

USING PARTICIPATORY BUDGETING TO IMPROVE MENTAL CAPITAL AT THE LOCAL LEVEL

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SUMMARY

My one suggested intervention for the new health and wellbeing boards is that they **develop and test a form of participatory budgeting to help make decisions on public health priorities and to choose interventions.**

"There is no health without mental health" is a common justification for action to promote psychological wellbeing. This has now been broadened by the concept of 'mental capital', which encompasses aspects of mental health; intelligence (IQ); and emotional intelligence. Because of the importance of mental capital and mental wellness to economic development, there may be less *wealth* without mental health.

Public health interventions to improve mental capital and mental wellness aim to change individual exposure to risk factors or build environments that promote resilience and health. But they can inadvertently increase health disparities and may not increase participation and active citizenship.

Identifying one intervention that can improve mental capital, equity and civic engagement is difficult. But it is possible if the *process* of implementation is designed to have an impact, as well as the intervention itself. Reflecting this, I suggest that new health and wellbeing boards develop a modified version of participatory budgeting, which could:

- help the health and wellbeing boards demonstrate their vision of a population having shared responsibility for public health;
- engage the population in discussions of public health and offer an avenue for identifying local priorities, and for consultation;
- give authorities the opportunity to develop vertical social capital locally and directly target fundamental causes of disparities such as power and access; and
- produce fairer, better-informed decisions about priorities which improve the effectiveness of existing and well known mental health interventions.

Initial experimentation and testing should focus on how the initiatives link with locally accountable, elected authorities and could usefully identify the right scale and scope for participatory budgeting in public mental health to be effective.

Introduction: the most important policy intervention for mental health

Giving an opinion on the most important policy priority for improving mental health and decreasing disparities is challenging. It would be tempting to argue that promoting mental health through a host of different interventions – not just one – should be the first thing on the list for local authorities, health and wellbeing boards and the new Directors of Public Health. Mental health is public health's superglue. It is difficult to think of any health issue that does not rely on good mental health, or any initiative that would not be derailed by poor mental health.

Suggesting only one intervention produces an array of philosophical and practical problems. It is not clear exactly how to compare initiatives that prevent mental illnesses with those promoting mental health, or with initiatives that have varying impacts at the individual, group and societal levels and act over different timescales. It could be argued that local authorities, health and wellbeing boards and Directors of Public Health should choose locally relevant initiatives based on their changing needs. Added to this, interventions outside the traditional remit of public health, such as increased support for early years,* and other suggestions by key policy groups, will improve mental health.^{1,2}

Because of these issues, and given the challenges for public health now and in the future, I am not suggesting a specific mental health promotion or mental illness prevention intervention. Instead, I suggest that the health and wellbeing boards use the process through which they work as a way of improving the mental health and wellbeing of their populations.

A robust commitment to shared decision making could be truly transformative for the public's health. Increasing community engagement and social efficacy is key to improving mental health and decreasing inequalities in mental health. The plans for the new health and wellbeing boards include elected officials and community voice, in part through Healthwatch.³ The guidance available to them calls for more robust shared responsibility and decision making between public health agencies and the community.⁴

But, I do not think it goes far enough. There needs to be a plan for achieving and sustaining shared decision making. My suggestion for the new health and wellbeing boards is that they use a form of participatory budgeting to make decisions on public health priorities, and to choose interventions.⁵ This could be made part of the DNA of the new health and wellbeing boards.

Participatory budgeting directly involves communities in making decisions about how to spend public money. There are a number of models, including using participatory budgeting to allocate grant money or various percentages of core budgets and business.^{5,6} Citizens identify, discuss and prioritise public spending and have the power to make decisions on how the money is spent. Typically, community members identify priorities and identify people from within their ranks to help work them up. They then sit with experts and local authority planners to produce actual proposals.

Lastly, community members vote on which proposals to fund and the municipality implements the top proposals within the money allocated.⁷

But how exactly do we make the leap from mental health and mental illness to democratising decision making? And why is this considered such an important public health and equity issue?

* See Edward Melhuish's proposal on Early Childhood Education and Care in this publication.

Fundamental connections – health, mental health and mental capital

"*There is no health without mental health*" is one of the most common justifications used for the importance of psychological wellbeing to the population.⁸ Adopted by United Nations Secretary-General Ban Ki-Moon, the World Federation of Mental Health, the Pan American Health Organisation, the European Council of Ministers, Mental Health Europe, and the Royal College of Psychiatrists (UK), and popularised by the Global Mental Health movement, the assertion is supported by hard facts about mental illness.^{2,8,9} For example, depression is one of the biggest contributors to the global burden of disease, after respiratory and diarrheal infections, and the biggest contributor to the burden of disease in the UK.² In some high-income countries, mental illnesses are some of the most common reasons for absence from work.¹⁰

Physical and mental illness are intertwined: just as depression may be sparked by a chronic physical disease, depression itself increases the risk of a number of physical illnesses and affects their prognosis.^{2,9}

But there is another approach to understanding the importance of psychological health that is compelling. The Government Office for Science *Foresight* project has offered a vision that goes further than mental illness to investigate mental health and mental wellness. It is based on the advice of over 400 international experts and stakeholders in disciplines as diverse as genetics and neuroscience, social sciences and ethics, economics, and modelling and systems analysis. The report spans the interests of key departments across Whitehall and takes a futures approach to strategic policy thinking.¹¹

Foresight started by identifying the most important opportunities and challenges facing the UK over the next 20 years. These include:

- the need to understand how to preserve the independence of the ageing population and make sure their knowledge is available to industry;
- the need to nurture the cognitive and emotional flexibility of the population to equip them to deal with changing work and societal norms;
- the increased expectations of the population;
- the fact that public services need to move towards more choice, active citizenship and co-production; and
- the need to harness technology and science to promote wellbeing.¹¹

The project then looked for solutions and concluded that our mental resources – mental health; intelligence (IQ); and emotional intelligence (EQ) – will be key to meeting the challenges, individually and as a country.¹¹

A new concept was also introduced – mental capital – which includes aspects of mental health as well as IQ and EQ. Mental capital encompasses a number of individual resources such as "*[people's] cognitive ability, how flexible and efficient they are at learning, and their emotional intelligence, such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high personal quality of life.*"¹¹

Reframing these resources as a combined set of capabilities reflects the fact that they are linked. Categorising them as capital introduces the idea that they can be built or diminish and are both a personal and public resource. We can help our mental capital grow by investment, but its relative worth can also go down if it is not properly looked after.

From a policy perspective, *Foresight* asserts that our society and economic viability are linked to our ability to preserve and promote mental capital. We have to be smart enough and flexible enough to out-perform our competitors. Because of this, it is not simply that "there is no health without mental health". The strategic economic importance of mental capital means that there may be less *wealth* without mental health. If public health is to promote and protect the health and wellbeing of everyone in society, it needs to engage with the concept of mental capital.

Public health has traditionally attempted to improve aspects of mental capital by preventing mental illness and promoting mental wellbeing.¹² There are a plethora of evidence-based approaches to both that could be deployed, though some would argue that the stigma of mental illness has prevented mental health promotion from getting equitable funding.^{2,12,13} Discussions about getting a bigger piece of the pie for mental health run the risk of cul-de-sac battles over which bit of the health budget should be decreased to accommodate expansion. In a fight between physical illness and mental illness, mental illness tends to lose. Because of this, it may be more prudent to identify win-win situations where interventions that target other areas of health are also effective in improving mental health.

The place of nature and green space in enhancing mental capital and public health

One suggestion that has currency as a win-win public health intervention, and which could improve mental capital and physical health, is access to nature – or green space. It was even alluded to in the Department of Health's literature for moving public health to local authorities.³ There is a wealth of evidence about the impact of the physical environment on health and now a growing literature on its impact on mental capital.¹⁴ The level of noise, light and the quality of the built environment are important for mental capital, but some of the best literature is about the importance of nature.¹⁴

Seeing nature, access to green space, and taking part in activities such as community gardens are generally beneficial for mental capital across all age groups. Planting trees in urban areas, making sure that there are parks, and the maintenance of lawns all have the potential to improve mental wellbeing. They also decrease stress and increase effective management of major life issues. Studies report that children exposed to nature and green space have improved ability to learn, better memory and better attention.¹⁴ At a community level, green space is associated with higher levels of perceived social connectedness to the community and decreased levels of violence.¹⁴

Because the majority of the population live in cities, and because city life is one of the major population risk factors for mental illness and poor mental health,¹⁵ access to nature could be argued as being a national priority for health and wellbeing boards.

But access to nature does not necessarily deliver health equity. The links between inequity and mental health have been well documented in *Fair Society, Healthy Lives*.¹ Social stratification leads to differences in life expectancy. And the pathways through which this occurs are through the psychological and psycho-social processes that modify risk** and exposure to risk factors.¹

The Government Office for Science¹¹ acknowledges that perhaps the biggest challenge in the UK will be ensuring that our understanding of the importance of mental capital is used to reduce social inequalities (rather than to fuel further divisions). It is conceivable that increasing access to green space may be effective in improving mental capital, but may not decrease disparities. Worse still, it could even increase inequity if it was delivered more in richer suburban areas, where it is easier to implement. However, because we are aware of this risk, an approach to improving access to green space could be specifically targeted at areas of higher deprivation. That would deliver an effective public health intervention that decreases disparities. But some would question how long the impact on disparities would last.

Social causes and social capital

I am persuaded by the view of Link and Phelan,¹⁶ who developed the theory of fundamental social causes. This aims to explain why the association between socio-economic status (SES) and health disparities persisted over time, despite interventions, and even after conditions previously thought to be the cause had been resolved.

Higher SES is an indicator for an array of resources including money, knowledge, power, and beneficial social connections. These ensure that disparities continue, unless interventions specifically target the factors and mechanisms that sustain differences between population groups. Despite advances in screening, vaccinations, or any other piece of technology, disparities persist because those from low SES communities lack resources to protect and improve their health.¹⁶

Improving mental capital equitably will require approaches that target the fundamental social causes. But, in addition to the concept of mental capital and the need to focus on the fundamental social causes of disparities, there is a further challenge for local authorities: how to promote greater choice, active citizenship and co-production in the way they deliver public services.¹¹ The ability to be involved in decision making and co-production will be different for different localities and population groups. One way of describing and understanding these differences is through the lens of social capital.

Social capital attempts to describe features of populations, such as levels of civic participation, social networks and trust.¹⁷ There are lots of different types of social capital.¹⁷ For instance, bonding social capital is inward-focused and characterised by ethnic homogeneity, strong norms, loyalty and exclusivity. It can be thought of as the type of social capital that a family unit has or which is found in small, close-knit migrant

** i.e. the factors that affect healthy versus unhealthy/risky lifestyle choices and behaviours are to do with social issues and psychology rather than the physical environment.

groups. In contrast, bridging social capital is outward-focused and links different groups in society. The ties between people or groups are weaker.¹⁷

Another dimension of social capital is horizontal and vertical. Horizontal social capital is that between people *within* similar strata of society, whilst vertical social capital is about the degree of integration *between* groups within a hierarchical society. The latter is important in allowing people to influence policy and access justice and resources from those in power. Vertical social capital can be seen as a type of bridging social capital. It relates to connections between the state and communities, including how far government and its public agencies have integrity because they connect to and work for those facing greatest disadvantage. It also includes cognitive elements that reflect group identity.¹⁷

Research studies have demonstrated a direct association between types of social capital and how well local government works. But, in addition, there are links between social capital and mental health. The key findings are that there is a stronger association between higher levels of bridging social capital and better mental health than there is for bonding social capital. The social efficacy of a community, its links to other groups, and access to their resources are important for preserving mental health.¹⁷ Vertical bridging social capital may be of particular importance in the mental health of marginalised groups.¹⁸

The challenge for local authorities and health and wellbeing boards is to identify locally relevant interventions that promote mental capital, decrease inequalities and improve active citizenship. The concepts of fundamental social causes and social capital suggest that an effective strategy to promote mental capital would need to increase the access of the most marginalised in society to opportunities to influence decision makers and resource allocation. Indeed, this may be one of the most important equity interventions that public health can undertake. In addition, it may facilitate the effectiveness of other interventions.

Rather than a single intervention, the way in which local authorities and health and wellbeing boards run their business may offer a way to meet all these needs. The introduction of participatory budgeting may help more equitable decisions to be made, while increasing public engagement in decision making.

Participatory budgeting has been used across the world for over 30 years. Since its emergence in Brazil, it has spread to hundreds of cities. The international results show that participatory budgeting produces more equitable public spending, better quality of life for individuals, increased satisfaction, and greater government transparency. It grows vertical bridging social capital and social efficacy and can decrease the impact of the fundamental social causes.^{5, 19}

Implementing participatory budgeting

Participatory budgeting has been used in the UK for over 10 years and there have been over 150 different projects since 2006. It has been deployed at local, district, borough and county council levels as well as in police authorities and even a fire and rescue service. It has been mostly small scale – £28 million has been allocated through participatory budgeting processes so far, with the largest budget being £4.8 million.²⁰

Scholars concede that the technical nature of much of health spending in hospitals argues against participatory budgeting, but agree its potential in public health and population wellbeing is immense.^{5, 6} The literature to support this is not substantial – a search for participatory budgeting examples in this field uncovered no papers at all. However, there have been multi-year projects in Southampton and Nottinghamshire, with case reports that indicate success in engaging the population.²⁰

There are many different forms of participatory budgeting, but most use a similar methodology: there is a defined budget set aside to be used for the purpose; residents in an area brainstorm ideas for spending it; they then select volunteer representative delegates to work with the budget-holding institution to develop proper proposals; once these are ready, residents are asked to vote; the proposals with the most votes are funded until the allocated budget is used.

Developing and testing a modified form of participatory budgeting for public health could have an impact on at least four levels:

- first, it would help the health and wellbeing boards demonstrate their vision of a population having shared responsibility for public health;
- second, it would engage the population in discussions of public health and offer a democratic avenue for identifying local priorities, and for consultation;
- third, it would give authorities the opportunity to develop vertical social capital locally and directly target fundamental causes of disparities of money, knowledge, power and access; and
- last but not least, participatory budgeting could produce fairer, better-informed decisions about priorities.

But implementation of this sort of experiment is not easy. It will require a significant commitment from local authorities and health and wellbeing boards. There will be a need for resources for community engagement through a number of media, and for community meetings, polling and feedback. And there are pitfalls. There is a clear potential for participatory budgeting initiatives to be hijacked by more powerful, connected and vocal groups. To ensure involvement of all, including traditionally excluded groups and marginalised populations, there will need to be a plan that ensures that the principles and rationale are clear within local authorities and health and wellbeing boards, as well as externally. The external strategy would aim to engage and enthuse the communities who have to support and take part in participatory budgeting for it to work.

The development of partnerships with third sector organisations may be key, but it is of note that there have been successes at a national level with working *directly* with communities to identify their mental health needs.²¹ It would be important not to fall into “take me to your leader” approaches to communities. Though the third sector is important, their major utility may be in providing access to marginalised populations, as well as adding legitimacy to the project, rather than as participants in priority setting.

Another way to protect against the dominance of one sector would be to set the parameters for acceptable priorities or proposals, so that they require partnerships or demonstrable benefit to a number of different types of communities. This would help to ensure vertical linkages.

Conclusion

My one suggested intervention for the new health and wellbeing boards, is that they **use a form of participatory budgeting to make decisions on public health priorities and to choose interventions.**

Because this is a new approach, and there are issues to resolve as discussed, I would suggest initial experimentation. This should include a research element to build the evidence base and may answer questions such as:

- How does this type of initiative link with locally accountable, elected authorities?
- What is the right scale of participatory budgeting to make a difference to health?
- How wide can the scope be?
- And, over what timescales can one expect to see an impact?

One may question why I have not chosen one of the many proven, effective mental health promotion and mental illness prevention strategies as my suggestion for local authority public health. The answer is that this is not an either/or trade-off. I have no doubt that there will be locally chosen and appropriate initiatives that promote mental capital. But participatory budgeting, if done correctly, has the potential to leverage those for even greater benefit, as well as developing resilient and socially cohesive populations.

Note on the author

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Definitions

A **mental illness** is a diagnosable pattern of thinking or behaviour which is generally associated with distress or disability and is not considered part of normal development or a person's culture.

Mental health is "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". 'What is mental health?', World Health Organization website: www.who.int/features/qa/62/en/index.html. Accessed 14 July 2012.

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