CENTRE FOR MENTAL HEALTH

Rethink Mental Illness

EXERCISING OUR RIGHTS

Improving access to physical activity for people living with severe mental illness

Julia Doyle, Zoë McHayle, Katie Yau, Andy Bell and David Woodhead

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ACKNOWLEDGEMENTS

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A NOTE ON TERMINOLOGY

Severe mental illness: We have used the term 'severe mental illness' throughout this report to refer to severely debilitating mental health conditions such as schizophrenia and bipolar.

Place-based approaches: A place-based initiative delivers mental health support by addressing unique needs, assets, and challenges within specific local community environments.

EXECUTIVE SUMMARY

Access to leisure and sporting activities should be seen as an essential component of mental health support, not an add-on to clinical care. It can help people to achieve greater autonomy, connection with communities, social inclusion, and personal growth.

People living with severe mental illness have a life expectancy that is 15-20 years shorter than average in the UK (Chesney *et al*., 2014). This is a deep injustice, and predominantly the result of poorer physical health. Access to physical activity may help to reduce the health gap, as well as bringing numerous other psychological and social benefits.

In 2021, Sport England funded Rethink Mental Illness to deliver a place-based programme aimed at increasing understanding of local system-level barriers and enablers to physical activity among people living with severe mental illness. The programme was delivered in Tower Hamlets in London and North East Lincolnshire – two areas selected for their high levels of deprivation and health inequality, but also for their contrasting local contexts.

Rethink Mental Illness worked alongside stakeholders from the health, physical activity, and voluntary sectors in both sites to identify and challenge the barriers that prevent people from accessing physical activity opportunities and support. The project centred on working with key stakeholders to improve access, increasing awareness amongst leisure centre staff, and focusing on excluded groups.

The overarching objectives were to improve physical and mental health outcomes for people with long-term mental health difficulties and their families and carers; reduce health inequalities; and demonstrate how inclusive, community-led approaches could support people with severe mental illness to move more and feel better.

BENEFITS FOR INDIVIDUALS

Participation in structured sport and leisure activities can yield profound benefits and foster essential life skills that extend well beyond the intervention itself:

- Engaging in structured activities fosters a sense of agency, enabling people with severe mental health difficulties to reclaim autonomy over their wellbeing
- The act of participation itself – whether through movement, social connection, or creative expression – cultivates resilience, strengthens self-esteem, and provides relief from the constraints of isolation
- Engaging in sport and leisure activities can provide the psychological benefits of feeling valued, seen, and included, particularly for those whose experiences have been shaped by exclusion
- Physical activity enhances mood, improves overall health, and supports cognitive function, contributing to both mental and physical recovery
- When engagement is meaningful and sustained, the effects ripple outward – supporting not only individuals but also their families and communities.

Learning to be part of a team, developing problem-solving abilities, and gaining confidence in social settings can all make a material difference for people whose lives are frequently dominated by clinical systems and therapeutic frameworks. These physical activities provide an opportunity to build resilience, foster independence, and create a sense of belonging, all of which contribute to long-term personal development.

When resources, goodwill, and organisational capacity are aligned, sustainable and meaningful change is possible. By embedding skill-building within accessible and supportive environments, interventions can support people to reclaim their autonomy, develop relationships, and engage with the world in ways that enhance their overall quality of life.

THE IMPORTANCE OF SYSTEM CHANGE

People with severe mental illness face multifaceted challenges that impede their engagement with sport and leisure opportunities. Stigma, anxiety, and social isolation compound practical barriers such as financial constraints, accessibility concerns, and inadequate transport links. Fragmentation across services and a lack of cross-sector collaboration often mean that people struggle to navigate provision, leading to disengagement and exclusion from activities that could significantly enhance their wellbeing. Addressing these barriers requires proactive policy intervention and a sustained commitment to inclusive practice.

Unstable living arrangements, financial insecurity, and systemic marginalisation create barriers that cannot simply be overcome through standard leisure and sport provision. Interventions to increase participation must acknowledge these complexities, ensuring that commissioners' expectations align with what is genuinely achievable and sustainable. Without this sensitivity, well-intentioned initiatives risk exacerbating rather than alleviating exclusion.

Effective leadership is fundamental to the success of interventions designed to improve access to sport and leisure for people with severe mental illness and their family and carers. Strong leadership does not merely direct initiatives but listens – ensuring that lived experience, frontline expertise, and community insights shape decision-making. Engagement must go beyond consultation, building meaningful collaboration and prioritising adaptability and responsiveness. Without committed leadership willing to challenge entrenched barriers and advocate for systemic change, interventions may face stagnation or fail to address the realities faced by those they aim to support.

THE VALUE OF COPRODUCTION

People with lived experience played a pivotal role in shaping interventions, ensuring cultural appropriateness and providing ongoing accountability. For example, both sites successfully adapted leisure opportunities to reflect the diverse needs of local communities, resulting in improved participation and satisfaction. Elsewhere, sustained dialogue with service users provided essential feedback on the realities of navigating support systems, which enabled interventions to remain responsive to the evolving challenges faced by those living with severe mental illness.

Coproduction is central to the legitimacy and effectiveness of interventions. Done well, it empowers communities, amplifies lived experience, and fosters lasting change. However, when handled poorly, it devolves into tokenism – a superficial engagement that appears inclusive but lacks real influence. People with lived experience reminded us that effective coproduction requires power-sharing, transparency, and continuous dialogue. Without a genuine commitment to meaningful participation, interventions risk reinforcing exclusion rather than dismantling it.

SUSTAINABILITY CHALLENGES

Introducing new models within existing systems is rarely straightforward. Poorly resourced services and systems, administrative inertia, and resistance to change can significantly impede efforts to create sustainable interventions. And the intense pressure on mental health services exacerbates the challenge.

What's more, making a compelling case for change can be difficult when immediate needs overshadow long-term planning. Without robust mapping and clear strategies for systemic transformation, interventions risk remaining fragmented or underutilised. Structural change demands not only vision but persistence, ensuring that opportunities are effectively integrated within local infrastructures.

RECOMMENDATIONS

Our recommendations are set out at the end of this report for national and local policymakers, commissioners and service providers. The two key recommendations are:

- Organisations and partnerships should work alongside individuals and communities to develop strategies and approaches that meet people's needs. This must include actively reaching out to groups and communities that are most marginalised
- Charities and charitable funders should commit to working long term in place-based partnerships so that initiatives are sustained and communities can rely on their support long enough to generate meaningful system change.

INTRODUCTION

People living with severe mental illness have a life expectancy that is 15-20 years shorter than average in the UK (Chesney *et al*., 2014). This is predominantly a result of poorer physical health. People with a severe mental illness face higher than average risks of multiple physical illnesses, including diabetes, cardiovascular diseases, asthma, chronic obstructive pulmonary disease (COPD), and liver and kidney disease, with especially steep inequalities among young adults with a mental illness (Public Health England, 2018).

Access to physical activity may help to mitigate some of the many risks people with a mental illness face with their physical health, as well as offering multiple other benefits. But levels of physical activity among this group are lower than average (Vancampfort *et al*., 2017) for a wide range of reasons including symptoms of mental illness, side-effects of medications, co-occurring physical health problems and disabilities, and a lack of enjoyable activities that are affordable and close to home (Wilton, 2020).

SPORT & PHYSICAL ACTIVITY FOR PEOPLE WITH SEVERE MENTAL ILLNESS

Sport England funded Rethink Mental Illness to deliver a place-based programme aimed at increasing physical activity among people living with severe mental illness. The programme was delivered in Tower Hamlets in London and North East Lincolnshire. These two areas were selected for their high levels of deprivation and health inequality, but also for their contrasting local contexts, and the shared characteristics of having strong relationships between the voluntary and public sector service providers. The overarching objectives were to improve physical and mental health outcomes for people with severe mental illness and their carers; to reduce health inequalities; and demonstrate how inclusive, community-led approaches could support people with severe mental illness to move more and feel better.

To achieve these aims, the programme focused on designing and delivering a range of flexible, inclusive, and psychologically-informed activities. These were shaped by early engagement work, including focus groups and surveys, which explored the barriers people faced. These included low motivation, stigma, medication side effects, lack of confidence, and limited access to safe or culturally appropriate spaces. The activities were designed to respond directly to these challenges.

The purpose of the projects in each site was to identify and challenge systemic barriers. It therefore focused on working with key stakeholders to make access easier, to increase awareness among leisure centre staff, and to focus on excluded groups.

The projects used a range of different approaches to improve access to opportunities for sport and physical activity for people living with severe mental illness in Tower Hamlets and North East Lincolnshire.

The projects delivered comprehensive training for professionals, including fitness instructors and health care workers, designed to deepen their understanding of trauma, stigma, and the psychological effects associated with mental illness. This included collaborative work – known as coproduction – where health care professionals were actively involved in shaping conversations around physical activity. The project team contributed to several Physical Activity Clinical Champion workshops and promoted online sessions tailored for health care staff in areas such as Tower Hamlets and North East Lincolnshire. As a result, in their discussions about physical activity with people with severe mental illness, health care staff were able to acknowledge and better understand how the patients' mental health might be a factor in their willingness and ability to participate.

Equally important was the support offered to carers, whose involvement is vital in motivating and maintaining their loved ones' participation in activities. Carers received essential information, opportunities for peer support, and the chance to participate in activities alongside their loved ones. The project also ran coproduced training sessions for carers in the role of 'health influencers', equipping them with a broader understanding of the factors affecting both physical and mental health. This training empowered carers with practical approaches to improve their own wellbeing as well as the wellbeing of those for whom they care.

The different strands of the project often overlapped and supported one another. In North East Lincolnshire, for example, leisure centre staff received training on severe mental illness and exercise, and the leisure provider offered volunteer-led Swim Together sessions. These were inclusive swimming opportunities designed to foster social connection and participation. Leisure centre staff initiated a pilot mental health and exercise session, aiming to demonstrate the positive impact of physical activity on psychological wellbeing. Activities were also conducted during Mental Health Awareness Week, including setting up an information stand at the leisure centre. A wellbeing service was influenced to include people with severe mental illness in their exercise referral scheme, and Lottery funding was secured to support the expansion of this scheme.

At the heart of the programme was a commitment to coproduction. People with lived experience of severe mental illness, referred to as experts by experience, worked alongside practitioners (or 'experts by training'), to design, deliver, and reflect on the interventions. This approach ensured that the support was grounded in real-world insight and was relevant to people with severe mental illness and their carers. It also helped build trust, create a sense of ownership, and challenge traditional power dynamics in service design.

This programme was never just about sport. It was about fairness, inclusion, and the right to live a full and healthy life. It showed that when people with lived experience lead the way, and when the voluntary sector and local government work together, real and lasting change is possible.

Centre for Mental Health evaluated the programme using both quantitative and qualitative methods. We tracked changes in activity levels, confidence and wellbeing, and gathered personal stories to understand what made the biggest difference. The findings are being used to inform future policy and practice, with the aim of scaling up what worked.

Before the study commenced, our focus was on exploring and testing key elements that could enable effective collaboration between sectors and improve inclusivity in physical activity programmes. These included:

- **Coproduction approaches:** We sought to understand how involving people with lived experience in designing interventions could make them more relevant and empowering. Testing coproduction required adaptation of our methods to ensure mutual respect, clear roles, and shared decision-making
- **Collaborative frameworks:** The presence of strong local mental health alliances was identified as a potential enabler. We aimed to test how trusted partnerships between voluntary organisations and statutory bodies could create a foundation for tackling inequality and embedding programmes within local systems
- **Staff training:** Leisure centre staff were identified as a key touchpoint for participants. We explored how tailored training, including trauma-informed approaches and strategies for welcoming people with mental health difficulties, could improve participant experiences and foster organisational change
- **Leadership and facilitation models:** Project coordinators were hypothesised to play a critical role in holding together diverse programme strands. We tested strategies for managing cross-sector collaboration, addressing differences in priorities and processes, and maintaining momentum through flexible and community-led methods.

Our pre-study efforts focused on evaluating how these elements interacted and whether the barriers to participation, such as lack of motivation, communication challenges and systemic inequalities, could be effectively mitigated through intentional design and integration efforts across sectors.

HOW WE DID THE EVALUATION

Centre for Mental Health worked alongside Rethink Mental Illness to evaluate the projects. Both localities were also sites where we evaluated Rethink's mental health alliances (Treloar et al., 2024), which provides an important context for this evaluation.

We sought to understand, from the projects and people's experiences of them, what barriers and enablers people with a severe mental illness face to participating in physical activity, and how the barriers can be overcome by organisations working in localities. To do this we used:

- A survey of people with lived experience of severe mental illness: respondents included 15 from Tower Hamlets and 17 from North East Lincolnshire. Eight respondents were carers for a person with a mental illness, and one had experience of being both
- A literature review of existing evidence on this topic
- Interviews with project staff members, experts by experience and local stakeholders who engaged with the project (such as physical activity and mental health support providers, and community organisations). A total of 13 people participated in interviews
- Two focus groups with experts by experience in each site
- System mapping workshops with local stakeholders in each site
- A review of materials used during the project, to deepen our understanding of how the work developed in each site over time.

This report explores key themes from the evaluation.

BARRIERS AND ENABLERS TO PHYSICAL ACTIVITY

The project highlighted the barriers to physical activity faced by people living with a mental illness, as well as some of the way they could be overcome. Identified barriers – many of which reflected existing literature on the topic – included:

- Lack of social support
- Lack of welcoming environment or worries that an environment will be intimidating
- Negative or discouraging conversations with health care and other professionals
- Environments (whether urban or rural) which pose challenges to everyday or incidental physical movement
- Limitations on time and capacity for carers
- Symptoms of mental illness, and other related impacts such as the side effects of medications.

Interviewees also noted that fear of physical injury, psychological distress or worsening of mental illness symptoms were also potential barriers (Glowacki *et al*., 2017). Additionally, comorbidities including physical illnesses which restrict mobility, energy or capacity for physical activity can be a significant barrier to physical activity (Leyland *et al*., 2018).

For some people with a mental illness, a barrier to physical activity in a gym or leisure centre is its physical and social environment. One participant described a preference for *"quiet places with no music, no bright lights, low sensory environment, no requirement to speak to people or make eye contact."*

INEQUALITIES AND INTERSECTING ISSUES

Our interviews and focus groups also identified barriers to participation faced by people from racialised communities, whose experiences of mental health services and public services more widely are often shaped by racism, structural violence, marginalisation, and discrimination. The need to build trust locally between people from racialised communities and service providers appeared particularly imperative in Tower Hamlets, where residents have historically felt over-studied or have experienced a succession of interventions which were not sustainably embedded or funded.

For many women, there are additional barriers to physical activity:

> **"I enjoy swimming but there are not many places that do women's sessions often. It is normally on days when I am not available, or at times where it's inconvenient like night. The gym I am closest to has the men's section where women have to walk through to go to the women's area."**

"As a Muslim woman I naturally feel more comfortable in a women's setting, but also I feel if I get myself more used to mixed environments I'll be okay eventually with it. The women's space at the gym is not as good as the mixed one. Limited resources. Then there is body confidence issues, lack of knowledge about the activities, sport, gym equipment."

Such barriers may be especially acute for trans women, especially in the wake of recent official guidance about their access to such facilities.

It was also noted that having more than one mental health diagnosis could exacerbate such barriers. In the survey, the more mental health diagnoses a person has, the less time they spend per week walking and taking part in moderate-intensity and vigorous-intensity exercise. It must be noted, however, that the survey sample size was small, so we are unable to draw reliable conclusions from that alone.

BARRIERS FOR PROFESSIONALS

We also identified barriers for professionals when supporting individuals into beginning or increasing physical activity. Barriers which received the most focus during this project include:

- Lack of knowledge or confidence in discussing physical activity with people severely affected by mental illness
- Difficulties getting colleagues on board with new approaches to conversations around physical activity
- Challenges around staying up to date on available provision, especially if previous physical activity interventions or services have been underfunded or discontinued.

Barriers and enablers can often be two sides of the same coin. For example, social support is reported as an enabler for accessing physical activity, while a lack is reported as a barrier.

"The people that I've had conversations with [...] have mentioned that sometimes the only place in which they receive any information regarding physical health and physical activities [is] when they have the annual health checkup or when they visit hospital or other clinical settings [and...] sometimes it's a problem because it's not enough time [...] and it felt [...] like they were being reprimanded for not doing enough activity [or...] it was just receiving a leaflet and [being told], you should do this and that and that's it. So, there was no more encouragement, or no discussion of what options are available to them."

It was noted how rare it is for all the necessary conditions to align and enable people to initiate or increase their physical activity, precisely when it would be most advantageous for supporting their mental health.

PHYSICAL BARRIERS TO PARTICIPATION

Access to leisure facilities and the most appropriate locations for physical activity were also raised as major concerns. In North East Lincolnshire, poor public transport was a major barrier. Questions were also raised about whether mainstream leisure centres were the most appropriate location for people facing multiple layers of exclusion:

"I don't think the leisure centre was the place for people. I personally think if you're wanting people with severe mental health illness [to participate in physical activity], it needs to be within where they are. They're not gonna be coming out to a leisure centre."

COPRODUCTION

The projects in both sites prioritised coproduction from the outset. In both Tower Hamlets and North East Lincolnshire, the projects began with engagement sessions with experts by experience to gather insights and shape the projects' direction.

Coproduction was crucial for building more knowledge about preferences for the type of physical activity, as well as the range of choices that would be preferred. This aligns with findings in the literature review, which indicate that lived experience insights are essential to navigating the complexities of promoting physical activity for people with severe mental illness, especially to challenge health inequalities (Sport for Development Coalition, 2022).

Coproduction played out differently in the two sites, with experts by experience in both North East Lincolnshire and Tower Hamlets shaping distinct but overlapping sets of knowledge. In North East Lincolnshire, experts by experience played an important role in recruiting both additional experts by experience and survey participants. They were recruited to the project through their GP during a blood test required due to their medication – demonstrating how this recruitment route helped to identify the right people to engage in coproduction. It was noted that this widened the cohort to include those with less positive or neutral attitudes towards physical activity.

This expansion has been beneficial for the project, as initial recruitment was slow, despite a strong desire to hear from people who were not currently physically active. Some new members were also recruited from other Rethink Mental Illness projects. This increase in experts by experience also meant that people with a wider range of mental health conditions were represented.

Many of the main elements of the project in both localities involved coproduction at different levels. This included the creation of training for health care professionals; the development of role descriptions for the 'navigator' roles; and the shaping and marketing of targeted physical activity sessions for service users. In North East Lincolnshire, for example, insights from experts by experience helped to create the title 'Movement 4 Mental Health' for its pilot physical activity programme, and avoid stigmatising language.

There were challenges in sustaining a consistent group of experts by experience over time, which made it more difficult to maintain the same level of coproduction throughout the project.

The project teams made efforts to engage a representative group of experts by experience, for example by identifying demographic gaps among the first groups recruited and using snowball recruitment techniques to address these as much as possible.

BENEFITS AND CHALLENGES

Building relationships between experts by experience has been a noticeable success, with many consequent mutual benefits including informal peer support networks.

The experience of collaborating with local stakeholders also reportedly increased the confidence of experts by experience. It motivated them to engage further with the project and to recognise themselves as holders of valuable knowledge on the topic.

The experts by experience we interviewed told us they would feel more supported if they could rely on having another expert by experience with them in meetings with stakeholders; one interviewee reported feeling more vulnerable and exposed when another expert by experience dropped out of a meeting, leaving them as the only person in the room sharing details of their lived experience:

> **"I felt like the focus was just on me and I was really honest about bipolar and medication side effects [and how] that can be a barrier [to physical activity] and other reasons why. But it would have been nice to have another voice in the room with me."**

There have been some periods of great success in maintaining contact with experts by experience, where project staff went above and beyond to keep in touch with people to provide both project-related and wellbeing support. Many interviewees attributed this to specific staff members who made noticeable efforts to make their presence and availability felt. One focus group participant in North East Lincolnshire who worked closely with the local project staff member attributed high-quality coproduction work to this support:

> **"I think the support they had was absolutely fantastic. You know... they were never... made to feel sort of anxious or nervous or anything like that. And I think that that probably laid the foundation and enabled them to identify the issues that would prevent people from doing activities."**

One expert by experience in Tower Hamlets also had strong praise for the project team around their clear communication of the project's aims, and for emphasising that their insights were valued:

> **"I feel like I got a clear breakdown of [...] where we're going or what the vision was, what the goal was, and that helped me a lot. But I also liked how they allowed me to kind of add my own touch, so it wasn't, "it's this way and there's no other way around it" [...] they were quite welcoming and it felt like it was a collaboration. So, I felt like, OK, I am respected for what I bring to the table as well. [...] And it just felt like teamwork." (Person with lived experience)**

Sustaining coproduction over time was a challenge in both sites, for example due to changes in people's lives and short-term funding that made it more difficult to pay people for their time.

IMPACTS OF THE PROJECT ON PARTICIPANTS

The project helped to address some of the barriers to participation in sports and exercise. Providing training to experts by experience to become 'health influencers', for example, made it easier for other people to participate in physical activity:

> **"I'm not always able to finish [physical activities that I begin] because I realised that the kind of support I need to continue is not there. But here I've noticed that with [project staff member], the support was there and I felt that whatever I'm saying is being taken on board and it will make a difference."**

Feedback on the health influencer training emphasised that discussion around physical activity and being severely affected by mental illness was rippling out into attendees' families and communities, as a result of their learning and experience on the training:

> **"I... shared my knowledge that I've attended this, you know, and this is what I've learned [with] my children, my family and community. They took it more seriously because it came from a source which was [reputable]."**

Additionally, dialogue that occurred within the training between participants with lived experience of caring, of severe mental illness, or both, was reported to be particularly welcome and impactful.

Supporting engagement in the project could take time, and putting effort into that process was important to gain trust and encourage participation:

> **"So a lot of people would say, initially, "I don't want to take part... I'm not ready to take part. I can't do this at the moment". But having that link worker [who] has been able to have those conversations in just a coffee [shop] and build that up. So [...] we start with little steps."**

The project's goal was to understand barriers and drive local system change. The leisure centre activities gave previously inactive experts by experience a chance to try classes, swimming, and the gym, then provide feedback for improvement. Some participants felt the project offered limited activity choices; one mentioned attending the gym despite not really enjoying it, but found it unrewarding:

> **"I don't like the gym. I hate the gym. It's alright if there's somebody out there that I can talk to, I'll do it and I will make an effort and turn up, which I did. But it got to the point that I was going up every week and I was getting nothing out of it."**

Barriers such as cost and the potentially intimidating nature of dedicated exercise facilities were felt to be only temporarily addressed by the project and its pilots, highlighting once again the need for sustained and systemic approaches:

"We do have a number of people, first of all, that cannot sustain that after they've been to [pilot sessions at the leisure centre]. It's simply not affordable to them. The second thing is, when you start with [the pilot location], a lot of people will say I don't even know if I'm capable of doing that or it's a gym [...] I think sometimes you have to start with something else and not just [the pilot location] first. [They] maybe have to be built up to that."

Challenges around sustainability are not unique to this work but rather reflect some of the problems within the wider systems of social services, health care and the voluntary sector.

"The other thing for me as well is the sustainability of things. So again, you know this [other] project, it's been a pilot but you know, at the end of the day, it finishes in March and we've got 75 participants. And what do we say to those participants? What happens to them?"

Some of the experts by experience who participated in the project gained employment as a result of their involvement and having received training as gym instructors.

The overall success of the severe mental illness and exercise training, delivered to leisure centre staff, is evident in the positive impacts it has had on participants. Many reported feeling more mindful, empathic, and sympathetic, with a heightened awareness of the complexities of severe mental health issues and how these can influence fitness. A participant noted: "*It has made me more aware of the issues surrounding severe mental health and the way this affects fitness*". Gaining knowledge about the wide range of conditions within the mental health spectrum, participants felt better equipped to engage with clients, approach sensitive situations, and handle challenges with greater confidence and understanding. As one participant reflected, the training was, *"a fantastic package of learning,"* and its positive influence is expected to grow: "*the more people that could do a course like that, the message will get out there and you will gradually see more and more people changing their lives*."

SUMMARY OF 'HEALTH INFLUENCERS' COURSE FOR CARERS IN TOWER HAMLETS

In November 2024, Rethink's Physical Activity team partnered with Ad Lib training to deliver a health influencers course to carers and supporters of people severely affected by mental illness in Tower Hamlets.

The course was delivered in six 2.5-hour sessions over the course of four weeks, which worked well in terms of retention of participants. Each session was recorded – a specific request for carers who may not be able to attend all sessions due to caring commitments. There were also people on the course who have information processing challenges and needed to be able to revisit sessions at their own pace.

Recruitment was initially challenging due to staff changes, but the final cohort was diverse, drawing participants from various backgrounds and reflecting the local population. The online format using Zoom was effective; it accommodated carers' responsibilities and enabled broader access.

KEY LEARNINGS, 'HEALTH INFLUENCERS' COURSE FOR CARERS, TOWER HAMLETS

- Building trust and rapport from initial recruitment through course delivery was essential for participant engagement
- Flexibility, such as removing assessment requirements and recording sessions, helped to meet the unique needs of carers
- Providing a psychologically safe space with check-ins and trigger warnings enabled open, supportive discussions
- Supplementary resources like Padlet (an online tool with 'boards' to organise and share ideas) were valuable, though future iterations could usefully include more hands-on demonstrations
- Regular reminders and flexible delivery retained engagement over six sessions across four weeks.

Participants overwhelmingly reported a positive experience. As one participant noted, "I feel more confident at how to talk about the benefits of physical activity to a person with mental illness." Another highlighted, "This course I feel covered quite a lot over the six sessions, and it was well facilitated too". All but one participant agreed – or strongly agreed – that the course content was beneficial and identified practical steps to apply their learning in their own circumstances.

Overall, the course was highly valued, with participants noting its relevance, supportive environment, and applicability to their personal lives.

WIDER INFLUENCE AND IMPACT

A significant benefit of the project was the way in which it reached out to multiple organisations and formed partnerships and connections in each locality. These promoted a greater understanding of the needs of people with severe mental illness within sports and leisure services, where this had previously been overlooked.

> **"We've definitely taken a lot of learning from Rethink. It all started [with] a listening event [...] It was one of the most powerful meetings I've been to and when I left that meeting and some of my team leads were there, we actually came back to the office and reflected and actually then discussed the whole thing with our team to make sure that we were doing what we say we do."**

> **"We absolutely now have mental health champions. We have mental health first aiders. We are mental health friendly. Our teams are all aware [about things like] people's perception, walking into a big building. What does that look like for somebody?"**

The project also had to address the entrenched separation between mental and physical health services:

> **"In the early days and we set up in mental health services, it was like, well, 'no, we work with the mind. What are you doing taking bloods? Why are you checking somebody's blood pressure? What, you mean you're asking about physical health? That's not our job'. And it took quite a few years for a lot of my colleagues to appreciate that, well, it's all intertwined."**

In North East Lincolnshire, local stakeholders reflected on how this project has encouraged them to further collaborate and enter into more deliberate dialogue with other organisations around this topic:

> **"So, we actually do work closely with [the leisure facility project stakeholder]. So, it's great that... they're also a partner that has been around the table and having those discussions."**

> **"It's brought everybody closer together in actually what's happening on our doorstep. What is the community telling us? And it's about listening, understanding and being able to hopefully do something about that. Knowing where to go."**

In Tower Hamlets, the Rethink project team was able to feed in learning about barriers and enablers to the local authority in advance of them taking over leisure services from May 2024. This followed a period of time when the previous provider of leisure services had not engaged with the project, which slowed down progress in the borough.

In addition, Rethink influenced the physical activity needs assessment for the place partnership with London Sport (which Tower Hamlets leisure centres are involved with) to include people with severe mental illness as a priority group. And it was able to feed back on access difficulties for carers, which has been incorporated to ensure this group gets better access to facilities and opportunities in future.

Wider system involvement was not consistent, however: in one of the sites, participants noted a lack of engagement by the local NHS mental health service provider, which meant that people with severe mental illness who might have benefitted from the project were unable to do so.

Across the project itself, and through its evaluation, numerous stakeholders have discussed the nature of local systems mapping and the drivers of systemic change. An extended example of a discussion about the challenges of navigating local systems related to mental health is reproduced below. This is taken from the dialogue between participants in the Tower Hamlets experts by experience focus group.

A: "I call myself a person with severe mental and complex mental health but a functioning person, I can communicate, raise issues, you know. But where the people under my care, who have a kind of autism, come in the picture [or have] communication, interaction difficulties, [then] accessing these services is a major issue [...] For example, yesterday [we had] two calls from the assessment from a hospital and as soon it comes from private number, you can't call them back. No e-mail address is provided. So instead of solving or healing, it triggers stress [...] it makes me feel quite helpless."

B: "My son has both physical [and] mental health and a learning disability, and the times we get bounced from one to the other because nobody will take responsibility. It's always it's a mental health issue. No, it's not. It's physical. No, it's both. He doesn't meet their silos."

C: [about the system map diagram] "It looks confusing and in reality, it is."

The critical importance of sustainable funding to maintain systemic efforts and deliver long-term impact was a major theme in our evaluation. This highlights the fragility of initiatives which are dependent on external financial resources, and emphasises the need for resilient funding models.

Maintaining momentum in systemic initiatives often proves challenging as the initial energy and engagement can wane, requiring adaptive strategies to keep stakeholders motivated and aligned toward long-term goals. 'Consultation fatigue' can arise when people and organisations are repeatedly asked to contribute their input without seeing direct or meaningful outcomes, potentially leading to diminished participation and trust in the process. People may experience frustration due to the slow pace at which systems change occurs, and this feeling can be compounded by the realisation that change is continuous. Flexible approaches and resilience are required to navigate the complexities of evolving demands and priorities.

CONCLUSIONS

Physical activity is important for everyone. For people living with severe mental illness and their carers, being physically active has multiple benefits. But access to physical activity is unequal, and people living with mental illness and their carers face multiple barriers to participation. Rethink's work with partners in Tower Hamlets and North East Lincolnshire has sought to address those barriers systemically, providing new opportunities and seeking to bring about lasting change.

Our evaluation has highlighted the following key areas of learning from the project.

COPRODUCTION

Despite the inherently time-consuming nature of coproduction, it is essential to the success of any intervention which seeks to tackle the barriers facing people with mental health difficulties. Careful adjustments to timelines should be made with as much communication and forethought as possible.

The nature of coproduction also means tolerating some uncertainty about the future and shape of the project, if done in a truly collaborative way. Such uncertainty can be better tolerated by a project team and external stakeholders where it is expected and planned for, for example by setting provisional decision points in a timeline, even when details are not yet pinned down.

Additionally, this evaluation has found that there is a risk of experts by experience feeling exposed or isolated if alone or outnumbered in a meeting setting with professionals, especially when sharing personal information about their mental health difficulties. It is not necessarily the case that experts by experience will not want to share information about their health, but support for such sharing is imperative. Support could involve having planned time for decompression and reassurance or ensuring that experts by experience attend meetings in groups and have an opt-out plan if others cancel last minute.

SYSTEMIC BARRIERS

There are complex and interconnected barriers and enablers to participating in physical activity. The findings of this report suggest that barriers and enablers are often two sides of the same coin; for example, social support is reported as an enabler for accessing physical activity, while a lack is reported as a barrier.

Similarly, acknowledging that individuals hold positive and negative beliefs simultaneously, including about the consequences of physical activity and self-perceptions, may add complexity to learning about barriers. But understanding this complexity is necessary to design interventions which are empathic and sensitive to people living with severe mental illness. For example, many people know that physical activity can boost their mood and confidence, but are still limited in accessing opportunities due to low mood and low confidence.

INEQUALITIES

Racialised inequalities also need to be acknowledged in place-based work to address mental health inequalities. Commissioners and those working in public health should seek out both qualitative and quantitative data on how experiences are shaped by systemic racism in each place to accurately identify barriers and needs. Additionally, we do not know enough about how people with severe mental illness who are also marginalised by other identities and experiences, such as sexuality and socio-economic status, experience barriers to physical activity. This knowledge gap suggests a need to learn, to ask questions with curiosity, and to have an awareness of bias, to uncover different experiences which may have been silent or invisible thus far.

STIGMA

Depending on the targeted population of an intervention, signposting to an intervention or even to the coproduction stage may need to be sensitive to stigma and a preference for privacy. For example, in this project, reservations were expressed about publicly advertising a physical activity offer to people with severe mental illness, due to the stigma which still surrounds mental health difficulties.

COMMUNICATION

An inherent part of place-based work is building trusting relationships where participants are clear on the intentions of a project and how their privacy and other concerns will be respected. Consistency in communication, alongside staff members who show dedication to face-to-face presence in communities, has been shown to be major factors in building such trust.

PREVIOUS EXPERIENCES

Similarly, when seeking to engage communities as participants or experts by experience, a place-based project cannot presume it is starting with a 'blank slate.' Past interactions with project teams from other interventions, with health care or other professionals, as well as with researchers, will shape individuals' and groups' willingness to engage and especially to share information. To work toward redress of historical extraction or other unethical practices, especially experienced by racialised communities, a place-based intervention should focus on addressing this marginalisation as a key part of its design and trialling.

RECOMMENDATIONS

There is a clear role for place-based approaches in improving access to physical activity among people living with severe mental illness and their carers. Current provision is inequitable, and unless the barriers are tackled, people will continue to miss out on opportunities which could improve their physical and mental health. These barriers are systemic, and they intersect with race, wealth, gender and other inequalities. This means they can only be overcome by sustained action to dismantle structural inequities. Our recommendations are set out below for national and local policymakers, commissioners and service providers with that in mind.

1. Mental health service providers, including the NHS and voluntary and independent sectors, should explore the barriers to physical activity for their service users, and develop ways to overcome them.
2. Sports, leisure and fitness services should actively reach out to mental health organisations to build partnerships through which they can facilitate equitable access to their services and facilities.
3. Local and combined authorities should seek to remove barriers to participation in physical activity, for example by offering concessionary fares on public transport for people living with mental illness and their carers.
4. Organisations and partnerships should work alongside individuals and communities to develop strategies and approaches that meet their needs. This must include actively reaching out to groups and communities that are most marginalised.
5. Charities and charitable funders should commit to working long term in place-based partnerships so that initiatives are sustained and communities can rely on their support long enough to generate meaningful system change.

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