JOINT MENTAL HEALTH COMMISSION & HEALTH OF THE REGION CORE GROUP INTERIM TOPIC REPORT:

Topic 3: The Mental Health and Cost of Living Crisis

Introduction

This paper reviews evidence about the relationship between mental health and the cost of living crisis, drawing on national and international evidence about this topic and indicating potential mitigating actions at the regional and local levels.

What is the Mental Health Commission?

The West Midlands Combined Authority (WMCA) has convened a Mental Health Commission because of the strong consensus that the pandemic has undermined mental health in the West Midlands, and that this has been experienced unequally, with some groups experiencing bigger (negative) impacts than others. The people more likely to experience negative impacts included people living in areas of higher deprivation, people on lower or more precarious incomes, people from racialised communities (i.e. those from Black, Asian and other ethnic minority communities), people living with pre-existing mental or physical health problems, people with caring responsibilities, especially women, and children and young people.

As such the West Midlands MH Commission aims to support the pursuit of a mentally healthier region by:

1. Supporting a clear regional understanding of the differential mental health and wellbeing impacts of the COVID-19 pandemic on local people – at home, in education, at work and at play.
2. Understanding the response to the pandemic, particularly recognising and celebrating local innovation and good practice in supporting mental health & wellbeing;
3. Co-developing priority actions for the WMCA and partners to make further contributions towards a mentally healthier region, and to reduce inequalities in mental health.

It is fulfilling its role by exploring 6 priority topic areas which its members have chosen. The implications of the cost of living crisis is one of those topics. For more information on the Commission see https://beta.wmca.org.uk/what-we-do/wellbeing/west-midlands-mental-health-commission/.

What is the Health of the Region Core Group?

In October 2020 the WMCA, in collaboration with partners from across the health and wellbeing system, published the Health of the Region Report. It highlighted longstanding inequalities in the region and identified 4 interconnected challenges to tackling health inequalities and a collaborative framework for action:

1. Improving outcomes for ethnic minorities and vulnerable groups
2. Tackling the wider determinants of health
3. Widening access to health and care
4. Enabling people-powered health, i.e. enabling people to take control of their health.

The Health of the Region Roundtable was initially convened to understand the impact of Covid-19 on ethnic minority groups and is now a regional forum for communities to directly engage with health and wellbeing leaders on issues identified in the Health of the Region report and is Chaired by the Mayor. Action is driven forward by its independent Core Group with leaders and representatives from the health and wellbeing system including the WMCA and voluntary, community and faith organisations. The functions of the action-focused Core Group is to:

a) Act in advisory capacity to WMCA Health & Communities Team on health inequalities activity
b) Take collective action that adds value to existing work and aligns resources and influence of its members

The MH Commission and the Core Group have agreed to work together to identify local and regional action that can be taken to support local people during cost of living challenges.

The purpose of this document

This document sets out the initial findings and emerging recommendations from the third topic that the Commission explored, in September 2022, and further discussed with the Health of the Region Core Group. We are sharing this with interested parties to get initial feedback, which will then be used to stimulate action as well as being used to inform the final findings and recommendations of the Commission. Some key considerations are:

a) ***Findings*** – do they cover the key issues? Is there any further, substantive evidence or information available to further develop them, particularly in respect of the local issues?

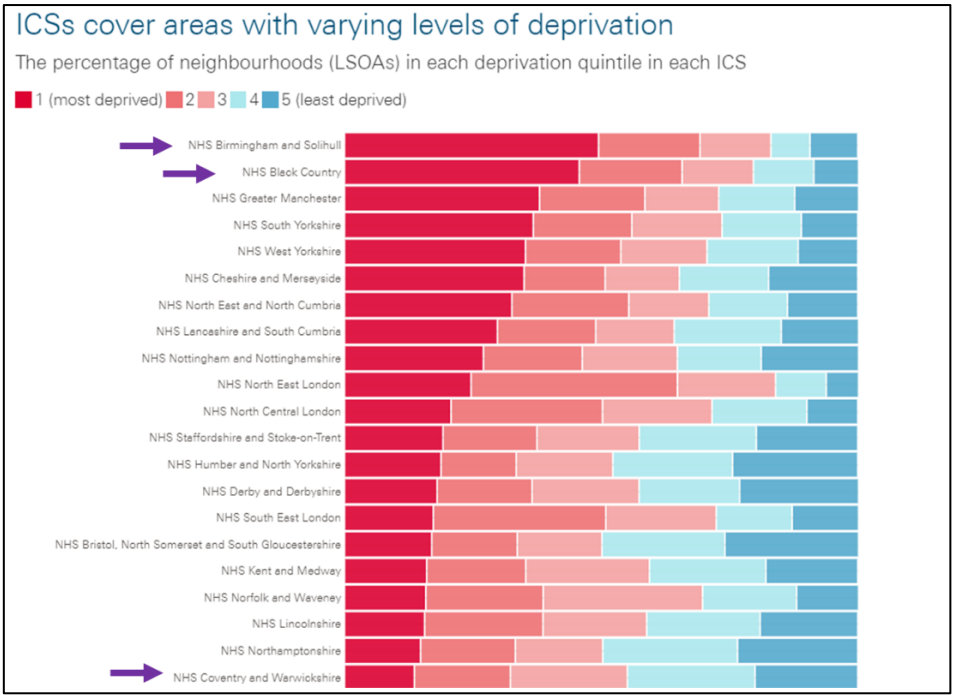
b) ***Recommendations*** – do they cover the key issues? What are the highest priority ones? How might the recommendations be delivered and involving whom?

Mental health and financial wellbeing

There is compelling evidence that financial wellbeing is a major determinant of mental health and the biggest single factor in explaining mental health inequalities. Mapping from the Government's Fingertips tool (originally created by Public Health England, now the Office for Health Improvement and Disparities) further shows a clear correspondence between rates of child poverty and poor mental health in different areas of the country.

Research has firmly established that poverty is associated with increased risk for at least 16 diseases, including psychiatric disorders, that form a 'cascade' of interrelated health conditions including later heart disease, lung cancer and dementia. It is clear that poverty is a key social determinant of health and illness and responsible for a large proportion of ill health, early deaths and costly health and care services.

Furthermore, deprivation is a particular challenge in the West Midlands, with Birmingham & Solihull ICS area having the highest proportion in the country of their population in the most deprived quintile and with Black Country ICS second highest. The remaining ICS, Coventry & Warwickshire, has the 21st highest proportion of the most deprived group out of the 42 ICSs nationally. (Please see diagram below).

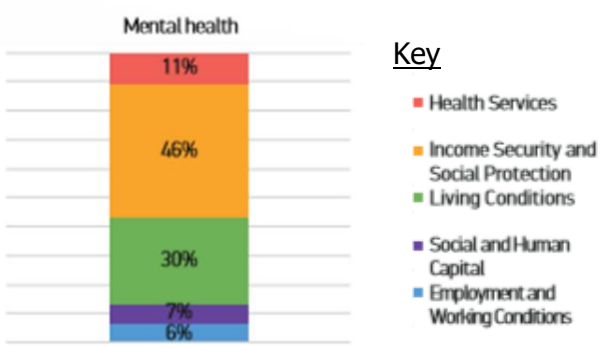


In 2020 researchers from the Massachusetts Institute of Technology (MIT) and Harvard University brought together the evidence linking poverty to mental ill health. They found multiple studies showing that job loss leads to reduced income and precedes episodes of mental illness. Evidence from 'natural experiments' confirms that this relationship is causal.

The most compelling causal evidence that poverty causes mental illness comes from randomised-controlled trials that evaluate anti-poverty programmes. The MIT / Harvard researchers cite several studies evaluating cash transfer and broader anti-poverty programmes which have found significant positive impacts on mental health, including over long time horizons, after the effects of any initial celebratory reactions among recipients have worn off. Across a wide range of populations and study designs, positive economic 'shocks' to individuals are shown to improve mental health, whereas negative economic shocks undermine mental health.

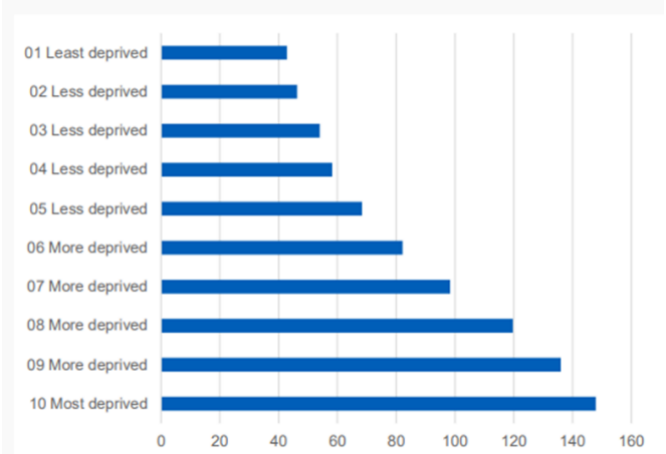
The adjacent chart, produced by the World Health Organisation, demonstrates the contributions in EU countries (2003 – 2016) from 5 conditions to mental health – highlighting the significance of income security and social protection.

Financial inequalities are the biggest influence on inequalities in overall health and wellbeing, and even more so for mental health, across Europe.



As such, there is evidence that indicates that detrimental changes in economic circumstances and poverty can *cause* mental illness. It therefore follows that raising people out of poverty reduces the risk of mental ill health and, presumably, taking steps to prevent people falling into poverty can have a preventative effect on the risk of mental ill health.

When looking at other facets of health – detention under the Mental Health Act, suicides and all physical illnesses (apart for sports injuries) – there is a clear correlation with levels of deprivation, as indicated in the adjacent graph.



Poverty increases the risk of experiencing multiple adverse childhood events (ACEs) which in turn leads to an increased risk of mental ill health. Research has indicated that ACEs are 5x more likely for the most deprived 20% of children.

When one has experienced multiple ACEs, there is an increase of negative outcomes, such as:

- Depression: +460%;
- Suicide attempts: +1220%;
- Intravenous drug use: +4600%

Intersectional inequalities

Poverty rates vary significantly by ethnicity, but all racialised groups are more likely to be living in poverty. This is due to lower wages, higher unemployment rates, higher rates of part-time working, higher housing costs in England's large cities (including Birmingham), and slightly larger household sizes. People from some racialised communities (i.e. people from Black, Asian and other ethnic minority communities) in the UK experience much poorer mental health outcomes than White British people, and this intersects with levels of poverty.

It is important to note that research indicates that racism, in itself and independently of poverty, causes and worsens mental ill health. Also, around 18% of Bangladeshi workers, 11% of Pakistani and Chinese workers, and 5% of Black African and Indian workers are paid below the National Minimum Wage, compared to 3% of White workers.

Poverty and financial inequality also intersect with gender, disability as well as other protected characteristics and consequently place some people at far greater risk of poor mental health than others. For instance, we know that a greater proportions of disabled households are in 'serious financial difficulties' - 29% compared to 13% of other households. Also, recent research has indicated that over half of disabled people surveyed were concerned that increasing costs would negatively affect their mental health.

Other societal implications

According to colleagues from the West Midlands Office of the Police & Crime Commissioner, there are indications of that the cost of living challenges are a driver for criminal activity, including –

- More theft
- Increased domestic violence
- Increased sex work (resorting to sex work; forced into sex work; 'sex for rent');
- Rising child exploitation;
- Increasing substance misuse / addictions as a coping mechanism;
- Increased loan shark activity.

Potential opportunities for action

A number of potential mitigating action areas were identified that might help to keep local people 'afloat' in the stormy waters associated with the cost of living challenges. There are a mix of potential immediate term and medium term timescales, which require 'system agility', collaboration and reduced bureaucracy.

1. Opportunities to increase income

1.1 **Pay a living wage** –

a) Take steps to encourage employers across different sectors to pay a living wage. This includes pursuit of accreditation by the Living Wage Foundation.
b) Take steps to encourage major employers to use their leverage and 'soft power' to encourage contractors to also pay a living wage.
c) Take steps to ensure that all jobs created in the region through investments, etc. are 'good jobs'.
d) Embed the aspiration in emerging ICS strategies on health inequalities and on 'people' / workforce.
e) Learn from local good practice (e.g. Birmingham City Council and Aston University) and also good practice from elsewhere in the country, e.g. work in London with NHS Trusts.

1.2 Skills development and career opportunities

a) To support better access to good jobs, to job retention and to career progression, by addressing discriminatory barriers. (Walsall Housing Group has done some positive work with a local college and a local NHS Trust to improve the recruitment and retention of local people in NHS jobs by changing advertising arrangements, using plain language, etc.).
b) To further promote existing and provide new skills development opportunities that help local people in good employment.
c) Exploring the potential to provide job guarantees for people who have been long term unemployed and for people who have had long-term social care support.

1.3 Driving social value in procurement

a) Systematic use of procurement levers to promote social goals, which lead to income ending up in the pockets of diverse groups of local people. Encourage the pursuit of this in key public and private sector organisations, learning from local good practice - the West Midlands OPCC have done some good work in this area. Work will include encouraging progressive practice and reducing risk aversion by commissioners, e.g. through myth busting activities.
b) Market management - enabling smaller community organisations to form consortia, etc. to bid for local contracts.

1.4 Maximising benefits take-up

a) Provide accessible, local (face-to-face and on-line) advice and support to enable local people to take up the benefits that they are entitled to, Healthy Start vouchers, etc. Walsall Housing Group has done some great work with their service users / tenants, helping them to access £5.6m worth of benefits that they were entitled to but had not taken up.
b) Train, develop and pay local people to act as 'connectors' or 'health champions' to link local people with various types of advice and support in a way that responds to cultural nuances and differences.

2. Opportunities to reduce costs

2.1 Explore rent controls, exploring learning from Scotland, etc.

2.2 Explore opportunities to reduce the costs of public transport

a) Subsidised and / or free transport for young people up to age of 25 and for some key workers;
b) Improve the frequency of buses;
c) Support with travel costs to access work, education, training, and leisure opportunities.
d) Actions to promote active travel.

2.3 **Funding for food costs;** including free dinners for those children most in need.

2.4 **Council tax relief -** We know that the West Midlands is the 3rd highest region for council tax arrears. Explore schemes to ensure people facing the biggest threats to their finances are not at risk from non-payment or legal action (which is costly in human and financial terms).

2.5 **Emergency support with energy costs;**

3. Other mitigating actions

3.1 **Pursuit of genuinely affordable housing** – consistently use strict / contractual levers to ensure delivery of good proportions of social housing in new housing developments and housing for key workers;

3.2 **Energy efficient housing:** more energy efficient genuinely affordable homes. Ongoing help for people to insulate their homes, reducing the costs of heating to those with the lowest incomes. (NB There is evidence that having a warm home has a direct and causal positive impact on mental health, with knock-on benefits to physical health).

3.3 **Advocating for more timely and supportive benefits processes -** impact of Disability Living Allowance backlog / PIP reviews

3.4 **Funding to enable community advice services** (delivered by VCS orgs), specifically supporting a local, physical presence and provision targeted to highly vulnerable sections of the population.

3.5 **How faith communities might support those affected**, e.g. by further developing further knowledge / understanding / skills in relevant areas;

3.6 **Make a case to central government for sustained local funding** – ringfenced funding for up to 12 months which allow local flexibility in use.

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4. Proposed Next Steps

4.1 In the spirit of 'deeds not words', some potential next steps are:

a) Briefing WMCA senior leadership, including the Mayor, about the issues and about the potential opportunities for WMCA mitigating action (by the end of November 2022);

b) Circulating the document to a range of stakeholders to 'stress test' the findings and potential action points (from late October 2022);

c) Continue to take steps to understand what local actions are being taken to support local communities;

d) Identifying and pursuing high priority 'quick wins' to mitigate the challenges of the cost of living crisis (from November 2022);

21st October 2022

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