TMS

THE MENTAL SHIFT CIC

Impact and Community Engagement Report

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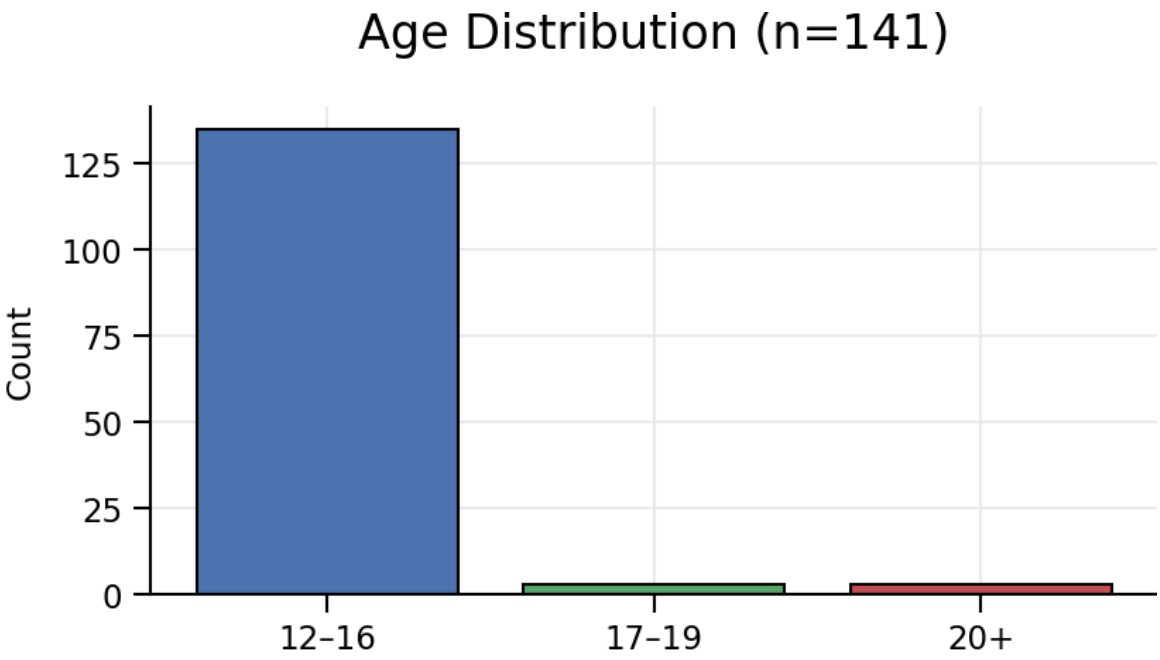
This report presents who we support, the most common needs at referral, the outcomes achieved during support, and what the community says it needs from local services. It then explains why the model is producing change: fast, youth-led, relationship-based mentoring with lived experience; no waiting lists; cost-free access; and activity-based pathways.

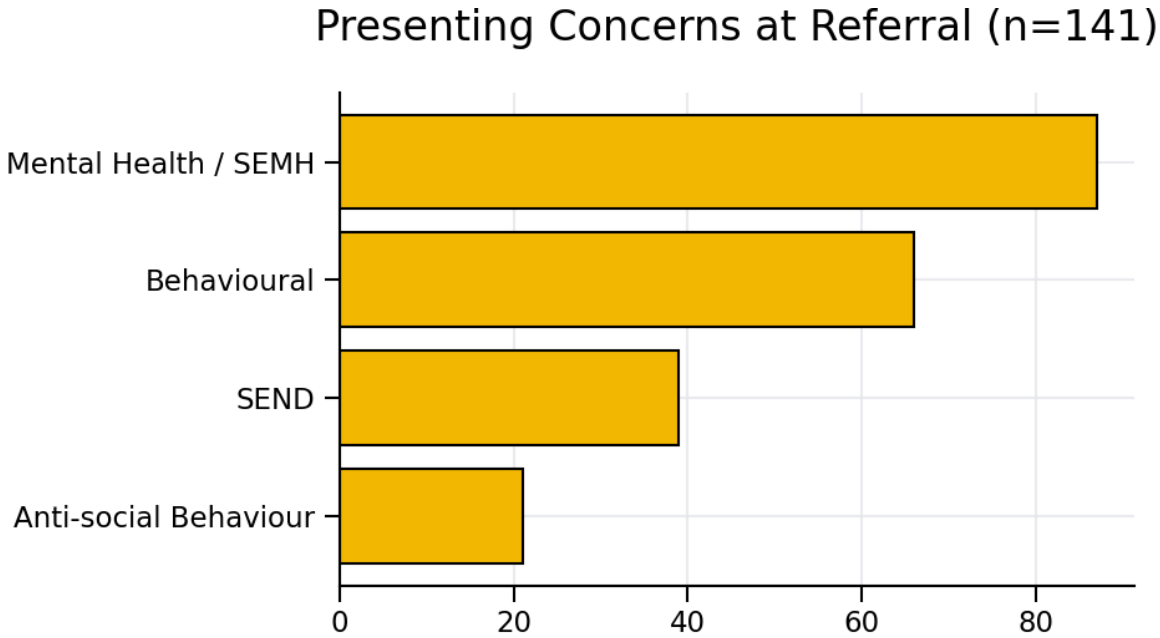
Who We Support

Age distribution among mentoring participants:



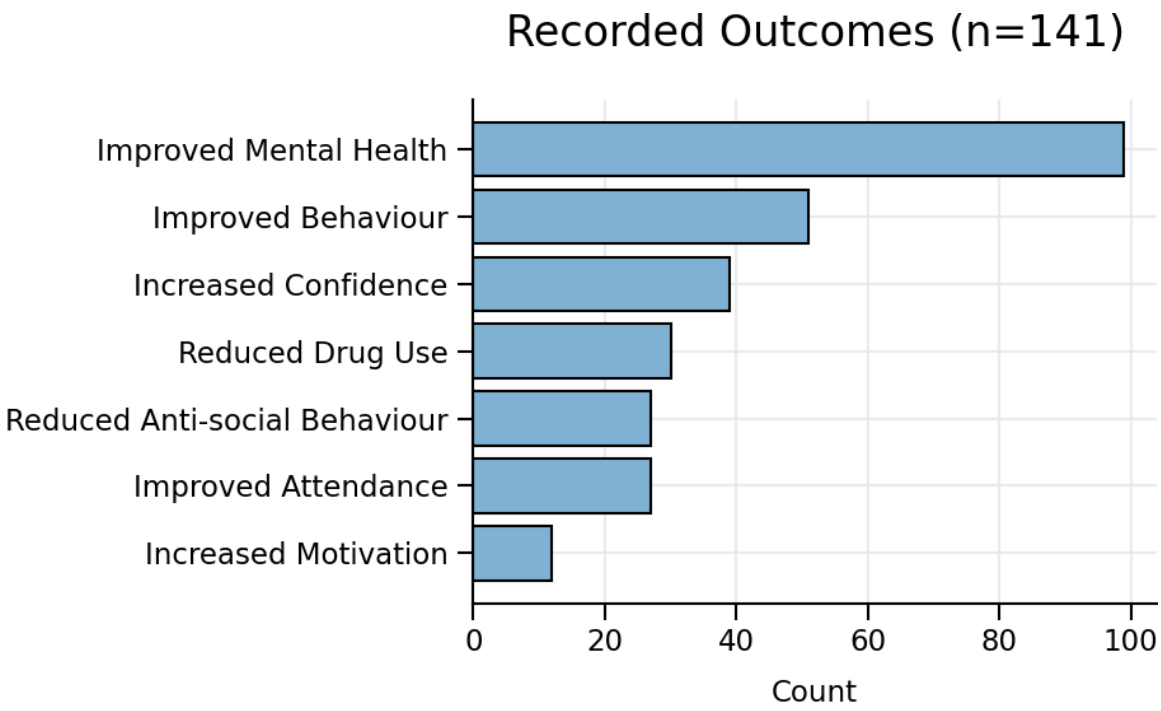
Interpretation: The cohort is overwhelmingly 12–16 (135 of 141), with small numbers at 17–19 and 20+. This confirms we are reaching early-to-mid secondary years when routines and peer influences are still forming. Working at this stage increases leverage for change in attendance, behaviour, and risk before patterns harden.

Presenting Concerns (Mentoring Cohort)



Interpretation: Needs cluster around Mental Health/SEMH (87 of 141) and Behavioural (66) with substantial SEND (39) and a notable ASB footprint (21). In practice these needs overlap: anxiety or low mood often drive classroom withdrawal or confrontations; SEND can magnify mis-cues with staff; and unstructured time feeds ASB. The pattern signals that purely punitive responses won't work; young people need both emotional tools and alternative routines.

Recorded Outcomes (Mentoring Cohort)



Improved Mental Health (99 of 141): The most common change. Regular mentoring provides a predictable space to name stressors, learn simple regulation tools (e.g., early trigger spotting, step-away plans), and reduce the build-up that leads to blow-ups or shutdowns.

Improved Behaviour (51): Behavioural gains tend to follow emotional stability. As young people rehearse calmer exits and re-entries to lessons and de-escalation scripts, staff conflicts decrease and lesson time increases.

Increased Confidence (39): The physical-activity pathway offers quick, visible wins (completing rounds, drills, or a session streak). Confidence inside the gym often generalises to taking prosocial risks in class: asking for clarity, attempting work after a setback, or walking away from provocation.

Reduced Drug Use (30): More structured hours and accountability to a coach/mentor create opportunity costs for use and dealing. Progress in fitness goals (e.g., cardio, weight targets) also competes with substance use.

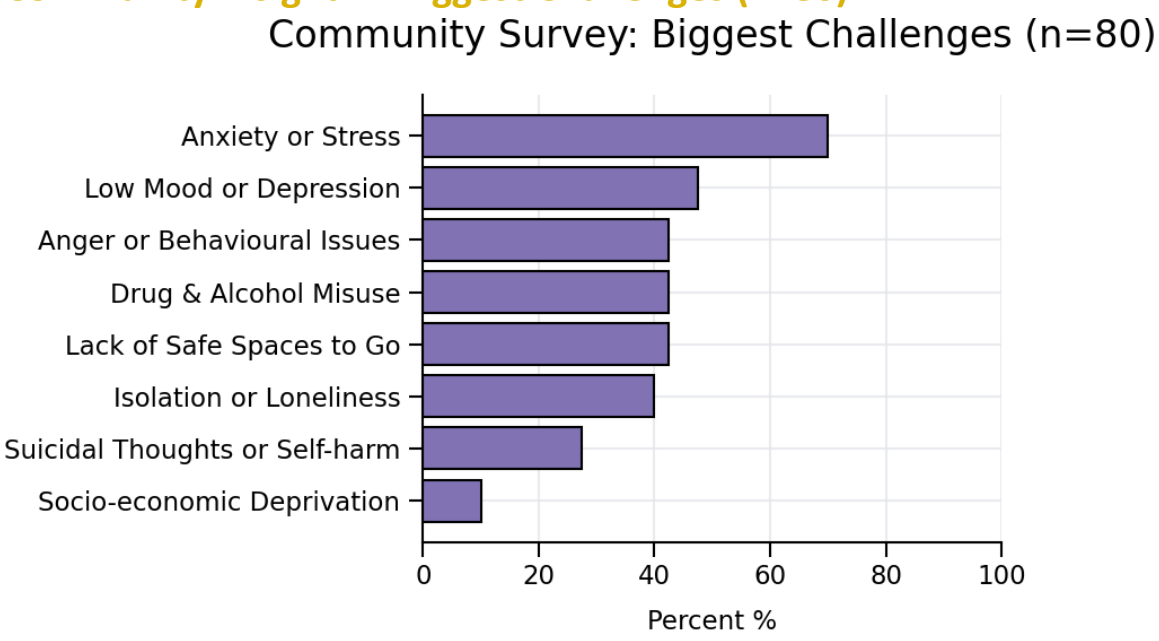
Improved Attendance & Reduced ASB (each 27): Attendance improves when mornings include a reason to turn up (mentor check-ins, training later) and when sanctions are paired

with a plan. ASB reduces as gym time and positive peers replace unstructured hours, and as young people experience status through sport rather than risk.

Increased Motivation (12): Motivation grows last because it relies on success feedback. As young people notice fewer crises and more wins, self-efficacy grows and future goals (qualifications, fights, apprenticeships) become believable.

Mechanism summary: talk changes how a young person understands pressure; training changes how a young person uses time; school-based delivery keeps everyone aligned. Together, that's why we see simultaneous improvements in mental health, behaviour, attendance and risk.

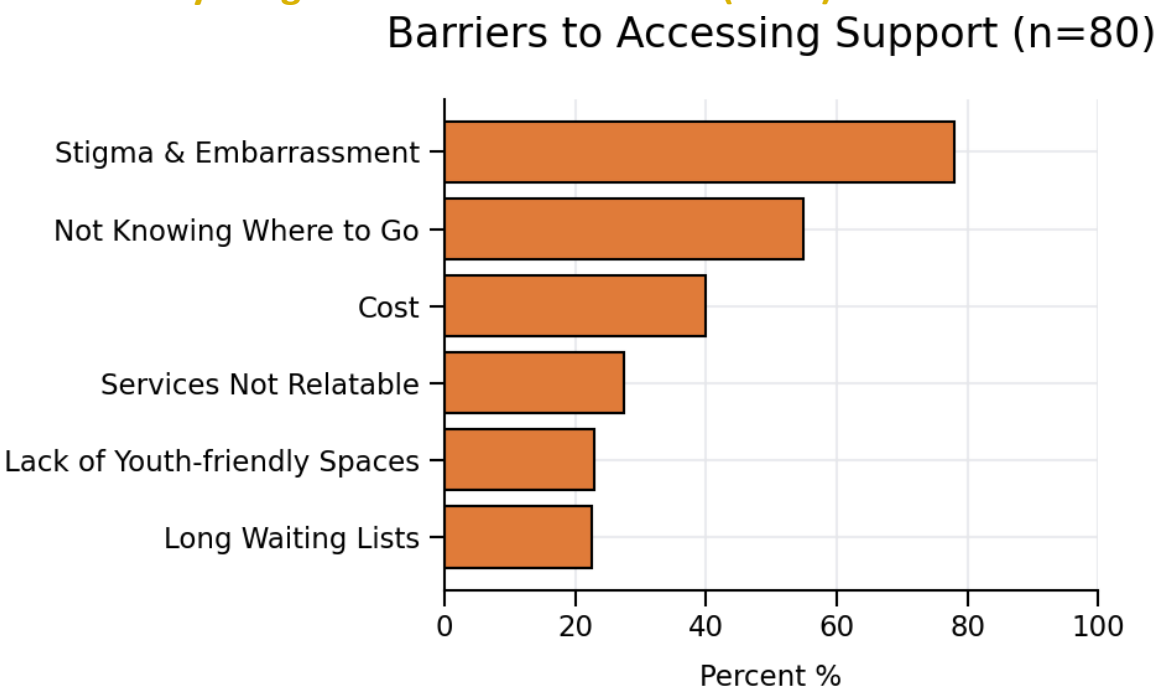
Community Insight — Biggest Challenges (n=80)



Interpretation: Anxiety/stress (70%) is the defining theme, with low mood/depression (47.5%) and a trio of environmental challenges — drug/alcohol misuse, lack of safe spaces, and anger/behaviour (each 42.5%). Isolation (40%) and suicidal thoughts/self-harm (27.5%) underline the need for interventions that are both relational and active, not purely clinical waiting-list offers.

Our response: deliver mentoring that feels human and is available now; combine it with activity-based sessions that reduce isolation, give a safe physical outlet, and build peer belonging without risk.

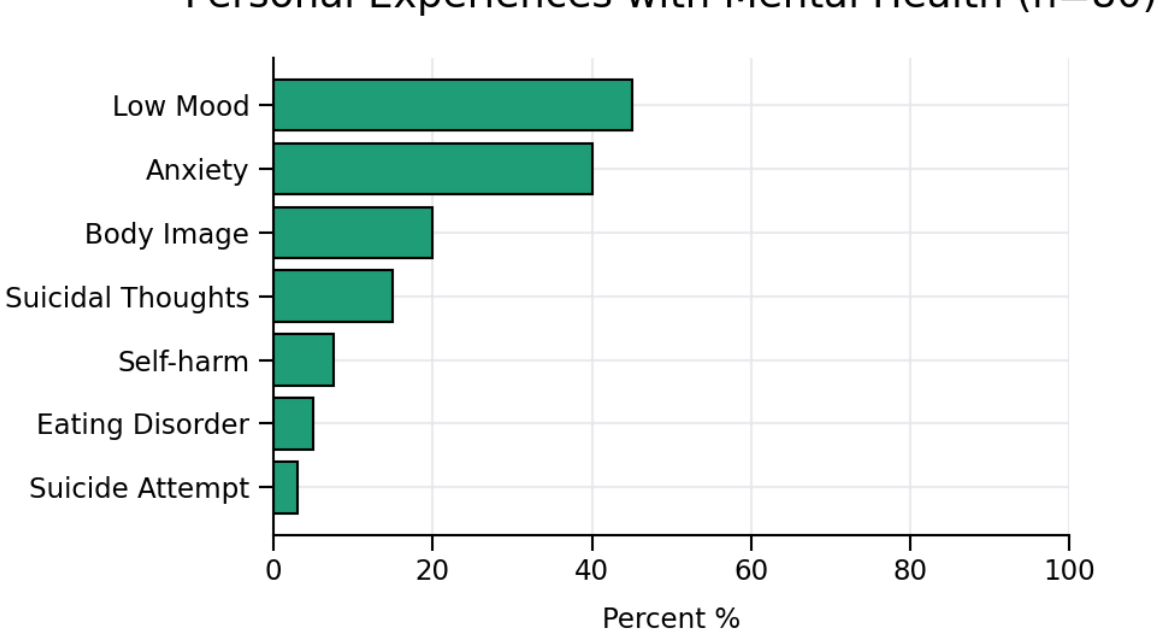
Community Insight — Barriers to Access (n=80)



Interpretation: The biggest blockers are stigma/embarrassment (78%) and not knowing where to go (55%), with cost (40%) and "services not relatable" (27.5%) close behind. This explains why traditional clinics and long assessments miss the very group we target.

Our response: zero-waiting-list entry, clear referral routes, free sessions/equipment/memberships, and mentors under 25 with lived experience in youth-friendly sites (schools/gyms). The offer is designed for the audience, not the system.

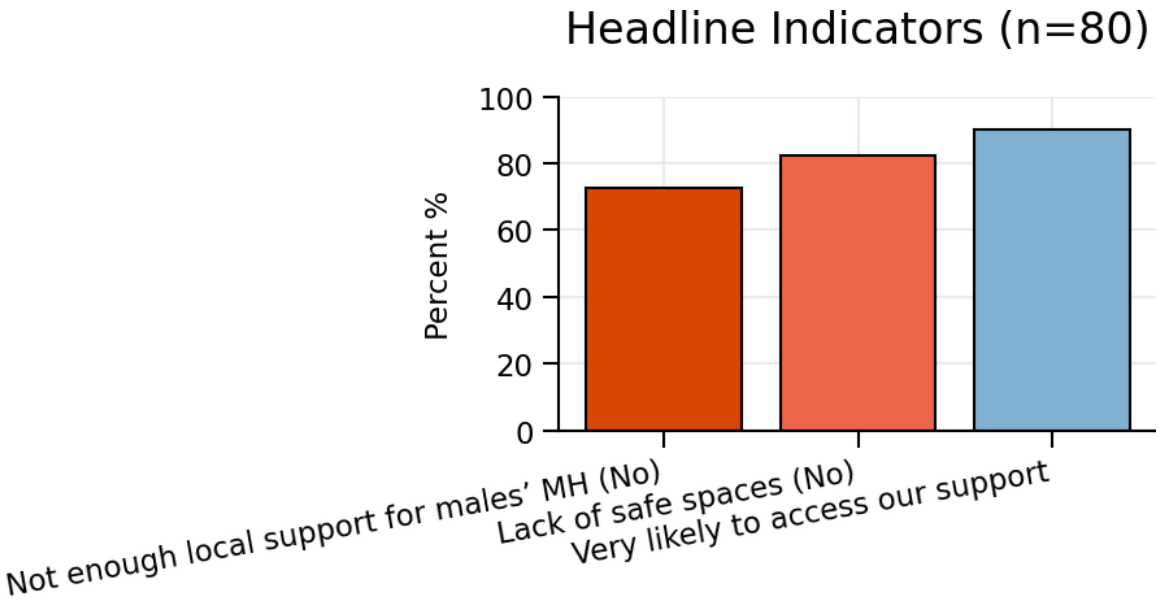
Community Insight — Personal Experiences (n=80)



Interpretation: Nearly half report low mood (45%) and two-fifths anxiety (40%); a fifth cite body image concerns (20%), with smaller but significant proportions reporting self-harm or suicidal thoughts. This profile matches the presenting concerns we see in mentoring and justifies early, non-clinical support that can triage, hold, and signpost when risk rises.

Our response: weekly 1:1s, simple language tools (e.g., "bottle filling" analogy), structured training time to lower arousal, and layered safeguarding that escalates calmly when needed.

Community Insight — Headline Indicators (n=80)



Interpretation: 90% say they are very likely to access our support — demand is not the issue. The gap is capacity and relevance: 72.5% think there is not enough local support for males' mental health and 82.5% say there are not enough safe spaces. The service directly addresses both by adding immediate capacity and by placing provision in the spaces young males actually want to be.

How We Translate Insight into Practice

- Fast access: initial assessment within 7 days; zero waiting list thereafter. Meets need for immediacy and reduces drop-off.
- Relatable people: mentors under 25 with lived experience — reduces stigma and increases trust.
- Cost removed: free sessions, kit, gym memberships, and PT time — eliminates price barriers.
- **Places that feel safe:** delivery in schools and partner gyms — increases safe spaces and routine.
- Activity matters: MMA/Boxing/Muay Thai provide regulated outlets and prosocial status cues.

Data Notes & Limitations

Mentoring counts were scaled from an original dataset (n=47) to n=141 to preserve percentages. Survey findings are n=80 (January 2026). Some needs overlap (e.g., SEMH and Behaviour), so totals across categories exceed 100%. Charts reflect the provided data; where percentages were given without sample bases beyond n=80, counts were not inferred.