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Promoting Health, Preventing Illness

Public health perspectives on London's mental health

Baljinder Heer and David Woodhead

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This is one of a series of papers being produced in 2002/03 as part of the King's Fund Mental Health Inquiry. The Inquiry aims to assess whether London mental health and mental health services have improved over the last five years. In 1997 the King's Fund produced a report entitled *London's Mental Health*, describing services in inner London 'that cannot be sustained'. The current Inquiry asks what, if anything, has changed since then, as well as tackling some new questions.

About the authors

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Executive summary

In the UK today, there are more opportunities to promote mental health and well being than ever before. The reasons for this include:

- numerous policy drivers
- the duty for primary care trusts and boroughs to develop strategies
- a growing evidence base
- developed models of delivery supporting wide-ranging activities.

Effective promotion of mental health and well being encompasses co-ordinated activities for communities, families and individuals. However, little is known about the current state of mental health and well being promotion in London. This paper seeks to fill that gap, drawing evidence from three 'case study' projects promoting mental health and well being, as well as from information generated through questionnaires, interviews and workshops. In addition, examples of positive practice were collected throughout the research process.

Across London, the development of local mental health and well being strategies has been inconsistent. Co-ordinating partnerships and engaging agencies in the process is a challenge, and often there has been little clarity about what mental health promotion is, and what it can achieve. Low levels of commitment, small dedicated resources and poor profiles make sustaining the work difficult. Organisational change poses additional challenges, as it can threaten continuity. National policy and local activities tend to focus on the delivery of services rather than developing a preventative agenda, and strategies seldom affect the commissioning of projects, or encourage innovation.

Working with vulnerable groups is a priority for those promoting mental health and well being. However, their work is complicated by shifting needs and dwindling resources. Access to appropriate services remains a significant issue in the capital, especially for black and ethnic minority communities and other vulnerable groups. The voluntary sector has a crucial role to play in delivering services, but projects are often commissioned on a short-term basis, making sustainability difficult to achieve.

Three key areas demand immediate attention:

- greater prioritisation of the promotion of mental health and well being
- co-ordination of policies and practices
- integrated, effective commissioning of programmes and projects promoting mental health and well being.

Introduction

London is a complex city characterised by huge inequalities in wealth, health and access to services. These inequalities relate to socio-economic status, ethnicity, gender and location (London Health Commission 2002). London is home to countless communities, which face, on a daily basis, the challenges of urbanisation – notably, poverty and the associated problems of crime, deprivation and ill health (Association of London Government 1998). An additional factor is that many of London's communities are highly transient and move around the city, migrating in and out, unable to settle (Bardsley *et al* 1998).

Living in London is often hard to manage, especially for people who are excluded from the mainstream, and that includes people with mental health problems. Living in the city, travelling across it, and making one's way within it, pose routine challenges, and these challenges have a disproportionate impact on the mental health and well being of its inhabitants. To promote their health effectively is similarly complex, as any planned interventions have to take into consideration the manifold problems and opportunities that the capital faces.

The context

The 'promoting health, preventing illness' strand of the King's Fund Mental Health Inquiry focused on current activities being undertaken to promote mental health and well being as a means of improving the mental and physical health of Londoners. In its examination of mental health services, the King's Fund London Commission (Johnson *et al* 1997) reported little about attempts to prevent mental illness, or improve mental health and well being generally in the capital. There is now a wide-ranging policy framework through which mental health and well being can be promoted, which did not exist in 1997.

Similarly, models of mental health promotion have been developed in recent years that have established mental health promotion as an important yet often neglected cornerstone of sustainable public health action. Recent national policy developments have enabled a systematic approach to promoting mental health and well being in London, and activities seem to be gaining momentum (Department of Health 1999a and 2001b). All boroughs are now charged with producing local strategies for improving mental health and well being. However, little is known about how the field of mental health promotion is developing. Important questions remain unanswered, including:

- What is the state of mental health promotion in London?
- What is it trying to achieve?
- What are the barriers and opportunities that key players face?
- What needs to change to develop effective delivery of mental health promotion in the capital?

To answer these questions, the research focused on two complementary areas. First, it sought to understand the issues being faced in the development and implementation of local strategies to promote mental health and well being. Second, it considered the development of effective interventions to promote the mental health and well being of vulnerable groups in London.

Methods

The research used a combination of methods to gain indepth information about the challenges and opportunities in developing strategies and activities to promote mental health and well being in London (see Appendix 1). To address the questions about local strategies, questionnaires were used, which informed workshops and interviews later in the process. To gain an understanding of projects working with vulnerable groups, three case studies were undertaken (see Appendix 2). Additional information was gained from exploratory workshops and one-to-one interviews. In total, almost 220 people participated in the research, which began in November 2001 and ended in October 2002.

Defining mental health

In common with the World Health Organisation definition of health (WHO 1946), in this paper 'mental health' is referred to as a state that is determined not only by an absence of mental illness, but also by a sense of well being. In order to develop critical thought about promoting mental health and well being, it is useful to establish a shared understanding of what it is to be mentally healthy and to experience well being. To date, much of this debate has focused on mental illness rather than mental health, being concerned with conditions such as anxiety, depression and schizophrenia. Less consideration has been given to issues of well being, such as isolation and loneliness, low self-esteem and fear, which are often debilitating and have direct effects on people's mental and physical health. Mental health is directly affected by the conditions in which individuals and communities live and interact, as well as by predisposition (Health Education Authority 1997, Department of Health 2001a).

Background

The health of a population is affected by a number of interlocking factors. These factors are social, economic, cultural and medical (World Health Organisation 1946). They originate from numerous sources; some global, some national and others local. A number of factors are closer still, located in the communities in which we live or in our families, and some are particular to ourselves.

Above all, it is important to recognise that each of these factors is intricately connected. For example, to focus on the individual's responsibility to keep healthy at the expense of ignoring the effects of societal factors (such as poverty, discrimination and inequalities of opportunity) is to fail to understand the complex circumstances in which we experience health (Dahlgren and Whitehead 1991). Communities that are disproportionately affected by poverty are often located in unsafe neighbourhoods, with poor infrastructures, sub-standard services and high rates of unemployment. They are also more likely to be ill and to live shorter lives (London Health Commission 2002).

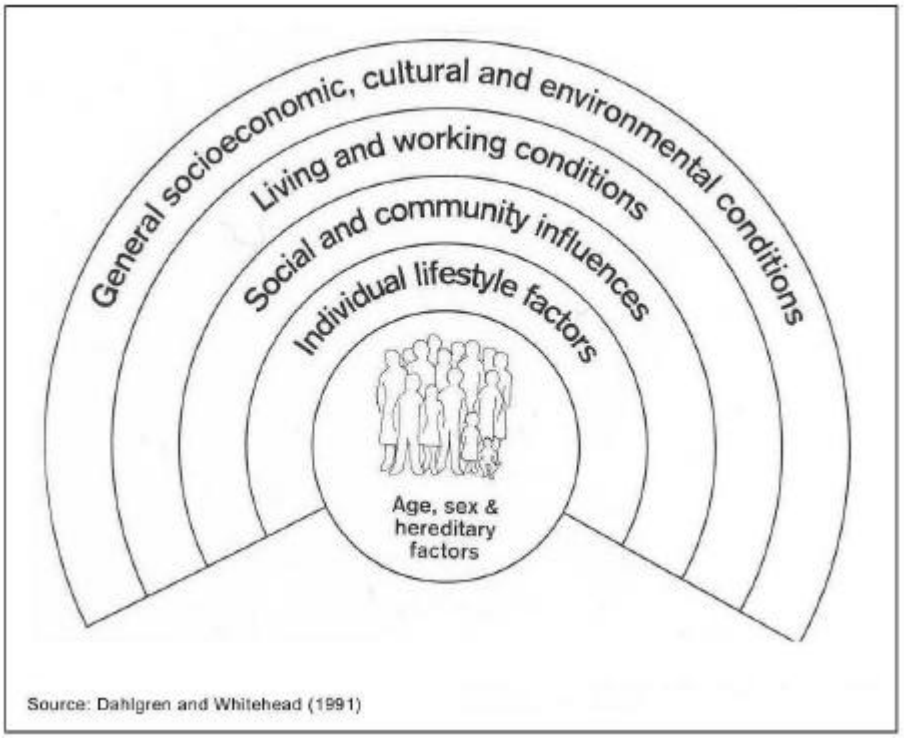
The economic costs of poor mental health and well being are significant. For example, in the UK, direct care costs for mental health problems account for an estimated 23 per cent of total NHS expenditure (Coombs *et al* 2001). Similarly, absences due to stress-related sickness cost an estimated £4 billion annually. Mental health problems account for the loss of more than 91 million working days each year and half of these days are lost due to anxiety and stress-related conditions (Gray 2000).

Similarly, communities and individuals who routinely face discrimination are also affected: institutional and interpersonal racism, homophobia and other forms of discrimination have far-reaching effects on people's health (Wired for Health 2002, Golding 1996, Karlson and Nazroo 2002).

The well-known Dahlgren and Whitehead model, shown in Figure 1 (below), illustrates this complex relationship. The general socio-economic, cultural and environmental conditions represented in the outside circle are referred to in this paper as 'upstream' factors. They are the broad, societal forces that are tackled through international and national action. The circles that refer to working conditions and community issues are referred to as 'midstream' factors, in so far as they have direct impact on people's lives and are often reflections of broader societal issues. Individual life style factors are referred to as 'downstream' as they are important, and are affected by other broader conditions in which individuals and their families live (the outer circle).

At the core are individuals. Gender, ethnicity, sexuality and ability are extremely important, and are personal to individuals. However, the ways in which individual and collective differences are experienced and expressed are intrinsically social and cultural processes, and have direct effects on health. Effective action to improve people's health co-ordinates activities at all the levels. There is a complex relationship between the worlds in which people live, how they collectively and individually make sense of what happens around them throughout their lives, and how those happenings affect their mental and physical health. It is this complexity that we aim to convey in this paper.

Figure 1



Mental health and well being: the evidence

Mental illness and poor well being are widespread. One in four adults suffers from mental health problems at any one time (Goldberg and Huxley 1982). About 16 per cent of adults aged 16 to 74 living in private households in Great Britain have a neurotic disorder (or common mental disorder), such as depression, anxiety or phobias (ONS 2000). Women have a higher rate of diagnosed neurotic disorder than men do – 19 per cent of women compared with 14 per cent of men (ONS 2000). London has higher rates of diagnosed neurotic disorder than other parts of the UK (Mind 2002a). For example, analysis of the percentage of the population with a mental health problem by former regional health authorities was as follows:

- North West Thames 15%
- North East Thames 19%
- South East Thames 16%
- South West Thames 15%

These are compared with England as a whole, where the rate is 14 per cent (Mind 2002a).

People living in poverty

Reviews of relevant literature confirm that social and economic factors have an impact on mental health and well being, and that there remain major inequalities between the worst-off people in society and the best-off (Acheson 1998). People with mental illness experience high levels of poverty, while mentally healthy people are more likely to be (and remain) in work, and financially independent of the state.

So poverty is both a cause and a consequence of poor mental and physical health (Payne 2000, Davis and Hill 2001). People in the lower social classes are nearly twice as likely to suffer from mental distress than those in the higher social classes – 10 per cent of social class I compared with 18 per cent of social class V (Mind 2002a). Similarly, children in the poorest households are three times more likely to experience mental health problems than children in the best-off homes (Department of Health 1999b), and poverty particularly affects certain groups, such as lone parents. Poverty is not an absolute measure, and measurements of it are widely discussed elsewhere (Payne 2000, p 7). In this paper we use 'poverty' as a broad term that indicates the income levels of the poorest, and also draws attention to their exclusion from mainstream society.

Ethnicity and mental health

Some ethnic minority groups are more likely to experience mental distress than others (see Davies *et al* 1996, Bhugra and Bahl 1999, Nazroo 1997, Bardsley and Lowdell 1999 and Reid-Galloway 1998 a, b, c). For example, African-Caribbean and Irish people are over-represented within psychiatric hospitals (Mind 2002b). For African-Caribbean men and women respectively, the rate for first admission with a diagnosis of schizophrenia is 4.3 and 3.9 times higher than it is for white people. Furthermore African-Caribbean men may be ten times more likely to be sectioned than their white counterparts (Mind 2002b, Reid-Galloway 1998c).

Some evidence suggests that Irish people living in Britain have one of the highest rates of admission to psychiatric hospitals and that they are twice as likely to be hospitalised for mental distress than their native-born counterparts. For example, in an analysis of admissions to psychiatric hospitals in the London Borough of Brent and the city of Westminster in 1991, Irish-born people comprised 15 per cent of clients with identifiable origin, while the local Irish population was far lower, at 8.7 per cent (Reid-Galloway 1998a).

The findings for mental health problems in South Asian, Chinese and other ethnic minorities are not consistent and accurate statistics are currently not available. (Ethnic origin has only recently begun to be recorded in official statistics, including hospital episode statistics and figures for detentions, under the Mental Health Act.) There are also a number of cultural and language issues for ethnic minority women whose first language is not English and who do not go out to work. Adolescent Asian girls are more likely other girls their age to suffer from certain types of mental health problems such as suicide, self-harm and eating disorders (Department of Health 2002, Chantler *et al* 2001, Yazdani 1998). In addition, racism has a significant impact on the well being of ethnic minorities.

A substantial body of evidence suggests that the rate of diagnosed mental ill health is higher among African-Caribbeans in the UK than it is with those living in the Caribbean (Institute of Psychiatry 1998, Nazroo 1997). This is true for many other migrant groups in western Europe and the United States (Gavin *et al* 2001). This increased risk of mental ill health, and particularly of schizophrenia, is greater for the second generation than for the first generation. There is currently very little data about subsequent generations. Furthermore, the incidence of schizophrenia in non-white ethnic minorities in London is greater when the minority group comprises a smaller proportion of the local population (Boydell *et al* 2001).

Asylum seekers and refugees

Asylum seekers and refugees experience multiple problems relating to their mental health and well being (Woodhead 2000). Some arrive in considerable ill health as a result of torture, conflict and war. They often show symptoms of post-traumatic stress disorder (PSTD), including flashbacks, intrusive thoughts, insomnia and eating disorders, compounded by depression and anxiety (Burnett and Peel 2001a, b, British Medical Association 2002). Services seldom meet their needs, and diagnoses are inconsistent in their quality and accuracy.

Occasionally, asylum seekers and refugees experience new types of problems on arrival in the UK – for example, lower self-confidence and a reduced sense of self-worth (Carey-Wood *et al* 1995). Legislation by the state further reduces the sense of well being of refugees and asylum seekers, as it leaves them feeling like second-rate citizens. It has been said that people often arrive in good health but become less healthy (Woodhead 2000).

Women

Women are exposed to numerous mental health risks that are particular to them. They are much more likely to live in poverty, particularly those who are lone parents and those in later life. Women are more vulnerable to social isolation because of higher levels of poverty, lone parenthood and lack of mobility. Women are more likely than men to be

dependent on public transport and they are less likely to be able to drive or to own a car (Department of Health 2002). Many women are fearful for their safety and choose not to go out alone at night (ONS 2001, Green *et al* 2002). Finally, women have longer life expectancy than men, and are more likely to live alone and in poverty in their later years.

Men

Men face specific mental health and well being issues. Alcohol and substance abuse is five times more common in men than in women. Men commit three-quarters of all suicides. Older men have the highest suicide rates in the UK, and young men have the fastest-rising suicide rates in the UK. Men are less likely than women to seek medical attention for mental health issues, and doctors are less likely to diagnose men with depression than they are women. Physical illness is a major contributory factor in men developing mental distress. Men also tend to have an earlier onset of schizophrenia and a poorer prognosis than women (Stewart 2000).

Older people

Older people encounter numerous problems in maintaining their mental health and well being. Nearly 1 million older people (10 per cent) in Britain feel acutely isolated, and an even higher proportion (12 per cent) feel trapped in their own homes. More than 630,000 (7 per cent) have felt in the last year as if no one knows they exist. More than 180,000 (2 per cent) have gone for a week without speaking to friends, neighbours or family (Help the Aged 2000, Cattan 2001). Depression and thoughts of suicide are significant problems for this age group, and this problem is further aggravated by widespread under-detection (Department of Health 2001b, Stewart 2001, Waern *et al* 2002). These issues are compounded by poverty.

Older people make up a diverse population, facing manifold mental health issues. For example, older gay men are isolated from the youth-orientated gay scene and frequently experience loneliness, often questioning the purpose of their lives (Smith and Calvert 2001).

Young people

Young people face a host of issues. An estimated 20 per cent of children and adolescents are experiencing psychological problems at any one time (Mental Health Foundation 1999).

- Young men who are suicidal are four times more likely than other young men to smoke and ten times more likely to take an illegal drug to relieve stress.
- 67% of suicidal young men say they have nowhere to turn for emotional help.
- 78% of depressed and suicidal young men have experienced bullying.
- 69% of suicidal young men have experienced violence from an adult.
- 50% have been in trouble with the police compared with up to 17% of the non-suicidal (Katz *et al* 1999).

Teenage mothers have an increased risk of adverse outcomes for themselves and their children (Department of Health 2002), and stresses on their families make it increasingly

difficult for vulnerable parents to meet all their children's needs (Mental Health Foundation 1999).

Indications show that circumstances that increase the likelihood of poor well being are generational; they are passed down from one generation to another. This means that children who live in poverty and routinely face disadvantage are more likely to experience high levels of mental illness and poor well being throughout their lives (Darton 1998). Particular childhood circumstances are strong predictors of corresponding levels of well being as an adult (Holland *et al* 2000). Over the course of their lives, individuals who have had an unstable or underprivileged childhood are often unable to cope with critical moments of transition, for example, leaving home, separation or the death of a loved one (Bartley *et al* 1997). However, it is unclear whether this is related principally to the social position of the child's family, or of the poor health the child experiences. It is likely that a combination of factors contribute.

Lesbians, gay men, bisexuals and transgender people

Lesbians, gay men, bisexuals and transgender people frequently face situations that affect their mental health and well being (Paul 2002). This stems from the cumulative effects of facing stigma and discrimination in the workplace (where there is no protective legislation) and in law (for example, inequality in partnership rights for same-sex couples). Homophobic bullying in schools is common, and harassment and violence are routinely experienced by these groups. For some gay men, being HIV positive has strong impacts on their mental health and well being, and carers of people with HIV/AIDS often suffer long-term stress (Golding 1996).

Gay people also experience prejudice within the health service itself: historically, psychiatry has viewed homosexuality as a psychopathology, and some doctors and therapists still subscribe to this view (McFarlane 1998). Currently, health services fail to recognise the importance of networks (Cant B 1999) in maintaining the mental health and well being of lesbians, gay men and bisexuals. Transgender issues are also important and remain largely ignored (Lombardi 2001).

People with disabilities

People with disabilities routinely face exclusion from mainstream society and this affects their mental health and well being. Wheelchair users find opportunities for working limited, as discrimination and environments that are poorly adapted (or frequently, not adapted at all) prevent them from gaining employment (Burchardt 2000). Disabled people and their families face poverty and exclusion from mainstream society, and this can give rise to, and compound, their poor mental health and well being.

In one large-scale study, Turner and Beiser (1990) found that adults with physical disabilities showed elevated rates of depression compared to non-disabled able-bodied adults. An additional problem is that developing appropriate services is seldom seen as a priority. For example, blind people have difficulties accessing relevant information about the services available to them (Vale 2001). People who are born deaf face a host of social and linguistic issues, which leave them excluded from the mainstream and 'at risk' of mental illness (Muth *et al* 1998).

People with learning disabilities

People in this group are more likely than others to encounter traumatic life events, making them vulnerable to mental health problems. Furthermore, they experience discrimination, lack of social acceptance, educational failure, lack of job opportunities, boredom and difficulties in finding acceptable sexual outlets (Reid 1995). An estimated 15 per cent of adults with severe learning disabilities have a severe associated behaviour disorder, although evidence suggests that a significant proportion of these problems are not diagnosed (Mind 1999).

Unemployed people

People of working age who are unemployed have higher levels of illness (shown by their use of health services, as well as other indicators), including mental ill health and associated poor well being (Warr 1987). In addition, the families of unemployed people experience higher levels of poverty and related poor health (Payne 2000, Davis and Hill 2001). People who are in employment are generally more likely to be mentally well than people who are not. Unemployed people are twice as likely as people in work to suffer from mental distress, with a figure of 10 per cent for full-time employed workers, compared with 23 per cent for unemployed groups (Mind 2002a).

Men are more likely than women to experience long-term unemployment and one in seven men who become unemployed will develop depression within six months (Stewart 2000). Unemployment is a major cause of depression and suicide in men. Unemployment as a result of retirement also poses challenges, especially for those older people who wish to work but experience discrimination.

Employed people

However, employment can correlate with a higher incidence of some forms of mental illness and poor well being. People in low-quality, stressful or insecure jobs with poor pay experience higher levels of mortality and sickness than their counterparts in jobs that bring greater satisfaction with better pay and conditions (Kivimäki *et al* 2002, Stansfield 2002), and people who have varied jobs and have control over what they do experience lower levels of illness. Bad working conditions can lead to mental illness and poor well being, and where the threat of redundancy is present, workers and their families may experience higher levels of mental illness and distress (Ferrie *et al* 1995).

People without access to transport

Access to transport affects mental health well being. Transport can enable people to access recreation, education, shops, health care and their social networks, so poor quality or inaccessible transport systems can bring isolation and loneliness, especially for the elderly, disabled and poor. Traffic reduces the use of residential streets and play areas for children, and traffic noise contributes to stress, depression and loss of sleep, which can lead to high blood pressure and poor well being (Transport and Health Study Group 2000).

People in poor housing

People who live in poor housing (for example, single parents, unemployed people and pensioners) often have low incomes, and higher levels of mental illness and poor well being than the national average (Hoggett *et al* 1999, Blackman and Harvey 2001). Children and older people are especially affected. There is additional evidence that living in a poor area close to an affluent and/or regenerated one can have adverse effects on health. Nevertheless, the process of improving housing can be stressful and disruptive for tenants, and relocating to new housing (on a temporary or permanent basis) can have a negative short-term effect on mental health and well being, although in the long term it can be beneficial (Huxley and Rogers 2001, Blackman and Harvey 2001).

Homeless people

Homeless people, rough sleepers and people living in temporary accommodation, along with their children, suffer high rates of mental illness (Diaz 2000). This is compounded by the fact that a high proportion of this group are from black and ethnic minorities and many are asylum seekers and refugees. People sleeping rough or using temporary night shelters are four times more likely to have a mental disorder than the general population (Department of Health 1999b). They are also exposed to more risks, including violence, sexually transmitted infections and drugs and substances (Diaz 2000). Homelessness can cause children to feel unsettled and become aggressive, and has significant effects on family relationships. There is a two-way process in which mental illness can lead to homelessness and homelessness in turn can lead to mental illness and poor well being.

People who are excluded from society

Some evidence suggests that people who are socially isolated and/or feel marginalised, who do not have strong sense of belonging to a community or neighbourhood and/or do not participate in local groups experience higher levels of mental ill health (McKenzie *et al* 2002). For this reason, organisations and communities need to focus on strengthening social networks, building capacity and investing in 'social capital' in order to develop effective responses that build prosperous, healthy communities. Similarly, family breakdown can have negative effects on an individual's well being.

People who have experienced abuse

Significantly, there is a positive correlation between a history of abuse in childhood and adult mental illness. This association appears stronger for women than men. People are at even greater risk of mental health problems if they have experienced severe physical or sexual abuse, repeated victimisation, abuse by a relative, the use of force or threats, and a negative response by someone who was told about the abuse (Mullen *et al* 1993, MacMillan *et al* 2001). Depression, anxiety disorders, suicide and substance abuse are the most common disorders associated with childhood abuse. One study found that almost half of the men and women in psychiatric inpatient wards had experienced physical and/or sexual abuse (Wired for Health 2002).

People living with long-term illness

Mental ill health can have long-term effects on individuals' physical health, with a higher susceptibility to heart disease, stroke, and susceptibility to viral infection and chronic conditions. This is another potential drain on health and social services resources. An ONS report found that people with a neurotic disorder were much more likely than those without a disorder to report a longstanding physical health problem. Thirty-eight per cent of adults with no neurotic disorder reported having a physical complaint. This rose to 57 per cent for those with one neurotic disorder, while among those with two or more neurotic disorders, 67 per cent reported at least one physical complaint (ONS 2000). Depression increases the risk of heart disease fourfold, even when other risk factors such as smoking are controlled for (Hippisley-Cox *et al* 1998).

In addition, sustained stress or trauma damages the immune system, thus increasing susceptibility to viral infection and physical illness (Stewart-Brown 1998). Depression, on the other hand, has a significant impact on health outcomes for a wide range of chronic physical illnesses, including asthma, arthritis and diabetes (Turner and Kelly 2000). One large-scale study found that emotional health problems were a more important cause of disability in adults of working age than all physical health problems put together (Stewart-Brown and Layte 1997).

Carers and loved ones

Carers and families of people with mental-health and well-being problems carry a huge burden and often feel isolated, which in turn can affect their health and well being (Flory 2002). The impact of having a loved one or close family member living with conditions such as cancer or HIV/AIDS-related illnesses is immense. Similarly, losing a loved one to a long-term illness also has considerable impact on the mental health and well being of the bereaved (Golding 1996).

People misusing substances

Mentally healthy people are more likely to make informed decisions about other health-related behaviours such as sexual activity, diet and exercise. People with mental illnesses often engage in unhealthy behaviours such as misusing drugs and substances and smoking. Drugs and substance misuse can be at once a cause and a consequence of mental illness, and can be associated with multiple social problems, including theft and intimidation. Smoking prevalence is significantly higher among people with mental health problems compared with the general population, with smoking rates as high as 80 per cent among schizophrenics (McNeill 2001). There is a shortage of targeted health promotion activities for people who are mentally ill, and they are seldom the recipients of services to improve their physical health, through nutrition or exercise programmes.

Cannabis use in teenage years and early adulthood may be associated with an increased risk of developing schizophrenia, depression and anxiety. Patton *et al* (2002) found a strong association between frequent cannabis use in teenage girls and later rates of depression and anxiety. They found that for young women, daily use of cannabis was associated with over five times the odds of depression and anxiety found in non-users. Weekly use predicted a twofold increase in later depression and anxiety, and daily use resulted in a fourfold increase. The picture for boys was not as clear. The association

between cannabis and schizophrenia has also been investigated, and appears to be a strong dose-dependant one (Zammit *et al* 2002).

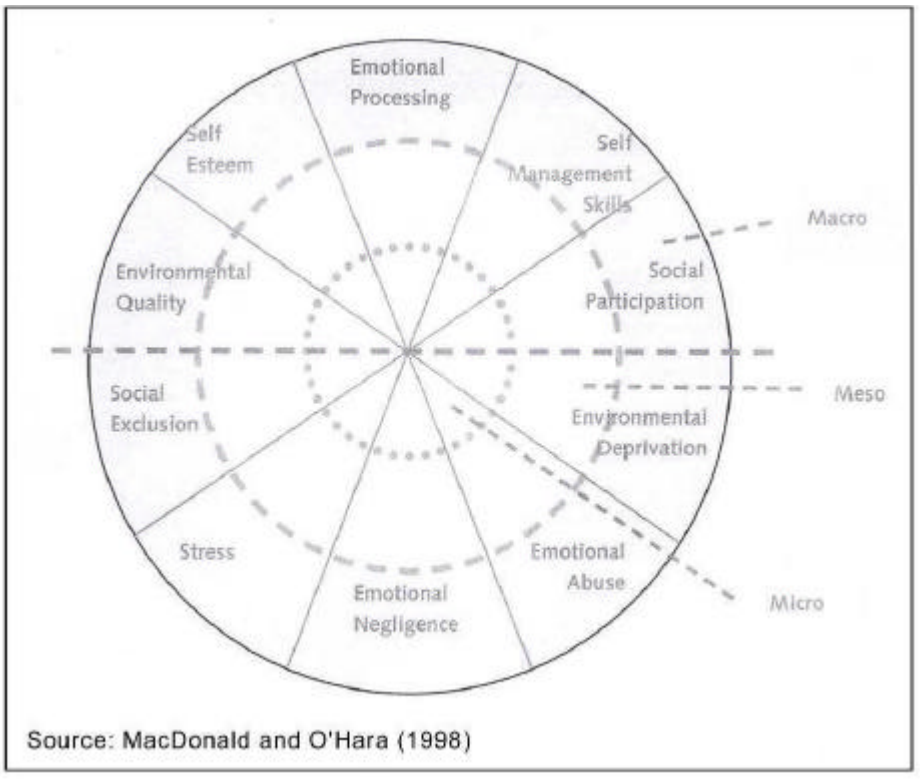
Mental health promotion

As we have seen, mental health is derived from a combination of the absence of mental illness and a sense of well being. Thus promoting mental health ranges from efforts to prevent mental illness to actions that seek to improve well being and protect people from adverse circumstances (Department of Health 2001a, Department of Health 1999a). For mental health to be promoted effectively, it must be based on a broad understanding of health and needs to encompass a correspondent breadth of co-ordinated interventions for maintaining and enhancing it.

As a field of activity, mental health promotion encompasses strategies, activities and interventions that seek to develop the resilience, resourcefulness and well being of individuals and communities as a means of improving their mental and physical health. It encapsulates a range of activities that seek to improve well being, including general action on the upstream determinants of health as well as specific, targeted health-promotion and health-protection measures.

These measures might include interventions for people in vulnerable groups who are 'at risk' of mental illness (primary prevention) and interventions aimed at maintaining the good health of individuals who have experienced mental illness, but are currently relatively well (secondary prevention). (See Department of Health 2001a, Department of Health 1999a.) Recent policy developments have provided a framework through which mental health promotion can be put into practice (Department of Health 2001b, Department of Health 1999a).

Figure 2



Source: MacDonald and O'Hara (1998)

It is generally accepted that a combination of protection and risk-reduction measures makes for sound mental health promotion strategies. Protective measures are those that create the conditions for good mental health, such as meaningful employment, good-quality housing and low levels of crime. Risk reduction measures include support for people 'at risk' in navigating through difficult circumstances. Figure 2 (opposite) shows how strategies that aim to improve the mental health and well being of a population function at several different levels.

There are a number of negative forces that can be inhibited (for example, poverty, poor services, lack of aspiration) as well as a number of positive forces which can be developed (for example social networks, safe environments, good services). The table below illustrates these forces and shows how developing protective factors and inhibiting risk factors can support the promotion of mental health and well being at different levels of society.

Factors that affect mental health and well being

Level of influence or action	Protective factors	Risk factors
Individual	• meaningful role in society • self esteem and confidence • resilience • adequate income, warm home, wholesome food, regular exercise	• living in poverty • inadequate social support • low self esteem and poor interpersonal skills
Family	• planned parenthood • loving, supportive relationships • adequate income	• living in poverty • teenage parents • abusive/neglectful parenting • parental substance misuse
Work	• respectful and trusting work environment • clear expectations of role and accountability • balance between effort and reward perceived to be fair	• lack of autonomy • lack of security • low pay • discrimination
Community	• high levels of interaction • high levels of participation in community activity • influence over decisions which affect community • physically pleasant surroundings	• poor housing • high crime rates • poor transport • poor local services • lack of trust between people
Society	• inclusive and participative • tolerant and caring • equitable	• exclusive and intolerant (for example, racism, ageism, sexism, homophobia, sectarianism) • inequitable

Source: Scottish Public Mental Health Alliance (2002)

Many agencies have direct influence on reducing negative forces and promoting positive ones. The private sector has a key role to play in developing its capacity to promote mental health and well being in the workplace, as well as in funding local community-based initiatives. The public sector also has a key role to play. For example, the NHS should provide effective public health and health promotion services, both to the community at large and also to its employees, in the form of workplace mental health promotion. Primary care can identify people who are 'at risk' of becoming mentally ill and making interventions to minimise deterioration.

Similarly, local authorities can improve mental health and well being through local attempts at area-based regeneration and poverty reduction. By investing in local providers of goods and services, authorities can improve the well being of its residents and provide opportunities for employment. Housing departments and housing associations can work to improve housing stock, as well as providing adequate accommodation for people with mental health problems. Social services departments can work with children who are looked after to improve their well being, as can local education departments. In partnership with the police, local authorities can consider the mental health impacts of local crime and use their community safety initiatives to improve well being. Improving transport and the environments in which people live can also be a way of promoting their mental health.

The voluntary sector has a pivotal role to play. Support for individuals experiencing poverty, stress or mental illness – and their families – is routinely provided by large organisations such as Turning Point, which runs programmes to help people with drugs and substance misuse problems and associated mental illness. Similarly, community sector organisations play important roles in offering support and developing the capacity of communities to identify needs and solutions to complex problems.

EXAMPLES OF EFFECTIVE PROMOTION OF MENTAL HEALTH AND WELL BEING

Upstream (protective measures)
At this level, systemic and structural changes are needed to create environments for better mental health. These measures include:

- improving the local environment
- raising quality of housing
- increasing community safety and reducing crime
- tackling social exclusion and provide local employment
- improving mental health promotion in regeneration initiatives.

Midstream (protective and risk-reducing measures)
This includes interventions that are focused on developing and mobilising communities. These measures include:

- developing communities to assess their own problems, identify solutions and build on resources to improve health.
- implementing mental health and well being policies in workplaces
- orchestrating mass-media campaigns.

Downstream (risk-reducing measures)
At this level, we find lifestyle-type interventions, focusing on families and individuals. These measures include:

- schemes to improve parenting
- support for identified children and their parents through schools
- life skills and coping skills for children and young adults focusing on factors such as self esteem, self worth, assertiveness and communication skills
- providing counselling in schools for children identified as being in need
- cognitive skills training for children if their parents are separating, if a member of the family is critically ill or if they are grieving
- support for older adults who have lost partners
- social support and problem solving for the long-term unemployed
- psychosocial support for long-term carers.

National policy

Mental health promotion is featuring more strongly than ever before in national policy documents. Although the picture is complex and uneven, the importance of an upstream preventative agenda is reiterated across numerous national initiatives aiming to improve health through regeneration, community development, and other schemes to promote social inclusion. In addition, the importance of supporting people who have been mentally ill in keeping well is as evident as ever. In particular, Standard One of the Mental Health National Service Framework (1999) suggests approaches designed to improve the health of the population by promoting its mental health and improving its well being. It states that health and social services should:

> *promote mental health for all, working with individuals and communities; combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.*
>
> Department of Health 1999a, p 14

The Mental Health NSF states that through health improvement programmes and local mental health strategies, local health and social care communities (which include local health authorities, local authorities, NHS trusts, primary care trusts, and the independent sector) should develop effective mental health promotion for:

- **whole populations** – through initiatives to promote healthy schools, healthy workplaces and healthy neighbourhoods
- **individuals 'at risk'** – supporting new parents, unemployed people, and families in distress – for example, making use of local self-help groups
- **vulnerable groups** – including specific programmes for black and minority ethnic communities, people who sleep rough, those in prison, individuals with alcohol and drug problems, people with physical illnesses, and others at greatest risk
- **action to combat discrimination against people with mental health problems** – and to promote positive images of mental ill health.

The policy provides manifold opportunities for promoting mental health and well being, not least in that it enables strategic connections to be made with other national initiatives designed to improve health and reduce inequalities. Every primary care trust or borough is charged with producing a strategy outlining actions to be taken at local levels.

Developing and implementing local strategies

The research found that developing and implementing local strategies made up of a series of complex activities, which differed from one borough to another. Capacity to realise the process in relation to promoting mental health and well being varied across the capital. However, several common themes emerged. Overall, participants were familiar with the principles of developing strategies. A range of issues were discussed, including:

- differences of opinion in understanding the scope and potential of mental health and well being promotion
- barriers to achieving a consensus about viable options
- problems in agreeing lines of accountability
- barriers to securing sustainable sources of funding.

Examples of positive practice were shared by participants in the workshops and telephone interviews (see Appendix 3).

Establishing awareness and enthusiasm

The following key themes emerged from the research:

- Different interpretations of the term 'mental health promotion' were a barrier to progress.
- Progress was made when co-ordinators pointed to concrete examples of what agencies could contribute, supported by an evidence base.
- Evidence of effectiveness had a strong role to play in making local cases for mental health promotion.
- It remained difficult to make a coherent economic case.

These points are examined in detail below. Quoted text is from personal interviews and workshops of local strategy implementers and practitioners by the authors, conducted throughout 2002 (see Appendix 1).

- **Different interpretations of the term 'mental health promotion' were a barrier to progress.** Language differences between the NHS, local government and the voluntary sector were felt acutely, especially where time had not been given to share meanings. There was a strong association in people's minds with services for people with severe and enduring mental illness, and opportunities for joint action were often missed. In some areas, strategy co-ordinators spent long periods of time explaining what mental health promotion was, and what it might look like – with varying effects. Similarly, for those who saw mental health promotion as a broad and inclusive enterprise, there were problems. One participant explained:

  The problem is mental health promotion can refer to everything or nothing, it's such a blunt instrument, I'm not sure what use it is at all.

It became clear that even among strategists and those 'in the know', a wide variety of interpretations existed. One noted:

> *Really, it doesn't matter what we call it, but we should seize the opportunity and use the influence we have to join up the agendas. When else can we get community safety people sharing a work programme with mental health nurses and teachers? We mustn't waste time arguing about semantics. Get on with it!*

Participants suggested ridding the terminology of any medical connotations and suggested focusing on the robustness, 'fitness for purpose', 'emotional well being', and feelings of self worth, both of individuals and communities.

- **Progress was made when co-ordinators pointed to concrete examples of what agencies could contribute, supported by an evidence base.** One participant explained:

> *And so I explained to the Cabinet member for housing, it's not just about housing for people after they have been discharged from mental health services. It's about making sure that the housing the council provides isn't adversely affecting residents' emotional state through overcrowding or poor insulation or anti-social neighbours. You could almost hear the penny drop!*

However, not all efforts to engage potential partners or champions were as successful. Succinct examples could illustrate why agencies and departments should get involved, such as the following participant:

> *They'll be interested if it helps them reach their own targets. We have to show them the benefit. The strategies really have to add something new, not just create a whole load of new work.*

- **Evidence of effectiveness had a strong role to play in making local cases for mental health promotion.** However, despite strong supporting evidence, there was not unanimous support for the aims of mental health promotion. When research was identified to support proposals, some participants felt that their work was likely to receive the support of sceptical colleagues. However, that was not always the case. One health promotion manager captured the complexity of the problem:

> *So a doctor from [the local mental health trust] argued that if we are to allocate resources in relation to proven effectiveness, then the prevention agenda shouldn't be a priority. He referred to various bits of research. Similarly, I stated what I knew about the evidence base and one piece of research that disputed the use of drug therapies he was proposing. We were just deadlocked and could get no further forward. In the end, we made a decision on the basis of what they – the professionals – valued. Evidence-based decision making is more complicated than a lot of the guidance seems to acknowledge.*

This was particularly felt in relation to psychiatric services, where colleagues were often wedded to traditional measurements of effectiveness and dismissed the claims of qualitative research:

> *It is difficult, we are trying to develop a common view with a set of people who see the world differently to us.*

Participants said that work done with the voluntary sector organisation Mentality, which pulled together available evidence, was particularly helpful in this regard.

- **It remained difficult to make a coherent economic case.** One participant argued:

  We need some data which shows that if we invest this much in mental health promotion, then we can expect this much of a saving in the uptake of physical and mental health services. Mental health promotion always sounds like a wonderful idea, but what are the real, measurable benefits to the communities we are working with?

  In a climate characterised by resource constraints, it was important to be able to demonstrate short and long-term cost effectiveness.

Developing strategies

In this area, the following key themes emerged:

- There was widespread frustration at the difficulties in developing borough-wide strategies for pan-London issues.
- Strategy documents were consistently of a high quality.
- A common focus supported the development of strategies from across sectors.
- Inclusive and participatory approaches were crucial.
- An established local commitment enabled effective development and implementation of mental health promotion strategies.
- Integration with other strategies and partnerships was crucial.
- Public involvement in developing strategies remained underdeveloped.
- The value in identifying and nurturing mental health promotion champions was underscored.

These areas are examined in detail below:

- **There was widespread frustration at the difficulties in developing borough-wide strategies for pan-London issues of immense historical and social complexity.** Participants were pleased that they had tools to influence and implement local change, but felt that a broader perspective was needed, as the actions and needs of the most vulnerable and at-risk groups did not correspond to borough boundaries.

- **Strategy documents were consistently of a high quality**, identifying national drivers, local needs, and current provision. Most went on to identify opportunities for development of initiatives and anticipated barriers. Few strategies considered the development of evaluation programmes for their work, and fewer still identified strong streams of resource specific to mental health promotion. Most sought to use other strategies and plans in such a way as to promote mental health and well being. Most participants expressed enthusiasm for the process of developing and implementing local strategies and underscored the opportunity presented within them to improve health.

- **A common focus supported the development of strategies from across sectors.** Rigorous need assessment and mapping of current services enabled strategists to ‘argue the case’ and gain the respect and interest of agencies. A common theme,

which could immediately show the benefit to potential partners, was occasionally established. An example of this was in Greenwich (contact: Carol-Ann Murray-Mohammed, Greenwich PCT, Tel: 020 8694 7321), where the strategy was built around the theme of isolation. As one participant explained:

> *When we are talking to community safety colleagues, they immediately see the connections between the fear of crime and isolation. When we talk to social services, they see the connections between young carers and isolation from their peers. When we talk to regeneration officers they see the connections for the long-term unemployed … taking [isolation] as the theme has given us an opportunity to engage a whole range of people.*

There was a need to think creatively and laterally. A shared focus gave the strategy momentum, kept it achievable and pointed to concrete ways of measuring success.

- **Inclusive and participatory approaches to developing and implementing strategies were crucial.** Where strategies had been successfully developed, there had been a process of involving organisations and establishing strong governance structures to support implementation. Where lead organisations had developed plans in isolation, strategies were often narrow in focus and were not able to capture the commitment of other local organisations, or to encourage them to deliver against targets. The development of successful strategies was often iterative, where strategy co-ordinators regularly reviewed progress being made and identified weak spots early on, enabling swift remedial action. Where stakeholders felt that they had a share in the strategy, or they felt a measure of ownership and accountability in what was being undertaken, greater levels of commitment and delivery were enjoyed.

- **An established local commitment to delivering public health and health promotion enabled the effective development and implementation of mental health promotion strategies.** In organisations where there was a broad understanding of the value of public health and health promotion – and recognition of the importance of preventative agendas – mental health promotion strategies were given a priority, which enabled significant progress. It was not only NHS agencies that were engaged in these activities; those local authorities that saw mental health promotion as part of their duty to promote the well being of their residents also performed well. Activities had been successful where there was an established commitment to building strong connections between strategic worlds and implementation with clear models of delivery. However, such success was seldom evident.

- **Integration with other strategies and partnerships was crucial in developing effective mental health promotion strategies.** Developing a multi-agency strategy for mental health promotion had been helped by allied and established partnerships that sought to reduce health inequalities (principally through health improvement and modernisation plans, or HIMPs, now replaced by local delivery plans). This had not always been the case. For example, as one policy maker commented:

> *The local HIMP embraced the idea of mental health promotion and saw it as a vehicle for bringing together its work with regeneration, education, and housing and other bits of the picture. Two years ago, that just would not have happened here. Because we had the arguments last year about inequalities and exclusion, we were pushing against an open door.*

Where HIMPs had taken a back seat in local health planning, mental health promotion had less of a profile.

- **Public involvement in the development of strategies remained underdeveloped.** While residents were occasionally well connected into local regeneration initiatives, and those views influenced developments, local people – including carers or service users – were seldom seriously involved in identifying needs, solutions or interventions.

- **The value in identifying and nurturing mental health promotion champions was underscored.** These included community leaders, key voluntary sector personnel and councillors. These individuals were instrumental in keeping mental health promotion on the agenda in a range of fora and agencies. They were outspoken people who were able to see the connections between strategies and could see the potential of them in promoting mental health. One participant commented:

  There's a particularly outspoken councillor who seems to understand what we are doing. She's been a great advocate of our work.

Implementing strategies

Research in this area revealed the following key points:

- The potential of local strategic partnerships in developing holistic responses to complex issues was well noted.
- Local implementation teams that were specifically set up to improve mental health services did not always welcome health promotion colleagues.
- Implementation was impeded by the changes in local commissioning and delivery organisations.
- PCTs prioritised health service delivery over health promotion.
- Robust models for delivery were being developed.
- Other models also bore results.
- Resource issues recurred.

These are examined in detail below:

- **The potential of local strategic partnerships in developing holistic responses to complex issues was well noted.** They created numerous opportunities to see issues 'in the round' and develop comprehensive responses. A small number of participants were working to develop tools for measuring mental health impact of local strategies and plans on local people, and the local strategic partnerships drove the work forward. However, participants complained about the enormity of the strategic agenda, the proliferation of local strategies and the large number of partnerships within which they were expected to work. Overwhelmed with strategic developments, some local policy managers found the monitoring progress difficult.

- **Local implementation teams that were specifically set up to improve mental health services did not always welcome health promotion colleagues.** It was often easier to make the case for work with colleagues from sectors not directly involved with mental health work, as their interest were not clouded by 'traditional' views of mental health and illness. One participant explained:

It's easier to talk to the officers in the regeneration team – they get what I am talking about straight away, unlike our local psychiatrist.

However, in some boroughs integration had been achieved, through the perseverance of individuals dedicated to improving the profile of mental health promotion locally.

- **Implementation was impeded by the changes in local commissioning and delivery organisations.** This was most notably the case in the establishment of primary care trusts. According to one interviewee:

  Few of us were certain we'd even have jobs in the new structure, let alone what we were supposed to do. Morale slumped and we slowly ground to a halt.

  In places, mental health promotion work was being done despite changes in structures, rather than because of them. Another described their situation:

  There's a small group of us [here] who get on with the work regardless, but it is difficult. One of the strongest connections in the council left last year and he has not been replaced. It is not easy finding allies… it's not easy getting work done.

  Complex issues that were hard to establish were more likely to suffer in times of change.

- **Implementation was impeded by the changes in local commissioning and delivery organisations.** PCTs prioritised health service delivery over health promotion. Participants pointed to the lack of priority given by PCTs to health promotion and prevention work generally. One said:

  We will be judged in terms of what we deliver in hospitals. How quick we can cut waiting times? How much money can we save on drugs spend? Health promotion is seen as the icing on the cake. Nobody has the time to lift his or her head up and think long term. It is getting better, of course, but slowly.

  The funding available for mental health promotion was, accordingly, minimal.

- **Robust models for delivery were being developed.** In some places, the co-ordinators were seen as the leaders of local partnerships who effected change through co-ordination and strategic leadership. In this model, the partner agencies were the deliverers of services. One explained:

  We have strong partnership arrangements here, and an understanding of the roles of partners in delivery. The council takes a strong role. And there are several councillors who support this work.

  Success was achieved when mental health promotion was brought into other existing initiatives, such as opportunities for developing healthy schools, as in Hackney. In Lambeth, the South London and the Maudsley mental health trust works with the local further education college and trains tutors in awareness about mental health (contact: Caroline Morris, South London and Maudsley MHT, Tel: 020 7411 6396).

  The training aims to dispel myths about mental illness and to improve the uptake of mainstream college courses by mentally ill students. The results have been

impressive, with significant increases in enrolment and completion by students who might otherwise have not succeeded. This has been heralded as a success for all involved. The students have been able to access courses and develop their knowledge and skills, improving their chances in the job market. Lambeth College has been able to meet targets in developing access for students, and the mental health trust has been able to support activities for a vulnerable group that often finds it difficult to access mainstream services.

- **Other models also bore results.** For example, the borough of Kingston has seconded a member of staff to the PCT to support the development of health strategies, including mental health promotion. In other places, the partnership met in an advisory fashion, offering support to the co-ordinator who was seen as the person responsible for implementing the strategy. In these cases, progress was slow. According to one participant:

  People talk a lot, but few people seem prepared to do any work.

  In most cases, a hybrid model was developed. Another explained:

  The reality is that [while] some partner organisations are able to act and get on with it, others are less able, or fail to see the roles they could perform. It is difficult trying to get people to take on extra work when they are stretched themselves with their services. I ask people to help but I have no way of really getting them to do anything, or even monitor the quality of what they do. It's like a partnership where everything relies on good will. I end up doing things; otherwise we wouldn't meet our basic targets.

  If resources were available to support the work, it would have been easier to secure action from partners.

- **Resource issues recurred.** Unanimously, participants thought that there were inadequate levels of funding for mental health promotion activities, and that this reflected a lack of understanding and will on the part of funders to secure the long-term success of their work. However, co-ordinators and others used the situation creatively and identified other sources of money to use to mental health promotion ends. As one noted:

  We have to use what we've got differently and influence others' use more effectively.

  Others saw the resources as being the people with whom they were working, and the authority and expertise they brought with them:

  Small financial resources do not equate with failure. We have to pool expertise, knowledge and resources, and keep optimistic.

  There was a high level of determination that poor levels of funding at this stage would not impede success:

  We can't 'magic' success out of thin air.

Progress and effectiveness

The key theme that arose in this area was that a strategic approach to evaluation was advocated. One participant commented:

> *Not every initiative needs a new piece of evaluation – we should be using what research money there is to evaluate the long-term changes of a whole load of related social issues, like community safety, employment and mental health.*

Other participants worried about the value of evaluation:

> *Nobody ever reads the reports – every time we do a new piece of work we seem to start from scratch. I'm sure we make the same mistakes over and over again.*

Other participants complained that there were no local mechanisms for sharing findings or learning and that agencies were slow to change. Notable exceptions included Health Action Zones, which exercised flexibilities and supported innovation. However, the funding of relevant and rigorous research was not always seen as a priority. A shortage of funds for co-ordinating action and delivery meant that it seemed inappropriate to spend disproportionately high levels of money on evaluation:

> *We have the research – we now need to get some bloody work done!*

Participants sought evaluation money from elsewhere:

> *They're spending millions on evaluating the neighbourhood renewal strategy. We need to make sure that there is sufficient 'buy in' from the [Neighbourhood Renewal] Unit to use some of their capacity to measure the impact of what is going on.*

It was not possible to show that innovation worked without rigorous evaluation, and resources were too constrained to measure effectiveness.

Conclusions

Developing and implementing local strategies was often difficult for those in charge of co-ordinating them. There were strong examples of positive practice, and participants were open and willing to talk about the manifold blockages they encountered, as well as the opportunities they seized. The agenda to reduce inequalities was a key incentive to co-ordinate strategies. There were groups of committed individuals driving the agenda forward, who thought laterally and creatively about how best to ensure 'buy in' and long-term success. However, low levels of commitment, lack of resources, and poor local profiles for the work were common. There was a general inability to manage the development and implementation of effective strategies in a time of considerable upheaval and organisational change.

Effective strategic partnerships were seen as key to developing integrated and successful services. However, several challenges had been encountered in adopting such approaches. Limited dedicated resources threatened implementation, and the focus on delivering health services rather than health promotion initiatives in the NHS were seen as potential problems.

There were multiple problems in using evidence to develop initiatives. Decisions were made as a result of complex negotiations, which took into consideration historical precedents, local personalities and national imperatives, as well as evidence of need and effectiveness. On occasion, participants did not know what the evidence was, or where to find it. Others noted that the concept of evidence remained wedded to a medical model of health that did not account for work being undertaken in community settings, using social models.

Working with vulnerable groups

Working with vulnerable groups in London brings manifold difficulties and opportunities. Several clear themes emerged from the research (see Appendices 1 and 2), including:

- terminology and classification
- the challenges of working with diverse communities
- the importance of developing effective interventions
- the poor levels of resource available for action.

Primary and secondary prevention activities were frequently undertaken together, making distinctions between the two difficult.

Concepts and frameworks

Across the workshops and case studies, there was a strong focus on what mental health promotion should be striving to achieve, underpinned by a strong values base. The main points raised were:

- The term 'mental health promotion' was problematic.
- There was strong support for approaches that considered the upstream determinants of health as well as individual behaviours.
- There was no single causality for mental illness.
- To work effectively with vulnerable groups, it was necessary to recognise the complexity of people's lives and respond accordingly.
- While these groups were not homogenous, the deep-seated societal problems they encountered were similar.
- It was necessary to tackle myths about mental illness.

These points are discussed in detail below:

- **The term 'mental health promotion' was problematic and should be used with caution.** It was strongly associated with medical models of illness and considered restrictive. In particular, it focused too strongly on the prevention of (recurrent) mental illness and not on positive actions. Other terms, including 'emotional health', 'spiritual health' and 'well being', were preferred.

- **There was strong support for approaches that considered the upstream determinants of health as well as individual behaviours.** It was recognised that sustainable wealth, opportunities for employment, access to education, allocation of decent housing, and availability of appropriate food all had effects on the mental well being of individuals, families and communities. There was also recognition that anti-social behaviour, violence and other crimes had an impact. Above all, poverty was a major factor – it was a cause and a consequence of poor mental well being, as expressed by one respondent:

  There's no point in looking at mental health without thinking about how to relieve poverty.

Poverty was seen to have cumulative effects on mental health and well being, where years of struggle affected individuals considerably.

- **There was no single causality for mental illness.** Similarly, there could be no simple 'one-size' approach to promoting mental health and well being. Many participants described the process as 'circular', where experiences such as homelessness, redundancy or marital breakdown might adversely affect the mental health and well being of people from certain vulnerable groups. Similarly, those same people found it harder to access support and develop resources to cope, which in turn would affect their ability to find accommodation or jobs, or to have successful relationships. As one participant put it:

  When you try to understand what makes good mental health, you have to admit that it's really complex, just as trying to understand society is really complex. The two go hand in hand.

- **To work effectively with vulnerable groups, it was necessary to recognise the complexity of people's lives and respond accordingly.** There was concern that to talk about groups of individuals in homogenous terms might serve to over-simplify personal experiences, or to assume wrongly that all people designated to a particular group would have similar views, experiences or needs. This was illustrated by differences between generations of South Asian communities, where attitudes to marriage and gender roles were changing. Seldom did individuals identify with only one group.

  While there were some common characteristics, such as poverty, within vulnerable groups, there were individuals who could identify with more than one group in ways that affected their mental health and well being. For example, one participant noted:

  Trying to access support in relation to my disability is difficult when I am in black services, and it's the same the other way round. I don't seem to fully fit any one service!

  Seldom did individuals see themselves as from one category or another – there remained challenges for policy makers and practitioners in recognising the complexity of needs. A frank and open discussion was called for to understand the complexity of individual needs and appropriate community responses.

- **While groups were not homogenous, the deep-seated societal problems they encountered were similar.** Participants brought a variety of illustrations. For example, they said that regardless of personal circumstances, disabled people faced similar types of prejudice on a daily basis, which affected their well being. Similarly, black and ethnic minorities routinely encountered institutional racism. In the past, people who were born deaf were often raised with little encouragement to be independent so for them, adult life brought significant challenges – although this was changing slowly. For all these groups, there was a history of being excluded from mainstream society and its services, and this had a bearing on their needs and expectations.

  It was seen as easier and more productive to identify the common problems they faced than to try and identify overarching cultural similarities within – and between – disparate groups. In the lesbian, gay and bisexual workshop, the point was clearly made: routine exposure to homophobia in school, the workplace and in everyday life had long-term and cumulative effects.

- **It was necessary to tackle myths about mental illness.** Participants were unanimous in their view that progress in developing adequate and appropriate interventions to promote mental health and well being was impeded by widely held misconceptions about mental illness. This had a two-edged effect. First, it made people from vulnerable groups uneasy about talking about their illness because they expected poor understanding from peers, colleagues and practitioners outside of their group, who would confuse their mental illness or poor well being with their sexual, cultural or physical differences. One participant said:

  We are not the problem, it is the material disadvantage we face and the prejudices of practitioners, organisations and the rest.

  Second, they were fearful of reporting their mental illness to people within their own minority groups as there were also high levels of misunderstanding and discrimination within them. These factors reinforced rigid misconceptions about mental health that participants were keen to dismantle.

Developing services

The participants from the workshops and the practitioners from the case studies talked at length about appropriate ways to develop services and deliver effective health promotion locally. Key points they raised included:

- Developing services in London brought specific challenges.
- Mental health promotion was not the sole responsibility of the NHS.
- Community development was advocated as a method for promoting the well being of vulnerable groups.
- The National Strategy for Neighbourhood Renewal provided manifold opportunities to promote mental health and well being.
- Community safety initiatives brought opportunities to significantly improve mental health and well being.
- Employment was key to promoting mental health and well being.
- There was potential to develop a stronger role for primary care in working with vulnerable groups.
- Schools were important sites for mental health promotion.
- Public and user involvement in the development and operation of projects was crucial.
- Access issues remained acute for black and ethnic minorities.
- Other groups saw access issues as equally important.
- Effective combinations of mainstream and targeted services to meet the secondary prevention needs of specific groups were necessary.
- Successful secondary prevention projects enabled individuals to take control of their lives.
- Effective services provided the means for individuals to improve their well being through supporting day-to-day activities and enabling social contact.
- The experience and expertise of voluntary sector was not always valued.

These points are discussed in detail below:

- **Developing services in London brought specific challenges.** For the voluntary and community sector, the complexity of working across and within numerous boroughs and funding regimes was difficult. Often there was a lack of co-ordination and difficulties in obtaining a full picture of how initiatives and services corresponded to need. In the workshops, participants were vocal in their desire to see the London Health Commission take a lead in seeing mental health promotion as a pan-London issue.

- **Mental health promotion was not the sole responsibility of the NHS – local authorities and the voluntary sector also had strong roles to play.** When working to shift the upstream determinants of mental health and well being, it was important that the local authority was aware of the potential of its actions to have impacts on local people. There was concern that local authorities were not as aware of the needs of their vulnerable residents as they might be.

- **Community development was advocated as a method for promoting the well being of vulnerable groups.** There were opportunities in healthy living centres and other community resources. The suggestions made were wide ranging. They included information points, one-stop shops and support and advice services. Others advocated community action to resist unwanted changes:

  We need to find ways in which we can provide the means for groups to organise themselves, work out what would help them and support them in taking action. It's all about empowerment. We have to stop turning up at community meetings with our own agendas; we have to let them tell us what needs doing.

  Community development approaches could effectively bring together people who had not experienced mental illness with those who had, through volunteering. Illustrative examples included gardening projects, which bore results in providing therapeutic activities as well as engaging individuals in community action.

- **The National Strategy for Neighbourhood Renewal provided manifold opportunities to promote mental health and well being.** Its focus on reducing inequalities was welcomed. There were examples across the capital of regeneration projects that were being developed to improve the mental health and well being of residents. For example, in Greenwich, the Health Benefits Regeneration programme (contact: Bridgett Puntis, Greenwich Council, Tel: 020 8921 6907) was working with local people to combat crime, anti-social behaviour and poor estate design as ways of reducing isolation for people living in poverty.

  The National Strategy offered opportunities to relieve poverty and its effects at local levels. However, tensions were expressed about how best to balance waiting for the long-term changes that regeneration might bring, with the immediate needs of vulnerable groups and the low levels of resources currently being issued. The tension between focusing on the upstream and providing services ran through the discussions. While participants understood the importance of the long-term agenda to shift the determinants of health, improve health and reduce inequalities, their interests in concrete terms were in providing effective interventions, with immediate positive effects for individuals and their families.

- **Community safety initiatives brought opportunities to significantly improve mental health and well being.** Participants saw the connections between the mental health promotion activities and those that sought to reduce violence against ethnic minorities. They also saw the close relationship between the causes and effects of violence on well being. It was noted that the situation was complex:

  Young black kids are more likely to be the victims and perpetrators of crimes. This has real effect on their well being, on the way they interact with each other, and the way they behave in public.

  A frank and open debate on these matters was called for. The fear of crime was also a major factor in considering the mental health and well being of older people, who often felt unable to leave their homes for fear of attack, resulting in isolation, loneliness and associated health problems. Similarly, domestic violence was seen as having long-term effects on victims' lives. One participant said:

  We are only just beginning to understand the effect of violence in the home on women, and the effects on children who witness violence over and over again.

- **Employment was key to promoting mental health and well being.** This was expressed in two ways. First, participants saw meaningful employment as a way of reducing poverty and engaging people in society, and therefore reducing the likelihood of mental illness and poor well being. This was especially important for people who had difficulties finding employment, including the elderly. Regeneration initiatives were crucial in this regard, as were attempts by the government to develop flexible employment schemes that were appropriate to individual needs and abilities.

  In addition, the provision of supported employment for people who had experienced mental illness was important to re-establish patterns of daily living and minimise the possibility of future mental illness. The NHS was a key provider of work, and participants spoke at length about exemplary initiatives at South West London and St George's Mental Health NHS Trust, which recruited mental health service users.

- **There was potential to develop a stronger role for primary care in working with vulnerable groups.** These developments could take many forms. Primary care staff could take a more proactive role in promoting mental health to patients accessing services for other related, and non-related, issues:

  We should be using every chance we get and encouraging people to address their emotional problems and realise that we can help.

  Other participants considered the role that primary care could play in offering welfare and benefits advice as a way of alleviating the effects of poverty. Lambeth, Southwark and Lewisham Health Action Zone had undertaken pioneering work in developing welfare advice in primary care settings (contact: Kathryn McDermott or Ian Sandford, Lambeth, Southwark and Lewisham Health Action Zone, Tel: 020 7902 2342/2349).

- **Schools were important sites for mental health promotion.** Participants spoke at length about the potential of using the National Healthy Schools Initiative as a vehicle to promote mental health and well being of young people. In Brent, the Kingsbury school has developed the CONNECT project (see Appendix 2), which

focused on improving the mental health and well being of students by tackling bullying. The project was successful because it used a whole-school approach in tackling bullying, supporting victims and engaging parents. In addition, working with young people was seen as crucial to changing societal attitudes to mental illness. For example, the Newham Asian Women's project (see Appendix 3) was working in schools to challenge misconceptions among young people about mental health.

- **Public and user involvement in the development and operation of projects was crucial.** Successful projects had high levels of involvement, not only in setting agendas and identifying problems, but also in delivering services. As one worker from Family Health Isis (see Appendix 2) commented:

  I think we are successful because this project is run by, and for, black people. Therefore, people who come here feel more at ease and there's greater openness to explore whatever the issues are.

  The CONNECT project at Kingsbury School was exemplary in this regard:

  It's all about involvement. Getting kids involved in the project makes school life more interesting for them. They feel part of the school and that they have a voice. This empowers them and makes the school a better place for teachers and the kids.

  Involving the young people was not only an ethical decision – it heightened a project's success.

- **Access issues remained acute for black and ethnic minorities.** While the exact nature of the problem varied between groups, it was clear that vulnerable groups had difficulty in accessing secondary prevention services. For example, there was a paucity of adequate provision for black and ethnic minority people who had used mental health services and were seeking support, rather than care, after leaving hospital. One worker from Family Health Isis commented:

  We could visit a hospital in-patient unit and see a lot of African-Caribbean people using those services. But when it came to day care services, there were hardly any black people at all. We felt: 'Where are these people – where have they gone?'

  The issues were cultural as well as linguistic. One African-Caribbean service user commented:

  You go into hospital and you may be frustrated, and you're talking to the doctor, but he or she doesn't like the way you talk. You're waving your hands about and you're talking loudly – so they hold you down, and then that goes down on paper that you were being hyperactive and aggressive.

  The fears of service users being misunderstood or badly treated by statutory services meant that community-based services were in a position to give support in more appropriate ways, reaching people who had 'fallen through the net'. Effective interventions with vulnerable groups recognised cultural differences

- **Other groups saw access issues as equally important.** For disabled people, physical access to buildings remained a key concern. For deaf people, the issues were different – most were about fundamental communication problems. For people who

had been deaf from birth, there needed to be an understanding of what it was like to have never heard. A service provider noted:

Being deaf from birth isn't like having a disability – it's like being from a different culture, with a different way of communicating and different mores. We have to publicise and adapt our services otherwise they will never get used.

People with learning disabilities faced particular problems and found accessing mental health services difficult, despite the fact that mental illness was widely experienced. Young people also found access a problem – they reported feelings of intimidation in relation to statutory services. The CONNECT project at Kingsbury School was keen to provide appropriate services, and had experimented with its approach:

When we first set up the project, we only had the drop-in centre. This wasn't working very well. We had lots of workers there but no one was using the service. This was probably due to the stigma attached to coming in to see someone from CONNECT. So we took the service to users and publicised the project more. This worked.

- **Effective combinations of mainstream and targeted services to meet the secondary prevention needs of specific groups were necessary.** Specialist services gave groups choices about how best to access support. Services dedicated to meeting the mental health promotion needs of a particular group created a safe atmosphere of trust and common understanding. Specialist services gave those groups choice. However, they should not be instead of, but in addition to, mainstream services. All services need to address the needs of the diverse cultural groups that cross their doors and strive to be accessible and appropriate. Above all, services had to be co-ordinated locally.

- **Successful secondary prevention projects enabled individuals to take control of their lives.** One participant explained:

  As people become ill, they begin to lose control over their own lives, and other people – such as those in mental health services – take control.

  Participants repeatedly emphasised how effective services supported individuals in establishing productive lives, and that they did not 'care' for them in traditional ways. As one worker commented:

  Some people come here and think that their life is over after their diagnosis: all they have is their medication and that is their life. We encourage development … doing short courses at college, gaining employment. We try to get them to realise that having a mental health problem is not the end of their life. They can get better. It's about building self-esteem and confidence and building trust. This is very important. We get them to make plans for the future and get them to have small, realistic ambitions.

  Success in this regard depended upon working with individuals rather than administering services to them.

- **Effective services provided the means for individuals to improve their well being through supporting day-to-day activities and enabling social contact.** A focus on life skills and practical skills were useful in developing coping strategies for individuals who had been excluded as a result of their mental state. One worker noted:

We encourage them to use borough facilities as well … leisure, gym, swimming, library, through one-day taster courses. Using mainstream facilities is very important for their self-esteem, self-identity and in order to combat social exclusion. We try to promote active participation in society for those able to.

Other activities focused on providing social contact, as one isolated older person from RISE (see Appendix 2) commented:

I wouldn't get out if it weren't for [the project]. They help me get out and about and drive us to pubs and gardens. I get to see people and places rather than just my four walls! They've saved me. They got me out of my depression.

- **The experience and expertise of voluntary sector was not always valued.** Project workers expressed feelings of not being seen as equal partners by the statutory services. Conversely, they viewed statutory mental health services as being too focused on the medical model of mental health and not equipped to deal with some of the social causes and consequences of poor mental health and well being. Considerable effort was needed to enable the different sectors to communicate effectively. It was felt that if agencies were able to work in a more joined-up way, a more comprehensive service could be provided. Efforts had to be made to ease inter-agency suspicion, and attempts to work in co-ordinated ways had been attempted, with varying levels of success:

  The statutory sector has mixed feelings about us. Some of them see us as necessary. Others see us as adversaries. Some see us as partners, others don't. One of the problems we have is working with people on the ground level. The managers have no problems with us whatsoever. The managers think that we are working wonderfully in partnership because they're very happy for us to be involved in things, but they are not looking at how their staff feel about all this.

  Working in partnership was necessary, but was often an 'uphill struggle'.

Conclusions

Developing and delivering mental health promotion for vulnerable communities in London is a complex task. Participants described in detail the issues that they faced, and offered examples of what mental health promotion looks like on the ground, rather than in the pages of textbooks or policy documents. Central to all the discussions was the importance of challenging tidy designations of identity or need, while also recognising that material disadvantage and discrimination affects the mental and well being of particular groups in the capital. Working in partnership was seen as necessary, but participants reported difficulties in putting partnership into practice. Organisational priorities did not always tally, and there was a feeling from the voluntary sector that statutory services did not value their contributions.

Availability of, and access to, appropriate services were seen as big issues. Despite the NHS commitment to the principles of equity, the problems remained disappointingly familiar. The costs of private counselling and talking therapies, for example, were prohibitive. Availability on the NHS was limited. Black people reported feeling unable to use mainstream services. Complex information was seldom translated accurately, which inhibited the use of services by people who did not speak English. Progress at local

levels was often dependant on champions who drove forward changes, but who were prone to ‘burn out’, making sustainability a problem.

Above all, it was evident that there was little connection between different local strategies and initiatives that sought to promote mental health and well being. However, there were numerous examples of positive practice from which projects could learn. Evaluation was discussed fleetingly by most participants.

Overall conclusions

Promoting mental health and well being in London was a complex task. Within the three categories of local partnerships, developing services and working with vulnerable groups, the following key points were made:

Local partnerships

- The National Service Framework for Mental Health provided opportunities to develop mental health and well being promotion in the capital. It supported the success of other policy initiatives that aimed to support vulnerable people and reduce inequalities.

- However, the promotion of mental health and well being was poorly resourced and generally had a low profile. Making sense of how the NSF fitted with the implementation of other strategies, frameworks and plans was a daunting task for local strategists.

- Local strategy implementers sought to influence how partner agencies worked to deliver on the mental health and well being agenda and add value to what was already being undertaken. However, low levels of dedicated resource did little to encourage sustained engagement.

- Working in partnership was hard work. Voluntary sector agencies felt that they were not fully engaged, and that their contributions were not valued. However, when successful, partnership working produced good results.

- It was difficult maintaining impetus to implementing mental health and well being strategies in times of organisational change.

Developing services

- Local strategists had difficulty in balancing upstream activities with downstream ones. Progress in the former was slow. Service providers recognised the importance of such action, but delivering face-to-face services provided quicker results.

- Local strategists had limited influence over the development of existing services. Strategic priorities were not always reflected in the shape and form of local provision.

- Developing evidence-based responses was difficult in the absence of relevant information and consensus about how best to use evidence to improve practice.

Working with vulnerable groups

- Projects were often commissioned on a short-term basis, which made sustaining action difficult. On the whole, mental health promotion remained a peripheral concern to statutory agencies.

- The voluntary and community sectors were crucial in working with vulnerable groups. However, their capacity remained under-developed.

- Simple services that sought to offer help in living active and fulfilling lives were effective.

- Gaining access to appropriate services remained a key issue for vulnerable groups.

- Evaluation remained problematic; findings were seldom disseminated or used effectively, and therefore resources which could be used for services were wasted.

Recommendations

Three key areas that demand immediate attention:

- Greater priority must be achieved for the promotion of mental health and well being.
- Polices and practices need to be co-ordinated and integrated.
- Effective commissioning of programmes and projects promoting mental health and well being must be developed.

National action

The following activities should be carried out at a national level:

- Investment in activities to promote mental health and well being should be calculated in relation to the potential savings that would be made. These would include costs for working days lost as a result of stress or illness, as well as the use of public sector resources, including health service provision.

- The Department of Health and other relevant departments should provide or commission opportunities for local strategy implementers to learn how to consider different aspects of delivering effective and joined up mental health and well being programmes. These might offer guidance, share positive practice and develop ways of exchanging information.

- Basic and post-qualification training programmes for mental health practitioners should include the promotion of mental health and well being and the needs of specific vulnerable groups. Medical schools, Royal Colleges and training institutions should develop curricula to encompass these concerns.

- The Government should explore how legislation such as the Asylum Act and Section 28 might be revised so that vulnerable groups such as asylum seekers and lesbians and gay men do not feel as though they are second-class citizens. It would be helpful if this was investigated in the context of wider reforms of equality and anti-discrimination legislation currently being considered by the Home Office.

Local action

The following activities should be carried out at a local level:

- Local mental health and well-being strategies should have clear action plans with designated resources. Partnerships should be influential, with high-level support, and be accountable to local implementation teams or strategic health authorities.

- Primary care trusts, local authorities and regeneration partnerships should work together to commission activities to promote mental health and well being, using Health Act flexibilities to pool resources. They should consider examples of good practice, including those revealed in this paper, when commissioning programmes and projects.

- Efforts to assess the health impacts of policies at regional and local levels should include consideration of mental health and well being issues.

- Opportunities to increase public consultation and involvement in the development and delivery of mental health and well being activities should maximised by using existing mechanisms developed by local authorities, the voluntary sector and regeneration partnerships.

Appendix 1: Methods

The research focused on two complementary areas. First, it sought to understand the issues being faced in the development and implementation of local strategies to promote mental health and well being. Second, it considered the development of effective interventions to promote the mental health and well being of vulnerable groups in London. The research began in November 2001 and ended in October 2002.

Given the sensitive nature of the research, the research team assured all participants of confidentiality in the questionnaires and one-to-one interviews. In the group interviews and workshops, participants were asked to respect the views of others and to speak from personal perspectives, not necessarily as representatives of their employers.

Developing and implementing local strategies to promote mental health and well being

Local strategies were due for publication in April 2002. This enabled us to follow developments from five months before publication to six months into implementation. A multi-method approach (Robson 1993) was used in a research process comprising the following three stages:

1. **Questionnaires.** During the latter stages of the developments of local strategies (autumn/winter 2001), a questionnaire was sent out to all primary care organisations and boroughs in London. A representative from each London borough completed the survey, producing a total of 33 respondents.

2. **Workshops.** Immediately after completion and submission of strategies (April 2002), workshops were held to identify key issues being faced, to hear peoples' expectations, and to discuss anticipated successes and failures. Examples of interesting practice were noted. Thirty-two people attended the workshops.

3. **Interviews.** Five months after implementation was complete (August 2002), interviews were undertaken with 25 local strategists about the progress being made locally and asked them to identify what they saw as the barriers to, as well as ingredients for, success.

Developing effective interventions to promote the mental health and well being of vulnerable groups in London

In order to understand the issues being faced in promoting the mental health and well being of vulnerable groups in London, the King's Fund undertook a process comprising the following four stages:

1. **Case studies.** These (Yinn 1989, Hewitt-Taylor 2002) were undertaken with three mental health and well-being projects across London (see Appendix 2). Qualitative methods were used to obtain indepth information about the projects. Observational techniques were used, as were one-to-one and group interviews with service users,

practitioners, and stakeholders. In Case Study 1 (CONNECT, Kingsbury High School), 20 people were interviewed. For Case Study 2 (Family Health Isis, Catford), 15 people were interviewed. For Case Study 3 (RISE, Roehampton), 18 people were interviewed. In total, 53 people were interviewed. In addition, relevant service documentation was analysed, including minutes of meetings, publicity and promotional materials and policy documents. The case studies were undertaken over a sixth-month period, from March to August 2002.

2. **Exploratory workshops.** Workshops were undertaken with key stakeholders to identify specific issues and hear about examples of positive practice. These events brought together academics, policy makers and service developers, as well as service users and community members. Four workshops were organised over the summer of 2002. They considered mental health and well-being promotion for the following groups:

   - lesbians, gay men and bisexuals
   - disabled people
   - South Asian women
   - people living in poverty.

   In total, 78 people attended.

3. **Interviews.** In-depth, one-to-one interviews were undertaken with 13 key stakeholders to provide supplementary information. These interviews sought clarification about specific points raised in the workshops and were undertaken in September 2002.

4. **Final workshop.** A final consultative workshop in October 2002 brought together 35 participants from a range of London-wide organisations. They commented at length on an early draft and influenced the final paper. Twelve people sent in written responses.

Appendix 2: Case studies

Three in-depth case studies were undertaken with projects across London. The first was the CONNECT project in Kingsbury School, Brent, which promotes mental health and well being through tackling bullying. The second was the Family Health Isis project in Catford, which works with African-Caribbean people. The third was with the RISE project in Roehampton, which promotes the mental health and well being of older people. The case studies provided valuable information about the challenges and opportunities faced when promoting the mental health and well being of London's vulnerable groups.

The case studies illustrated the breadth of activities undertaken by mental health promotion projects working with vulnerable groups in London. The projects were chosen after an initial scoping of activities in the capital. A review of literature highlighting positive practice informed the way the criteria were developed for choosing projects. The criteria included the following:

- a commitment to addressing the needs of population groups considered 'at risk'
- innovation in practice
- holistic approaches (including a combination of mental health promotion and primary and secondary prevention measures)
- high levels of user involvement
- commitment to partnership working
- potential to provide evidence about effectiveness.

CASE STUDY 1

CONNECT anti-bullying project, Kingsbury High School, Brent, London

Contact: Ita McNamara. Tel: 020 8204 9814

Background

Young people face a host of mental health and well-being issues. These issues relate to being young, and are compounded by gender, sexuality, ethnicity, ability, physical health and the socio-economic status of their families. It is important to see young people as individuals with complex needs, as well as to consider their family circumstances and broader cultural allegiances.

Identifying the needs of young people, and acting on them effectively, is a complex process. Children are less likely to develop mental health problems if they have:

- good communication skills
- a sense of humour
- religious faith
- the capacity to reflect
- at least one good parent–child relationship.

Other important factors include:

- affection
- a family environment without severe discord
- appropriate and consistent discipline
- family support for education
- a wider support network within the community
- good housing
- a high standard of living
- a range of positive sport and leisure activities.

School also plays a significant role; a high-morale school offering a safe and disciplined environment alongside strong academic and non-academic opportunities supports positive mental health and well being. In addition, schools have a critical role to play in aspects such as the early identification and referral of children with mental health problems.

The project

CONNECT is an anti-bullying project based in Kingsbury School, which has two sites with about 2000 students from a range of ethnic backgrounds. The initiative started in 1997, and is led by students. In 1997, a questionnaire was designed for Year 7 students to assess levels of bullying. Seventy-five per cent reported having been bullied, which they described in terms of physical violence, name calling, aggression and being ignored. The school restated its commitment to ensuring that every child was happy, comfortable and secure. As a result, RELATE was commissioned to provide training to students and staff on listening skills. From this initial training, CONNECT grew.

Aims

The project aims to:

- set up a bullying support group – CONNECT – to be run by students (Year 12) for students (initially lower school students) who bully and who are bullied
- develop students' coping strategies and life skills to deal with all forms of bullying that they may experience
- increase awareness throughout the school of the aims and objectives of CONNECT
- improve the mental health and well being of students by working closely with individuals, staff and the wider community.

Achievements

The project has achieved the following activities and services:

- **Lunchtime playground listening service**. Year 12 and 9 students walk around the lower school playground, and anywhere else that the younger students go to at lunchtime. They introduce themselves, chat about general matters and talk about CONNECT. CONNECT peer workers have a high profile and younger students feel able to approach them and talk.

- **Assertiveness skills workshops**. Year 12 students undergo a six-week training programme to build their self-confidence and assertiveness in dealing with a range of situations. Sessions take place once a week.

- **A buddy system**. Each Year 7 and 8 tutor group has its own CONNECT peer worker from year 9, to whom they are introduced at the beginning of the year. The peer worker offers support.

- **Life skills workshops**. Brent MIND supported the CONNECT project by organising and delivering peer-led workshops, covering topics about bullying, self-esteem and attitudes to mental health. Six Year 12 peer support workers were trained to become borough-wide peer workers.

- **Year 7 induction programmes**. CONNECT peer workers attend induction days at the four main feeder primary schools to inform the incoming Year 7 students about the work of CONNECT. Similar events are held for parents of new and current students.

- **Drop-in centre**. The centre provides a variety of activities, advice and support. It is staffed and managed by Year 12 students trained in listening skills, and provides a social centre for the school.

- **Paired reading scheme**. CONNECT support workers help younger students with literacy problems.

- **CONNECT magazine**. This publication contains information about CONNECT's work, and articles about self-esteem and mental health.

- **CONNECT website**. The site provides anonymous 24-hour email advice, so students can talk anonymously to the project workers without accessing the service directly.

- **PSHE.** The project works in conjunction with the Personal, Social and Health Education (PSHE) curriculum, the school counsellor and the strong pastoral system. It has diversified greatly since its inception, and with increased staff involvement and management it continues to grow and develop.

- **Awards.** The project won the Phillip Lawrence Award in 2001 for its anti-bullying activities.

Learning points

The following key learning points were specific to the study:

- CONNECT was successful because it sought to work holistically, and adopted a whole-school approach.
- The success of the project was directly related to the students' autonomy.
- The project benefited from clear but flexible goals.
- Constant monitoring and evaluation helped provide a user-led service.
- Participation in CONNECT also brought benefits to the peer workers.
- The project successfully managed to raise awareness of issues around mental health and mental illness.
- There had been positive visible changes to the school community and environment.
- Working in partnership with other agencies was vital to the project's success.

These points are explored in more detail below:

- **CONNECT was successful because it sought to work holistically, and adopted a whole-school approach.** It did not specifically target problem children with behavioural problems, although they too were included. It recognised that young people's emotional well being affects their educational attainment, and similarly, that educational attainment affects their well being. It strove to integrate mental health and well being agendas into all aspects of school life.

- **The success of the project was directly related to the autonomy students had in developing and implementing it.** Peer-led support is more effective than adult-led support (Imagine London). Peers were perceived as being less judgmental than teachers. There was a fear that in telling teachers, one was either being a 'grass' or a 'cry-baby'. Furthermore, the participants felt that if they told a teacher, matters were likely to be taken out of their control and formal processes would take place. Talking to older pupils was considered easier, as they were likely to understand more, having gone through similar experiences.

- **The project benefited from clear but flexible goals that enabled swift and effective actions.** All the support workers interviewed could clearly describe their goals and were able to explain how they intended to achieve them. At the same time they stressed the importance of flexibility and the need to adapt the service to the changing needs of users. This resulted in the project aiming to meet a range of needs using multi-dimensional approaches, encompassing advice and support on the website and magazine, informal discussions in the playground, and in-depth one-to-one peer listening. One strand of the service often led to another. For example, during paired reading sessions trust was often built up between the worker and reader, and this trust fostered the confidence to talk about other problems.

- **All aspects of CONNECT were constantly monitored and evaluated in order to provide a user-led service that met the needs of the users rather than the service providers.** This was achieved through a variety of methods, ranging from students and staff completing evaluation forms at the end of all training to evaluators talking to pupils who received the service. In addition, questionnaires were produced to target the opinions of parents, staff and governors. All one-to-one peer support listeners completed regular diaries and had frequent meetings with a support teacher to offload any problems they had, and to provide feedback. Awareness of the project and its work among the pupils of the school was also assessed. This enabled the project to develop according to the needs of the pupils and the school. Furthermore, the frontline support workers strongly influenced strategic and developmental decisions.

- **Participation in CONNECT brought benefits to the peer workers, improving their confidence and developing their skills in listening and communication.** Through the training they developed life skills that would serve them once they had left school. Many reported good conflict- and crisis-resolution skills and improved self-esteem, which they related to the responsibility they had been given and the trust that had been developed. They felt they were making positive contributions to the school. As the head of the school put it, 'They get out of the project what they put in.'

- **The project successfully managed to raise awareness of issues around mental health and mental illness.** Pupils across the school knew what CONNECT was, and

understood what it was aiming to achieve. There was also an increased awareness of mental health and well being issues among staff and pupils.

- **There had been positive visible changes to the school community and environment.** Participants reported a noticeable reduction in anti-social behaviour and in the incidence of playground fighting. Teachers and pupils said the school felt safer, and that it was more welcoming. Parents were confident that CONNECT contributed to the well being of their children.

- **Working in partnership with other agencies was vital to the successful implementation and development of this project.** CONNECT worked with voluntary organisations, such as the Mental Health Foundation, Relate and Mind. The school worked with other schools and recently initiated joint working with the local primary care trust to run a health-promotion week. The project organisers found this partnership worked well and was effective. The expertise and knowledge of the other agencies helped make the project successful.

Observations

The CONNECT project is successful because it adopts an inclusive approach that allows staff and pupils to fully understand its aims and objectives. It is integrated into the fabric of the school, and is not viewed as an 'add-on', or peripheral, activity. The pupil-led nature of the project allows for innovative ideas to be tested and developed. Importantly, the project brings positive effects to the pupils it seeks to support, and brings a set of valuable skills to the peer workers, equipping them for life beyond their school years.

CASE STUDY 2

Family Health Isis, Catford, London

Contact: Julianna Frederick. Tel: 020 8695 1955

Background

There are circles of fear that stop black people from engaging with mental health services. Users fear that engaging with services will lead to loss of control over their lives and will ultimately cost them their lives. They liken in-patient wards to prison sentences. This has led to mistrust between service providers and service users, and has resulted in many patients being stuck in the revolving door of mental health services. The mainstream services often find it difficult to engage black patients in self-help groups or therapy groups.

Stereotypical views of black people, racism and cultural ignorance, compounded by the stigma and anxiety associated with mental illness, often combine to undermine the way in which mental health services assess and respond to the needs of black and African-Caribbean communities. Social isolation and exclusion are key issues for this client group, particularly for those with mental health problems. Unemployment, poverty, poor housing and high crime are everyday challenges.

The project

Family Health Isis was set up after a gap in service provision was identified. Despite black patients being over-represented in the mental health service, they were not using community facilities such as day care services. It was felt that there were no 'safe' places for these people to go, and that existing services were not providing appropriate care.

The project is run by Family Health Isis, a voluntary organisation based in Lewisham, south-east London. It targets individuals and communities with primary and secondary preventative interventions. It works with African-Caribbean men and women with mental health problems, with or without a clinical diagnosis. The age range of the users on the list is 16–90 years old. Referrals are made from a variety of sources, such as self, other agencies and through carers and relatives.

Aims

The project aims to:

- provide a safe environment for African-Caribbean people experiencing mental health problems, their carers and relatives
- offer support to the users on the wards and in the community, and to provide activities to develop their skills
- provide the space and environment for users to express themselves, develop positive self-images and build self-esteem, through therapy, education, entertainment and a social environment
- keep people out of psychiatric services and to promote good mental health and emotional well being.

Achievements

- **Counselling**. At present there are 1.5 paid counsellors providing this service, plus students on work placements and volunteers.

- **The centre**. The venue hosts weekly activities, including a women's group, men's group, music workshop and the social gathering group, in addition to regular sewing and creative writing groups and gym sessions. It is also open most days as a drop-in centre, and lunch is provided three times a week. It has on average 130 visitors per week – 58 per cent male and 42 per cent female.

- **Excursions**. These include day trips to the seaside and visits to theatres, parks and gardens, exhibitions and leisure centres.

- **Advocacy and hospital-liaison work**. The service incorporates hospital visits (both crisis and regular visits), and representation in court, mental health tribunals and in police stations.

- **Outreach work**. There is an increasing emphasis on outreach work in the community as a means of identifying gaps in provision, monitoring progress and supporting those members of the community who are hardest to engage with the mental health services.

Learning points

The following key learning points were specific to the study:

- For the groups that FHI worked with, the recovery model was more effective than the management model of care.
- Services need to be sensitive to the cultural needs of their service users.
- By providing help rather than care, projects can enable individuals to build self-esteem and confidence and live independently.
- Therapy groups are an effective method for working with service users.
- Responding to individual needs as well as family and community circumstances can enable an organisation to provide a comprehensive service.
- Lack of funding is the most significant barrier to providing services.

These are explained in detail below:

- **For the groups that FHI worked with, the recovery model was more effective than the management model of care.** There is widespread belief that people with mental health problems do not get better, so the focus of care tends to be geared towards managing that illness as best as possible. However FHI believed that although most people will never completely eradicate their illness from their lives, some individuals can recover and go on to lead 'normal' lives, with full-time jobs, relationships and families. They believed this could be best achieved by dealing with the causes of poor mental health, using a social model.

- **Services need to be sensitive to the cultural needs of their service users.** FHI managed to create an atmosphere of trust and common understanding. Specialist provision offered choice to service users and was intended to be a complement to statutory services. Mainstream organisations could learn from the project in relation to developing appropriate provision.

- **By providing help rather than care, projects can enable individuals to build self-esteem and confidence and live independently.** By providing encouragement and advice, FHI was able to support many people back into education, employment, better housing and improved financial security. This was achieved by providing a multi-disciplinary, holistic approach, all under one roof.

- **Therapy groups are an effective method for working with service users.** FHI found that the most effective way of engaging people in self-help groups was to keep the groups small, and to provide activities that enabled participants to develop practical skills, while also allowing them to be creative and expressive. For example, in the music workshop participants learned how to write songs and melodies, and to play instruments. They formed a band called 'Doctor's Orders', which played many gigs, including at mental health promotion events. Other examples included workshops on practical parenting and budgeting skills. Project staff reported that the development of such transferable and specific skills increased empowerment, autonomy and self-esteem.

- **Responding to individual needs as well as family and community circumstances can enable an organisation to provide a comprehensive service.** FHI encouraged the carers and relatives of service users to attend the centre. More than 80 per cent of the women using FHI had children, but there was no provision for women to seek help and bring their children along. The service was open to anyone, and the centre

welcomed a mix of people, including people with, and without, mental health problems. Consequently, people conversed freely without knowing that they were talking to someone with a mental health problem. This helped to challenge the way people perceived mental health and combat the stigma.

- **Lack of funding is the most significant barrier to providing services.** People had been turned away from the counselling service on the basis of lack of resources. The music equipment was very old and the tutors had to bring their own along. In addition, it was felt that more one-to-one time would be valuable to the service users. Funding for carrying out mental health promotion work, to help people recognise the early signs of illness, and to give people the information to deal with these problems, was urgently needed.

Observations

This project developed many innovative approaches to promote the mental health of its service users. Using multi-dimensional approaches and recognising that users have a diverse and varying needs, FHI helped them develop skills that helped 'buffer' threats to mental health and well being. This had positive effects and contributed to service users taking greater control over their lives.

CASE STUDY 3

RISE, Regenerate.com, Roehampton, London

Contact: Jon Wilson and Mo Smith. Tel: 020 8878 8648

Background

Older people are likely to live alone, to experience long-term debilitating illness and to be poor. Their social networks diminish as friends and peers die, or move away. The loss of friends, family and partners has cumulative effects, and long-term depression is common in older people but not always identified. For those who are unable or incapable of finding work, feelings of despair and worthlessness are common. Fear of crime means that older people are less likely to go out (especially at night), making it difficult for them to maintain social networks. This has a threefold effect:

- It leads to feelings of loneliness and isolation.
- It reduces the amount of physical exercise they take.
- It makes buying food difficult.

These three factors have significant impacts on their mental health and well being.

Reaching the Isolated Elderly (RISE) is run by Regenerate.com. The organisation also runs a lunch club for older people, a youth project and a mother and toddler group. The main aim of the project is to bring about social regeneration of the area in which the project is set. Through work with the local community, elderly day-care centres and the lunch club, the project workers found a significant population of isolated older people living in their

catchment area. Many of these people had not left their homes for more than a year and had no social contact except for carers and health service professionals.

Regenerate.com is a voluntary organisation based on the Alton Estate in Roehampton, south-west London. RISE aims to promote mental health and emotional well being through health promotion and primary prevention approaches, targeting individuals and the community. Its services are available to people over 60 who are deemed to be isolated. The project currently has 36 clients. Thirty of these are over 80 years old, seven have a mental illness, 23 have a physical illness and five clients suffer from both.

Aims

The project aims to combat fear, loneliness, isolation, and depression among isolated older people living in its catchment area. It achieves this by providing friendship, transport, support, advice and a basic lifeline to the outside world.

Achievements

- **Variety of provision** – the project runs on Mondays, Wednesdays and Fridays. The clients are picked up from their homes in the morning and taken to the lunch club for older people. Here they can socialise with other RISE clients and with members of the lunch club. After lunch there are activities or outings. They have visited pubs for lunch, farms, garden centres, parks, Hampton Court, variety shows, theatre and many places outside of their local community. Activities with other day care centres such as in-door bowling and dancing are also regular features.

- **Home visiting and befriending** – an important strand of the project is the home-visiting and befriending scheme. Some of the clients do not wish – or are not able – to attend the centre, so this is extremely valued by the clients.

- **Inter-generational work** – regenerate.com has recently been awarded funding to expand on its pioneering inter-generational work. This work will fall under a new project called Inter-Gen (starting November 2002), which will bring Regenerate.com's work with young people and older people closer together. Current work has involved encouraging clients from the youth project to carry out jobs, such as cleaning the mini-bus or gardening, in return for points that can be used towards paying for outings.

Learning points

The following key learning points were specific to the study:

- By receiving help rather than care, older people are able to build self-esteem and confidence.
- Providing transport and support to leave the house is one of the most effective ways of alleviating isolation in this group.
- Meal services provide important health and social benefits.
- Bereavement is a significant problem among older people.
- RISE has close links with district nurses and wardens of sheltered housing.

- **By receiving help rather than care, older people are able to build self-esteem and confidence and are able to live more independently.** Social isolation and exclusion are key issues for this client group, particularly for those with mobility problems. The success of this project was rooted in its commitment to support isolated older people in maintaining their independence. The project makes them feel wanted and provides structure to their week. Acknowledging that they are lonely can be a painful experience for older people who may have become isolated through ill health, loss of loved ones, loss of mobility or a visual or hearing impairment.

- **Providing transport and support to leave the house is one of the most effective ways of alleviating isolation in this group.** Providing transport as an integral part of the service allows greater flexibility to the workers and clients of the project and makes it very user-friendly. This project is fortunate in having its own mini-bus. RISE provides a door-to-door service, which enables the clients to take part in social events and go on day trips. However, the demand for the service is greater than the ability to meet it, mainly due to limited space for wheelchairs. At present, the mini-bus can only accommodate one wheelchair.

- **Meal services provide important health and social benefits.** Many of the clients live alone and find it difficult to cook for one, and to cook with their physical impairments. They also stated the food was of an excellent quality, saying it was better than what they ate most days, such as 'Meals on Wheels'. The meals are well balanced and significantly contribute to the nutrient intake of the participants, helping ensure that the minimum nutritional requirements are met. This issue is of particular concern, as this age group is most at risk of specific diseases such as cardiovascular disease, stroke, diabetes and osteoporosis. Interaction with other projects within Regenerate.com, such as the lunch club, also increases service users' social circle.

- **Bereavement is a significant problem among older people.** People in this group are more likely to have experienced the loss of a number of people close to them over the years. The loss of a partner is often one of the main causes of depression and loneliness. The clients valued the companionship of people who had experienced similar loss. The social networks they built at RISE helped to create a nurturing environment, where they could learn to grieve and could offer each other a vital source of support.

- **RISE has close links with district nurses and wardens of sheltered housing, who saw the service as essential, and referred clients to it.** The project worked closely with the Roehampton and Putney Primary Care Trust and the local authority, which monitored the work and provided the funding. There were also close links with other day centres in the area, which brought the benefit of having other venues, facilities and a wider social circle. This also enabled other activities, such as indoor bowling tournaments and dances, to take place.

Observations

Older people are marginalised and neglected, and are often excluded from wider society. RISE provides a service that enables them – and their carers – to play as an active role in community as possible. Many of the clients stressed how important it was for them to avoid isolation by having the opportunity, as one service user put it, 'to share fellowship

and a hot meal with others'. By providing this low-intensity service, the project is able to promote self-esteem, confidence and help to alleviate depression.

Conclusions

Several common factors emerged from the case studies, from which other projects might learn. All three projects featured recognised the importance of what they were trying to achieve within the broader context of people's lives, and the manifold influences upon them and their mental health and well being. Additionally, they operated in settings that were familiar to their service users, and in which they felt a level of comfort and ownership. There were also high levels of service-user involvement in decision making and influence over the direction of the work.

In addition, all three projects strove to be sensitive to the needs of their service users and to provide appropriate activities and interventions. Also, they all built networks of people, and linked into other agencies and organisations to facilitate access to alternative and complementary services. Finally, they all wished to expand and develop their services, but were hindered by lack of sustainable funding: need and demand exceeded availability.

Appendix 3: Examples of positive practice

The following examples of positive practice are presented here to illustrate the breadth of activities undertaken to promote the mental health and well being of vulnerable groups in London. Web and email details are provided for organisations that have them; some are only contactable by telephone.

Community Mothers Programme

Contact: Celia Suppiah. Tel: 01375 843241

The Community Mothers programme, based at the Tilbury Health Centre in Essex, offers informal support and befriending to parents with young children. Experienced mothers are trained as 'community mothers', who then visit other local mothers as peers and promote health and parenting skills. The emphasis is on helping to build up parents' self-confidence and coping abilities by sharing information and experiences, rather than by giving advice. The programme offers a unique and powerful resource for local parents.

Proven outcomes include: reduced isolation and depression in mothers, raised maternal self-esteem and confidence, improved child behaviour and cognitive abilities, and improved child physical health. The scheme addresses inequalities by improving the health and development of young children in disadvantaged areas through encouraging positive parenting.

Greater London Action on Disability (GLAD)

Contact: Millie Reid. Tel: 020 7346 5805 Web: www.glad.org.uk
Email: m.reid@glad.org.uk

GLAD is an organisation of disabled people working to improve the lives of disabled Londoners. The project helps ensure the needs and interests of particular groups of disabled Londoners (such as disabled women, disabled people with learning difficulties, disabled lesbians and gay men, mental health system user or survivors and disabled people from black and minority ethnic backgrounds) are not marginalised. GLAD provides advice and information to disabled Londoners and promotes joint working between survivors and disabled people, and between user groups and groups of disabled people. It promotes joint working, particularly in four boroughs within London, and aims to educate Government, local authorities and statutory authorities on the issues facing these client groups.

Imagine London

Contact: Kate Healey. Tel: 020 7307 2400
Web: www.imaginelondon.org.uk Email: k.healey@kehf.org.uk

Imagine London was set up by the King's Fund in 1998 to explore young people's concerns around health and well being in the capital. The programme has been working directly with young Londoners, both to identify the environmental factors that influence their health and well being and to promote their ideas on how to improve quality of life in London. It has achieved this through participative workshops using creative methods to engage with young people (drama, poetry and art), and through a survey of London schools.

These activities culminated in the research summary *A Good Place to Learn?*, the emotional well-being event 'Key Points', and the *Imagine London Manifesto*, which lists young Londoner's overall priorities for change around health and well being in the capital (all published by the King's Fund). Imagine London also worked with the Office of Children's Rights Commissioner for London to highlight the major concerns of young Londoners, following the launch of the Greater London Authority's first Children and Young People's Strategy.

London Time Bank – Rushey Green Group Practice

Contact: Liz Hoare. Tel: 07946 411177
Web: www.londontimebank.org.uk/rusheygreen
Email: rusheygreen@londontimebank.org.uk

London Time Bank supports new kinds of community participation, and builds this activity into the delivery of social and community services. Participants 'deposit' their time in the bank by giving practical help and support and are able to 'withdraw' their time when they need something done themselves. Almost anybody in society, including the elderly and housebound, can make a contribution and feel needed. The types of activities include: making phone calls, giving lifts, peer tutoring by schoolchildren and telephone counselling by housebound older people. One such organisation involved in the scheme is the Rushey Green Group Practice – a doctors' practice based in south-east London, which covers Catford and Rushey Green.

Time Banks increase social capital by providing a way for people to support themselves, each other and their communities.

MELLOW (Men Emotionally Low Looking for Other Ways)

Contact: Sandra Griffiths. Tel: 020 8880 6232

MELLOW is a network of African and Caribbean service users, carers, relatives and professionals based in east London. It uses music, arts, sport and drama to promote mental health and raise awareness of mental health issues. In addition, the project has held various 'Conscious Clubbing' nights, where cutting-edge club nights take place alongside health education. Ultimately, the project aims to deliver a range of services

including personal development programmes, outreach and employment/training opportunities to enhance the quality of life of young black men.

Naz Project

Contact: Bryan Teixeira. Tel: 020 8741 1879 Web: www.naz.org.uk
Email: teixeira@naz.org.uk

The Naz Project is a sexual health and HIV organisation working with black and minority ethnic groups. It provides a range of prevention and support strategies that are culturally and linguistically appropriate. It also promotes good mental and physical health among South Asian, Muslim, and Latin American gay men, lesbians and bisexuals. As well as social activities, the project provides advice, information and one-to-one and group support. The project is committed to challenging homophobia and racism, and works in partnership with lesbian and gay voluntary sector organisations.

Newham Asian Women's Project

Contact: Anjum Mouj. Tel: 020 8472 0528 Web: www.nawp.org
Email: a.mouj@nawp.org

The Newham Asian Women's Project principally functions as an emergency refuge for Asian women and their children fleeing violence, and to provide services to meet their needs. It develops innovative services to promote the mental and physical health of Asian women in the area. The project provides advice, counselling, female therapy groups, befriending and social activities within a culturally appropriate programme. In addition, the project carries out structured workshops with young Asian women. These are directed to promote self-awareness, raise self-esteem and build confidence.

Place to Be (P2B)

Contact: Benita Refson. Tel: 020 7780 6189
Web: www.place2be.org.uk Email: enquiries@theplace2be.org.uk

P2B is an innovative and growing charity that provides effective emotional and therapeutic support to children within the primary school environment. It helps children cope with the wide range of difficulties that they may face during their school years, from family illness and death to the trauma experienced by war-zone refugees. In September 2002, P2B was working in 74 schools in the South East, Nottingham, Durham and Edinburgh, reaching a child population of 23,000. The direct service model is made up of a range of services, delivered in each school by a P2B school project manager (a salaried and fully qualified professional psychotherapist), who is supported by P2B volunteer counsellors. P2B has won many awards, including the Guardian Charity Award 2000.

Regenerate.com

Contact: Mo Smith. Tel: 020 8878 8648 or 01483 761979
Email: mosmith@regeneratecom.co.uk

Regenerate.com is a voluntary organisation based in a deprived area of south-west London. Set up in January 2000, it aims to bring about 'a change in society that gives individuals value, self-worth and a better quality of life', through a wide range of strategies and projects. It provides a lunch club for the elderly, a befriending scheme for isolated elderly, a parent and toddler group and various youth projects, including a scheme that offers mentoring and assistance to realise the ambitions and dreams of 10–13 year olds at risk of offending. Regenerate.com works in partnership with the local youth offending team, the youth inclusion project and the local primary care trust.

Thrive

Contact: David Foster. Tel: 0118 988 5688 Web: www.thrive.org.uk
Email: info@thrive.org.uk

Thrive is the national charity that uses gardening to improve the lives of disadvantaged, disabled and older people. The organisation's garden projects give people of all ages and abilities the chance to develop their horticultural, social and independent living skills. Through the projects, people are able to build or regain confidence, lean basic skills such as numeracy and literacy, gain practical experience and accredited qualifications, restore strength and mobility, and play an active part in the community.

Wandsworth Primary Care Mental Health Resource Directory

Contact: Ros Lobo. Tel: 020 8687 4509

The Wandsworth Primary Care Mental Health Resource Directory is a reference source for primary care staff working in Battersea, Balham, Tooting and Wandsworth, and Putney and Roehampton GP practices, and their colleagues in the non-statutory and private sectors. It was developed by the Merton, Sutton and Wandsworth Mental Health Promotion Alliance to enable people with personal and emotional difficulties to have access to the widest range of resources, from counselling to services for young people, including family services, financial and legal services, services for refugees, carers, and people with learning disabilities. It also includes helplines, as well as general guidelines for staff and patients on the care and management of mental health problems commonly presenting in primary care.

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