. [pdf] Centre of People, Work and Organisational Practice. Available from: **http://cpwop.org.uk/wp-content/uploads/sites/3/2021/03/NTU-Covid-voluntary-sector-report-Mar-2021_DIGITAL.pdf** (accessed 14 July, 2021).

Nottingham Trent University, Sheffield Hallam University and NCVO (2021b) *Respond, recover, reset: The voluntary sector and COVID-19, April 2021*. [pdf] Centre of People, Work and Organisational Practice. Available from: **http://cpwop.org.uk/wp-content/uploads/sites/3/2021/04/NTU-Covid-voluntary-sector-report-Apr-2021_DIGITAL.pdf** (accessed 14 July, 2021).

Nottingham Trent University, Sheffield Hallam University and NCVO (2021c) *Respond, recover, reset: The voluntary sector and COVID-19, May 2021*. [pdf] Centre of People, Work and Organisational Practice. Available from: **http://cpwop.org.uk/wp-content/uploads/sites/3/2021/05/NTU-Covid-voluntary-sector-report-May-2021_DIGITAL.pdf** (accessed 21 July, 2021).

Nottingham Trent University, Sheffield Hallam University and NCVO (2021d) *Respond, recover, reset: The voluntary sector and COVID-19, July 2021*. [pdf] Centre of People, Work and Organisational Practice. Available from: **http://cpwop.org.uk/wp-content/uploads/sites/3/2021/07/July-Report-v2.pdf** (accessed 21 July, 2021).

NPC (2016) *Untapped potential: Bringing the voluntary sector's strengths to health and care transformation*. [pdf] NPC. Available from: **https://www.thinknpc.org/resource-hub/untapped-potential-bringing-the-voluntary-sectors-strengths-to-health-and-care-transformation/** (accessed 21 July, 2021).

NPC (2020) *State of the sector 2020: How charities have reacted to Covid-19*. [pdf] NPC. Available from: **https://www.thinknpc.org/resource-hub/stots-covid/** (accessed 13 July, 2021).

O'Shea, N.(2021) *Covid-19 and the nation's mental health: May 2021*. [pdf] Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/covid-19-and-nations-mental-health-may-2021** (accessed 10 August, 2021).

ONS (2021) *Are we facing a mental health pandemic?* [online] ONS. Available from: **https://blog.ons.gov.uk/2021/05/05/are-we-facing-a-mental-health-pandemic/** (accessed 12 September, 2021).

Osborne, S.P., Chew, C. and McLaughlin, K. (2008) The once and future pioneers? The innovative capacity of voluntary organisations and the provision of public services: A longitudinal approach. *Public Management Review*, **10**(1), 51-70.

Priebe, S., Matanov, A., Barros, H., Canavan, R., Gabor, E., Greacen, T., Holcnerova, P., Kluge, U., Nicaise, P., Moskalewicz, J. and Díaz-Olalla, J.M. (2013) Mental health-care provision for marginalized groups across Europe: findings from the PROMO study. *The European Journal of Public Health*, **23**(1), 97-103.

Royal College of Psychiatrists (2020) *Psychiatrists see alarming rise in patients needing urgent and emergency care and forecast a 'tsunami' of mental illness*. [online] Royal College of Psychiatrists. Available from: **https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/05/15/psychiatrists-see-alarming-rise-in-patients-needing-urgent-and-emergency-care** (accessed 05 August, 2021).

RSA/NCVO (2021) *Meeting as equals: Creating asset-based charities which have real impact*. [pdf] RSA. Available from: **https://www.thersa.org/reports/meeting-as-equals** (accessed 06 August, 2021).

Satinsky, E., Fuhr, D.C., Woodward, A., Sondorp, E. and Roberts, B. (2019) Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, **123**(9), 851-863.

The King's Fund (2017) *Modelling excellence in the charity sector: Learning from 20 years of the GSK IMPACT awards*. [pdf] The King's Fund. Available from: **https://www.kingsfund.org.uk/sites/default/files/2017-09/Modelling%20excellence%20in%20the%20charity%20sector_2.pdf** (accessed 14 July, 2021).

The King's Fund (2020) *Tough challenges but new possibilities: Shaping the post Covid-19 world with the voluntary, community and social enterprise sector*. [online] The King's Fund. Available from: **https://www.kingsfund.org.uk/blog/2020/05/covid-19-voluntary-community-social-enterprise-sector-vcse** (accessed 03 August, 2021).

The King's Fund (2021) *Making an impact: Small and medium-sized voluntary sector organisations' responses to the Covid-19 pandemic*. [online] The King's Fund. Available from: **https://www.kingsfund.org.uk/blog/2021/01/small-medium-voluntary-sector-organisations-responses-covid-19** (accessed 18 August, 2021).

Third Sector (2021) *Nine in 10 charity workers have felt stress, overwhelm or burnout over the past year, survey shows*. [online] Third Sector. Available from: **https://www.thirdsector.co.uk/nine-10-charity-workers-felt-stress-overwhelm-burnout-past-year-survey-shows/management/article/1705083** (accessed 13 August, 2021).

Thrive LDN (2021) *Additional guidance on the mental health and wellbeing aspects of coronavirus (COVID-19) for London*. [pdf] Thrive LDN. Available from: **https://thriveldn.co.uk/wp-content/uploads/2021/01/The-impact-of-COVID-19-on-Londoners-mental-health-and-wellbeing-V8.4.pdf** (accessed 12 July, 2021).

WHO (2014) *Social determinants of mental health*. [pdf] World Health Organisation. Available from: **https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=F392EA24F9A06870A470304EDB86141B?sequence=1** (accessed 13 July, 2021).

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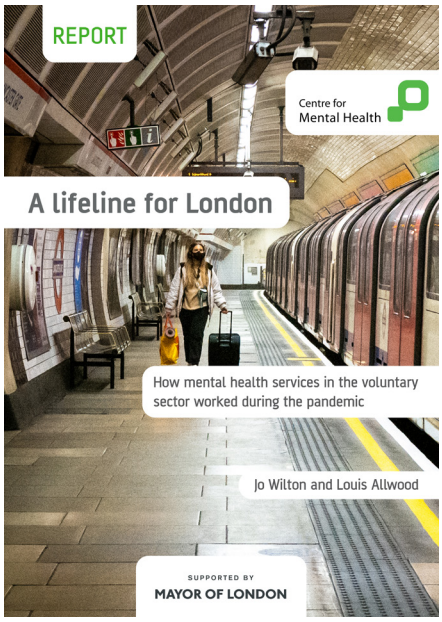

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