



Bridging the Gap

Peer research on people with mental health issues accessing community activities and groups | Bath and NE Somerset

Research designed and conducted by New Hope peer researchers
Report written by Helen Bilton, Independent Researcher
With additional material researched by: Robyn Williams, St Mungo's
November 2012



Introduction

This report examines what helps and what hinders people affected by mental health issues when accessing groups and support which would improve their overall wellbeing. The research was carried out by St Mungo's peer researchers who are clients and carers affected by mental health issues themselves. These researchers were particularly keen to research access to peer support groups and statutory mental health services. However the findings and recommendations can be applied to any form of group or service.

Method

St Mungo's commissioned this peer-researched qualitative study in early 2012 in order to find out what needs to be done to build bridges between people with mental health issues in B&NES and services, groups and activities that could support improvements in their wellbeing. Through the peer research process and interviews with 42 service users with experience of mental health issues (including some carers) the five New Hope peer researchers identified the problems and came up with suggested solutions.

It should be noted that the majority of people interviewed were already accessing groups and have support networks in place. However most had been more isolated at times in their lives; the report examines this experience.

Structure of the report

We organised our findings around six 'gaps'; areas where there was clearly room for improvement and where we could recommend bridges to better wellbeing.

The 'gaps' take many forms showing that there is simply no one-size-fits-all approach to improving access. The six gaps are:

1. Improving wellbeing in general
2. Connections between people
3. Statutory services
4. Motivation
5. Accessing services
6. Finding out about services

1. Improving wellbeing in general

We took it as a base assumption that good wellbeing is a desirable goal. In our background research we looked into many different studies which showed that wellbeing involves not just feelings of happiness but elements of functioning well both personally and in society¹. We also found evidence for the crucial point that wellbeing and mental illness can be separated; that it is possible to have lived experience of poor mental health and good wellbeing (and the opposite).



Sociologist Corey Keyes argues for a "dualcontinua" model of mental health. In this approach, mental health and wellbeing are conceptualised as being separate dimensions from mental illness, allowing for the possibility that people with no mental health issues can still have low wellbeing "languishing" (in Keyes' terminology) whereas, conversely, those with significant mental health difficulties may also experience high wellbeing.²

The first thing we did in our study was to find out whether people had good or poor wellbeing, and what factors they felt affected their wellbeing. This is an important background to the subsequent sections on increasing participation in community activities; it provides the ultimate reason behind the work. If wellbeing were static or already optimised then there would be no reason to continue looking at improved access to community activities.

We looked at ratings of wellbeing against a definition devised by our own peer researchers:

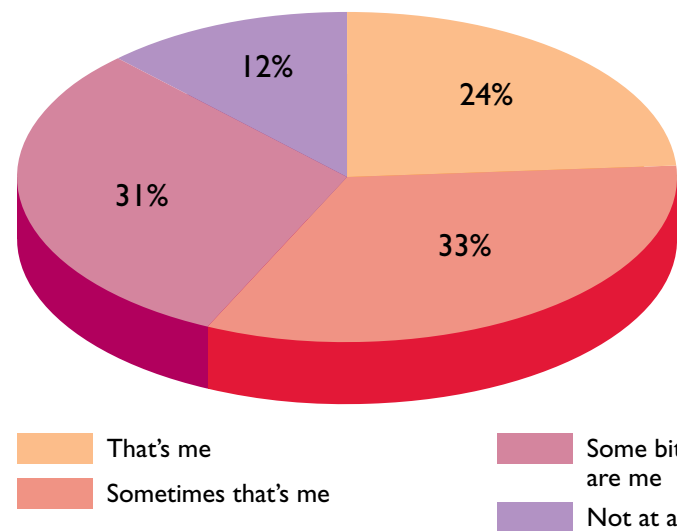
Someone who has good wellbeing has a clear mind and feels safe, self-confident and happy. They have a sense of purpose and positive connections with other people and the community around them.

¹ Sources of this information are e.g.:
nef (2009) *National Accounts of Wellbeing: Bringing real wealth onto the balance sheet*. nef. London, 2009 <http://www.neweconomics.org/publications/national-accounts-well-being>
Foresight Mental Capital and Wellbeing Project (2008) *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century*. Government Office for Science: London, 2008 <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/mental-capital-and-wellbeing/reports-and-publications>
Jahoda, M. (1958) *Current Concepts of Mental Health*. Basic Books Inc: New York, 1958 <http://archive.org/stream/currentconcepts00jaho#page/n5/mode/2up>
BNES Joint Commissioning Board *Mental Health Commissioning Strategy 2008-2012* <http://democracy.bathnes.gov.uk/Executive/WL/2007/071221/01E1733zAnnex1.pdf>
nef (2011) *Five Ways to Wellbeing: New applications, new ways of thinking*. nef. London, 2011 <http://www.neweconomics.org/publications/five-ways-to-wellbeing>
² nef (2011) *Five Ways to Wellbeing: New applications, new ways of thinking*. nef. London, 2011 <http://www.neweconomics.org/publications/five-ways-to-wellbeing>

We asked them to define their current wellbeing against this definition in general terms and also on a scale of 1-10. We discovered an average rating at present of 6.6 compared to 2.03 at respondents' worst ever point. Respondents wellbeing was overall three times higher now than at its worst, but still a long way from being at its optimum.

The real interest, however, came from the findings about how wellbeing fluctuates over time, and also how only parts of the definition apply as you can see in the following graph:

How much does our definition of wellbeing sound like you



For example:

Not like me. Have a sense of purpose, not a clear mind, don't feel safe or self-confident. Happy sometimes, connections with people with same condition as me. Find connections with people outside mental health difficult.[changes in the nature of wellbeing].

When I'm in a bad state, having one of my bad parts I can change very, very rapidly, change from positive and outgoing and suddenly pull back in, withdraw, don't speak to anyone, don't trust

myself, don't believe in anything, I'm argumentative, I can go from being reasonably OK to suicidal in a matter of hours. [time-based changes].

We found that the parts relating to 'confidence' and 'connections with people and the community' were the areas that people were most likely to struggle with.

Our own work bears out the key point that good wellbeing and mental illness can co-exist; there are many examples of people who, despite suffering with a diagnosed mental illness, still rate their wellbeing highly. For example:

Since I've been in Bath I feel very confident, getting better rather than up and down. [Woman who lives in mental health supported housing who rated her current wellbeing as 10/10].

Does improve and change. May not know when it's gonna happen. When things are bad something positive generally comes out of it. [Man who suffers from depression who rated his current wellbeing as 10/10].

We asked our respondents directly how their wellbeing affects their day-to-day lives. We found that without exception wellbeing affected their ability to do things.

When I'm feeling really down my get up and go gets up and goes without me.

My level of wellbeing affects whether I go out or not. Bus service is terrible anyway but if I'm bad I just sit around in my pyjamas all day, not bothering to get dressed.

My level of wellbeing affects me massively. When its good I want to do all things. When bad it affects everything, all relationships, lifestyle.

My wellbeing can dip all of a sudden then I shy away from people and turn reclusive. I can sometimes control it, other times not.

Totally affected by my level of wellbeing. How I feel changes on what I feel I can do, its very, very important.



So, increased overall wellbeing is clearly a desirable goal and strongly related to activity and 'doing'. If we turn our definition on its head we would discover that what destroys wellbeing is having an unclear mind (i.e. feeling mentally ill), feeling unsafe/insecure, unconfident, having no sense of purpose and being isolated from other people. Therefore the means to raise wellbeing involve tackling these issues. Subsequent sections address issues of statutory support, connecting with others, and participation in purposeful groups and activities. Each of these sections relate to the different components of our definition of wellbeing.

Recommendations for bridging the wellbeing 'gap'

- Build your service on a base assumption that improving wellbeing for people living with mental health issues and their supporters is both possible and worthwhile.
- Flexibility and continuity are the key to meeting the needs and aspirations of people who have variable mental health. This is particularly important for people rejecting support because of their low mental health (see 'Motivation').

2. Connections between people

People need connections. Our research shows that loneliness, isolation and disconnection exacerbate (even cause) mental health problems and impede wellbeing. We have already seen respondents were likely to feel their wellbeing was less good in the area of social connections and the need for positive, meaningful connections with others is rippled throughout the entire dataset.

We found that the people in our study highly valued their social networks and 78% had good support from either family or friends. The top answer to 'What helps the most' was basically 'connections with other people', e.g.

[What helps me most is] knowing people are there for support. Knowing that I am not alone even though it feels like it sometimes.

[What helps me most is] human contact.

[What helps me most is] having someone to talk to.

[What helps me most is] Talking, being listened to, being noticed. Knowing someone will share load/ understand what you are going through. Speaking to someone with MH problems.

[What helps me most is] Talking, medication is important but talking more so.

A couple of stories from our interviews are particularly poignant in showing how the simplest friendly action can have a profound impact on someone else. This woman doesn't feel like she has any friends but..

I'm a member of the WI although I haven't been to a meeting for a long time. The woman who runs it rang me to see why they hadn't seen me for a while and we got chatting. I told her I was due to go to the dentists and she offered to take me and she did. I offered her petrol money and she said 'You don't take petrol money from friends'. I was just so pleased that she said I was her friend, it really gave me a lift.

This woman, when asked what helps her the most says:

I would love to have a letter every day. I had an invite to a wedding the other day from an old friend, that was nice, made me feel nice – at least she hasn't forgotten me. You don't think people are thinking about you but they are.

We looked into the reverse of connection – loneliness and isolation³ – with one of our questions 'Why do you think people with mental health issues often end up isolated?' Responses mainly split into two camps. One group said it's the nature of the illness; some mental illnesses make you want to retreat from the world, become apathetic to doing things or isolate yourself through fear, shame or low confidence. The other group of responses blames other people – people don't understand, stigma, judgement and fear.

Stigma or lack of understanding came through strongly with 69% of respondents saying that the attitude of others had a negative effect on their wellbeing. One of our interviewees said that:

[people become isolated because of] stigma, tend to keep to themselves because of how they're feeling. They disengage, I won't 'inflict' myself on others. Worry that others will think you're odd, worry about how you come across. Can make you less able to interact, depending on the issues.

Examples from the wider literature show that good social relationships are a protective factor for mental health and wellbeing. For example, a WHO report about the social factors involved in health concludes:

Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health.

Supportive relationships may also encourage healthier behaviour patterns. [...] People who get less social and emotional support from others are more likely to experience less well-being, more depression ... In addition, bad close relationships can lead to poor mental and physical health.⁴

A Mental Health Foundation report shows the far-reaching effects of loneliness and concludes that:

If loneliness is persistent or recurring, the person finds it even harder to relate to others. One of the paradoxes of loneliness is that it leaves people less able to forge the relationships which they crave⁵.

Client-led groups and user involvement

There is a clear case to be made for user-led groups of clients with similar health issues, and peer support⁶. 53% of our respondents agreed or strongly agreed that they liked to be with other people with similar problems and only 13%

disagreed. Many respondents said that they wanted to see more support groups, that such groups were what helped them most and that being with others with the same problems would help them feel more supported. This comment from someone attending a group for people with depression illustrates:

I don't talk a lot about my problems here but we're all pretty much in the same boat. I do like the company, reassuring to know you're not on your own, some of us go out for tea afterwards and carry on talking, not just about depression.

and this person would like more groups that bring together people with similar mental health issues:

A way of socialising – meeting other with similar issues. "There might be someone else like me", I would like to meet someone with the same diagnosis.

³ It's fascinating that we used the word 'isolation' ourselves and not loneliness. Loneliness has such dreadful connotations in our society, we're almost scared to use the word. But also, isolation is something we do to other people (think prison, hospitals) and it is clear from the data that everybody has their part to play in reducing isolation/ loneliness.

⁴ Wilkinson, R. and Marmot, M. (eds) *The Solid Facts (2nd Edition): Social Determinants of Health*. WHO Europe: Denmark, 2003 http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

⁵ MHF (2010) *The Lonely Society*. MHF: London, 2010 http://www.mentalhealth.org.uk/content/assets/PDF/publications/the_lonely_society_report.pdf

⁶ See also, for example, Tait, L and Lester, H. 'Encouraging user involvement in mental health services' *Advances in Psychiatric Treatment* (2005), vol. 11, 168–175 at <http://apt.rcpsych.org/content/11/3/168.full.pdf> for an academic review of evidence.

People also talked about greater user involvement under ‘what would you like to change about the services you use?’ and ‘What support would you like to enable you to access a new group?’ For example:

[I would like to change services by having] more members to become involved in running things and making decisions. Staff to remain to take responsibility though. More frequently for longer hours.

[I would like to change services by having] more client-based groups where clients have greater input.

[To access a new group I would need] Something like Bath Survivors Network – the idea is we run it ourselves for people like us.

[What would help me feel more supported is] a group for mental health. As a group can get more access to services. Finding groups is hard.

There are two benefits with user involvement. One is the clearly identified benefit of meeting other people who have similar problems. The other is to do with autonomy and the fact that self-managed groups are effective in achieving the aims of service users. Client-led groups also link in to issues about motivation and access.

We will see, when we look at these later in the report, that groups based around a common purpose are the most likely to succeed in improving wellbeing, and that most clients have a desire to ‘put something back’ and are therefore potentially motivated by

being involved in setting up and running groups.

Recommendations on how to build connections between people

- Create accessible group and activity opportunities for people, that provide a sense of purpose, build confidence and reduce isolation
- Develop opportunities for people with similar health or caring issues to spend meaningful time together and peer support opportunities
- Maximise client involvement, including in service design, review and implementation
- Train staff and volunteers to model friendly, welcoming behaviour from the top-down. Even the tiniest of gestures can make a big difference to someone struggling with low wellbeing.



3. Statutory services

We looked at the support received from professionals because this was seen by our peer researchers and interviewees as a key factor in underpinning improved wellbeing. Respondents showed that if statutory services are not providing appropriate support, people feel ‘stuck’ and unable to improve their wellbeing.

Our respondents said they needed the bedrock of professional mental health support to rely on.

We looked at the support received from statutory services: 33% said that what would make them feel more supported was better professional support; 38% said that they wanted more services to be available; and 75% said they’d encountered delays or difficulties in getting someone to help them. Overall respondents reported that services need to improve.

Tried getting CPN (many years ago) was self-harming, unable to get support. Don't bother trying to get help from CMHT any more.

When first diagnosed – wrong tablets – tired/ sleepy and took a long time to convince doctor that the tablets were wrong.

Over medication and insufficient diagnosis, not enough support and groups to try and get back to normal life. Not just medicating.

Partner encountered problems when I had an episode – making phone

calls – getting someone to help. Dr very unhelpful, I had left the house, the police were phoned and they picked me up. I was put in a police cell for nine hours. Episodes always seem to happen out of hours.

Over half of respondents who had been discharged had a negative experience of the discharge process, with 20% who had been discharged saying they had felt abandoned. One person made the point that services in general need to pay attention to endings and what happens when the group/activity stops:

Informal support ending – can be really damaging, no exit strategy. Rejection. Volunteers, e.g. when they go, just disappear.

Mental health crises are frightening and can be serious so we also asked about where people would turn in a crisis. We found that most people would contact their GP in a crisis but one in seven didn’t know who to go to. Additionally there was a lot of distrust displayed regarding the statutory crisis team, particularly in terms of its reliability out-of-hours.

Have crisis team's number and did phone them recently and they were worse than useless. So [in a crisis I'd contact] probably no one. Next day I'd phone the GP but by then the crisis is probably over. I do have a couple of friends I could call but it depends what time of day it is and whats happening. I don't like to bother people.

Frightened to contact anyone, you'd be banged up immediately. They have terrible trouble with mental health services in this area.

Have no faith that the crisis team would answer their phone – making you more desperate.

When it works, this is what good support looks like:

Rang GP last November and got dealt with very quickly and also rang my consultant.

Good CMHT – current ones all turn up – good.

Suggestions from respondents:

At evenings and weekends there is less help than during week but needed more.

If the services were more open to honest discussion about what is going on – feels like banging your head on a brick wall.

A lot more frank information out there in much more publicly and upfront ways – e.g. about drugs and effects.

If you try and complain or address the issues, services close up and make you feel you're out of line. Acknowledgement on their part, genuine equal partnership, respect for you as the carer, respect for the family members, respect for the fact that you know yourself better than any professionals ever going to.

We have seen earlier that the people we interviewed typically had below-optimum wellbeing. When this is combined with poor mental health, this can easily create a gap between what people expect of services and what, realistically, those services can provide. We did find that as people's wellbeing increases it is likely to reduce their need for statutory services. In other words, whilst statutory services are clearly needed as a solid underpinning, their role is less critical as wellbeing improves and people are able to function better and manage their mental health more effectively. What also know from our research that people have strong opinions on statutory services and a variety of positive and negative experiences. People feel passionately about improving mental health services but find it hard to feed back their experiences:

[What would help me feel more supported is] knowing the system is being improved, so others don't have to go through the same issues with no support. Mental health services also need to take into account the impact on other family members.

Things do need change. There is a gap in the help process. Ground needs to be made in helping.

We call on statutory service providers to utilise this valuable feedback via the independent voluntary sector organisations

who work with people affected by mental health issues. We also call for further research to be done to explore the issues of what statutory services could and should provide.

As with the previous section, individual social networks are seen as most important for replacing and complimenting a person's experience of statutory support. All these people rated their wellbeing as eight or higher – they are coping:

One thing that helps a lot that I've put into place is having a network of other people so its not just me who is responsible for my mum.

I find it very disturbing when she's psychotic – now with CPN and community living team and friends and neighbours, it really helps not being the only one.

[What helps me most is] Meeting friends and socialising. Seeing the counsellor. Getting away – visiting family.

Since I've been here I don't think I've needed support. If I got really ill I'd talk to Mary.

Building relationships between statutory mental health teams, people with mental health issues, their carers, supporters and peers is essential.

Recommendations for statutory services

- Develop closer working relationships between statutory mental health services and community organisations
- People's individual support networks consist of a mix of statutory and informal. Statutory services need to work as closely as possible with the individual's friends and family as they will be there when statutory services are not
- Statutory services need to request and utilise feedback from current and former services users via voluntary organisations
- Discharge is a particularly critical point where support is needed and statutory services need to ensure people don't feel 'abandoned'. Peer support could be especially valuable here
- Promote positive stories/outcomes you've had.

For all services, (especially) including informal groups

- Pay attention to exit strategies and don't allow people to end up feeling abandoned. Understanding and information will go a long way.

4. Motivation

Throughout our interviews we heard people talking about lack of confidence, fear, low self-esteem, apathy and tiredness. But we also realised that, despite this, most of our interviewees did actually do at least some things to fill their time. We needed to look in a bit more detail about what makes people get up and do things.

There is a known link between mental health issues and low motivation⁷. There is also a body of evidence to lead us to the key conclusion that 'doing' is important and motivation can be raised as a *result* of 'doing' rather than the other way around. Mastery of something – be it music, sport, an educational subject, arts or crafts or building a friendship, is an important psychological tool for improving wellbeing.⁸

The key motivating factors in our data were doing things people are interested in, and a desire to 'give something back'. For the first of these, we gave people a list of statements to see what level of agreement there was:

Table 1: General statements

Statement	% of agree + strongly agree
I find it easier to attend groups that have a purpose that I'm interested in	95%
When supporting people with mental health issues it is important to pay attention to details	89%
I like informal groups, more like meetings with friends	81%
I think there should be groups especially for older people	76%
I like to be with people in general, regardless of their mental health status	73%
I like groups in general	71%
Walking into a room full of strangers is intimidating	71%
I think there should be groups especially for younger people	68%
I find it hard to cope with full-on commitment to groups	55%
I think there should be women-only groups	55%
I like to be with other people who have mental health issues	53%
I think there should be men-only groups	48%
I like formal, structured groups	45%
Most people have a good understanding of mental health issues	15%
I like groups where I don't know anyone	12%

⁷ For example in: nef (2011) *Five Ways to Wellbeing: New applications, new ways of thinking*. nef: London, 2011 <http://www.neweconomics.org/publications/five-ways-to-wellbeing>
Mental capital and wellbeing – making the most of our selves in the 21st Century. Executive summary final report. 2008. <http://www.bis.gov.uk/assets/foresight/docs/mental-capital/mentalcapitalwellbeingexecsum.pdf>

⁸ Same resources

As you can see, the top most-agreed-with statement, for which support was almost unanimous, is 'I find it easier to attend groups that have a purpose that I'm interested in'. Whilst on the surface this might seem rather obvious it is actually very important to understand that motivation really is that simple – people will do stuff that they're interested in. There is more in the next section on the actual kinds of things that our respondents said they were interested in.

Another important finding is that almost half of our respondents are already involved in voluntary work, driven by the desire to fill their time and to 'give something back'.

[what helps most is] my structured lifestyle. Get up at 6, have a structure. It's nice to get up even if we have something wrong with us. Keep busy, do something for someone else. I feel very supported with the people I work with. All the young people teach me so much. It's almost unbelievable how much they teach me. At City farm – I'm a trained cook and she's not but she's better than me so we're connected. Support is getting on with people, in a way.

My sense of pride/ self-respect is tarnished by being on benefits – restored by putting something back to community e.g. playing piano at old people's home. Having self-respect is very important.

This woman's story vividly illustrates the varied and multiple factors that motivate her, including the support she gives back to other women:

I've enrolled on a three year Masters related to mental health issues. My mother was bipolar, my brother committed suicide, he was schizophrenic with a personality disorder. I don't like to subscribe to labels, I like to be unjudgemental. I'm a carer for my daughter who is 14 and hearing impaired, and my mother. Since I had her I've had post natal depression so I've had all kinds of psychiatric drugs which I know a lot about now, trying to come off them and never want to go back on. I love reading, I read loads both books and the internet. I walk a lot with dog. Hanging out and socialising with friends, lots of friends. I run a women's support group, informal helping women to link up together and help each other, supporting each other to achieve our hopes and dreams. Wednesday nights, we meet in a pub.

Recommendations to do with motivation, for service providers

- Flexible services, as recommended under the 'wellbeing' heading will accommodate people's fluctuating motivation
- Design services to overcome low motivation – attractive, based around people's aspirations, easy to use. People will be attracted above all by the 'purpose' of the group but may be put off by barriers – use the recommendations of the next two sections to ensure your services are easy to use and known about
- Develop involvement and volunteering opportunities for and with people affected by mental health issues. People want to get involved, so ensure your offer is as good as it can be.

5. Accessing services

In many ways this is the real crux of this research. The researchers took a look at the wide range of activities that people are currently involved in and then looked at what they would like to do but feel they can't and discovered some large gaps. We then looked at what specifically was preventing people from participating in the things they wanted to do.

This chart shows what our respondents are already doing:

Clearly this shows a wide range of activities and dispels the common myth that people with mental health issues spend all day in front of the TV.

We found that ordinary, everyday mainstream activities such as talking, socialising, faith, music, creativity, sport and work were what people were seeking. Getting together with other people who have mental health issues was also seen as important, as is involvement in setting up

and managing activities and groups (see Section 2).

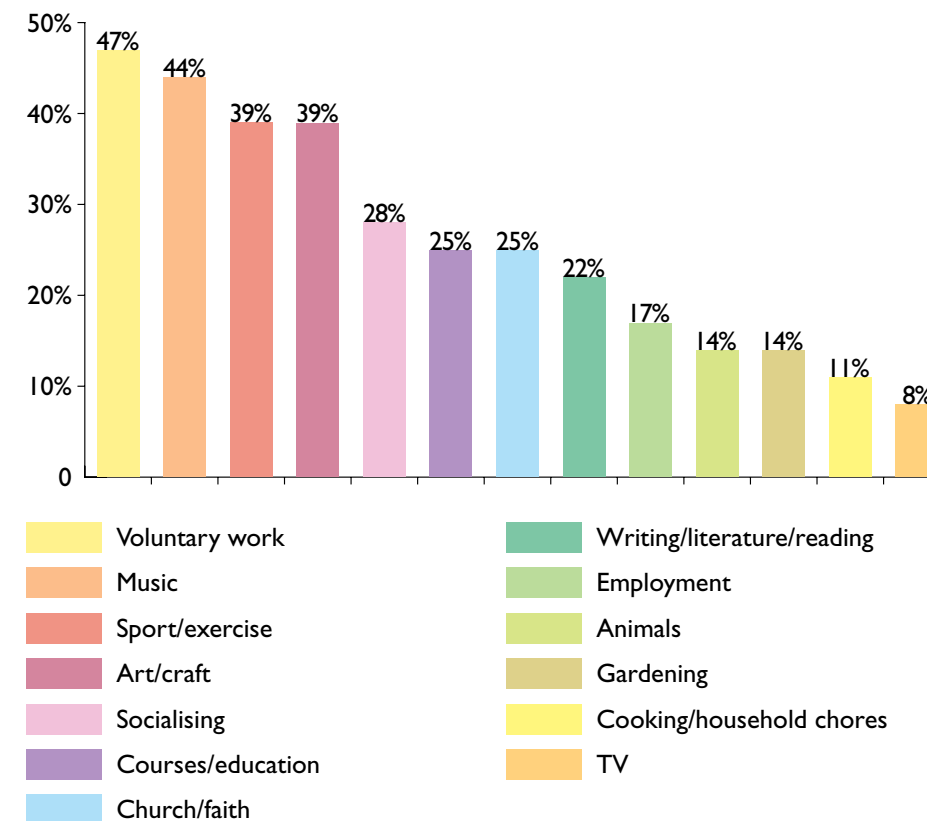
The purpose of the group is only one aspect; there are also other characteristics of a group such as the age or gender of people it is aimed at, or whether it is aimed at people with a particular mental health issue.

There is some support in figure 1 for groups targeting particular demographic groups – groups for older people get the most support (remembering that most of our interviewees were themselves older). We have already looked at the positive value of groups for people facing similar mental health issues under 'connections with people'.

Purely social groups are also considered valuable. There was considerably more support for 'informal groups, like meetings with friends' (81%) than 'formal, structured groups' (45%) in figure.

[I do go to a] social support group. Ladies group, meeting with friends – it did have support worker. 10 years - 6 people.

Activities respondents are currently involved in



The key to getting people involved is to offer things they are interested in. What is very clear is that the purpose of the group does not have to be 'improving wellbeing'; that will naturally follow from people doing things they are interested in. Part of the remit of Bridges to Wellbeing is to get people involved in mainstream groups not just specialist mental health groups and the data proves this would be valuable – for example a specialist mental health allotments

group simply may not be viable in terms of numbers or finance, but enabling someone with mental health issues to attend a mainstream group is much more achievable.

Most of our respondents had some kind of activity that they wanted to do more of but felt that there were things stopping them. The chart below shows what they wanted to do.

Sport overall came out as the

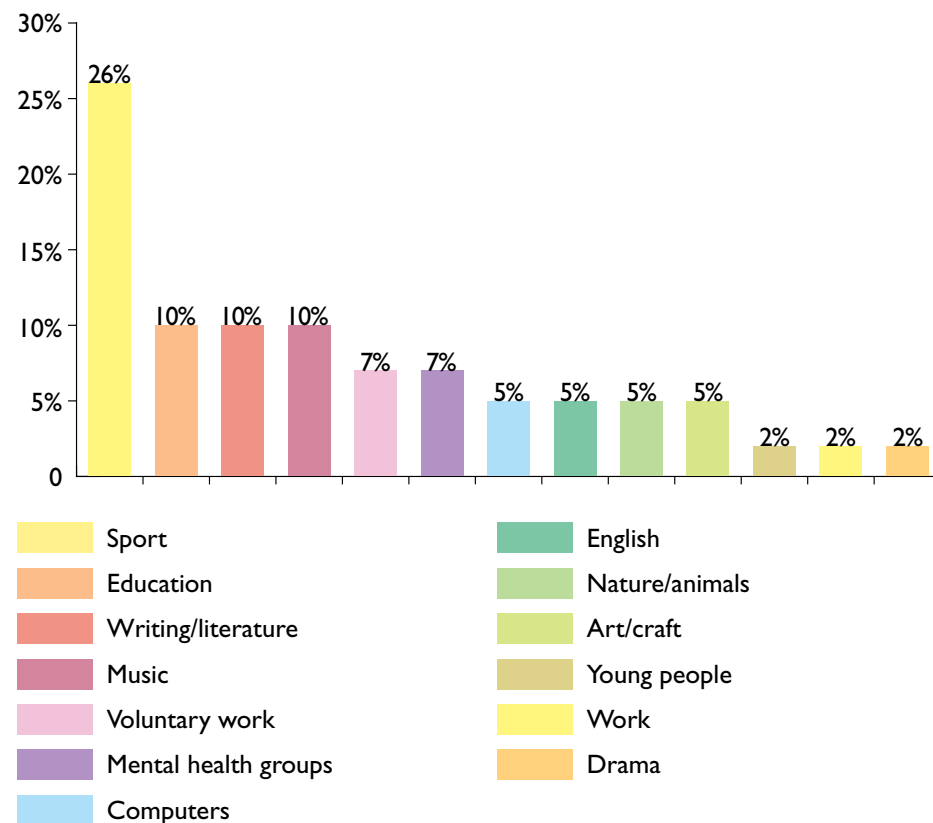
most common activity that people wanted to get involved with but couldn't. Usually people mentioned quite specific things rather than the general categories – cycling, allotments, singing etc. Of course to an extent these things are localised – what may be hard to access in some areas may be easy in others.

We then asked specifically about the barriers which prevent people from participating once they have identified an activity they'd like to try (how to find out about groups and activities is dealt with in the next section, and we looked at low motivation as a barrier in the previous section).

Barriers to participation ranked in order of importance

1=	Cost
1=	Transport
3	Confidence
4	lack of groups to go to
5	Mental health issues get in the way
6=	Unfit/no energy/tired
6=	Lack of time
8	Lack of knowledge about groups

Activities that respondents would like to try but can't



What is interesting here is that the top factors are not psychological but highly practical – cost and transport.

Many people with mental health issues are on extremely low incomes or managing on benefits due to being unable to work. Cost is also linked to transport which, whether driving or buses/trains, costs money. Many mainstream groups cost quite a bit to take part in.

I'd like to find another pottery group – doesn't have to be professional but access to clay and kiln is expensive. I find sculpting and pottery very therapeutic. I would also like to go to poetry reading group – but it's the cost of getting there and accessing the group that means I can't.

Mainstream art groups costly. MHISU groups are free – maybe should encourage to attend mainstream.

A lot of it comes to travel, and cost. I wouldn't mind salsa dancing but you need black shoes and they're expensive.

Music lessons – used to have them but they are too expensive. Would like to see a group which teaches musical instruments (not just music therapy).

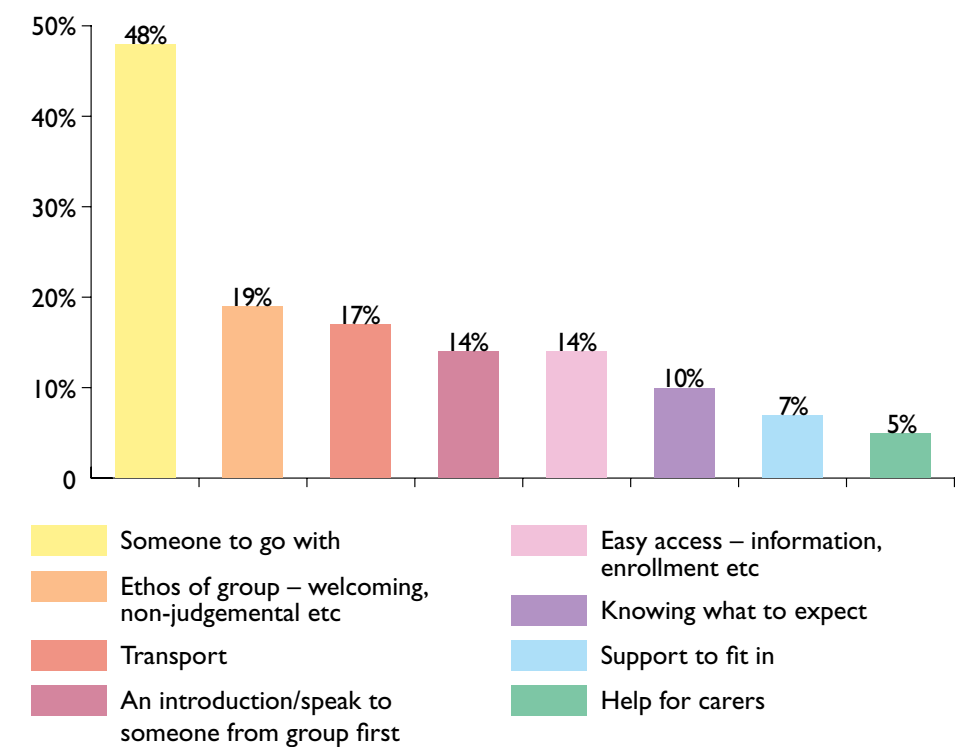
Transport problems are wider than just money, though. Parts of B&NES are extremely rural and transport can be hard to come by. This woman explains how her physical health problems prevent her from reaching an activity which would be ideal for her:

Also I used to be into gardening but with fibromyalgia I can't do



that any more, just look and weep. Got a little dog, keeps me going. There is a gardening group with raised beds in Bath but I can't get to it. I have a mobility scooter but can't get it on the buses.

Support people need to enable them to start new groups



6. Finding out about services and activities

Cost and transport are barriers to everyone, or at least they have the potential to be. Additionally, people with mental health issues and/or low wellbeing may have low motivation and poor resilience which means that they find it harder to overcome these barriers by themselves.

Confidence is a key barrier. We know from several other areas of the data that confidence is often lacking in our respondents. We asked a further specific question which asked what support people would need to attend a group for the first time. The results are pretty conclusively in favour of someone to accompany them, once again repeating our finding that connections between people are vital. However, the ethos of the group and ease of access are also very important.

This extract from one of our interviews shows how one woman learned the value of support and now offers it to others:

Recommendations for service providers on breaking down the barriers to their services

- **Cost.** Think about ways you can reduce, offset or subsidise the cost of your activities to make it more manageable for people on low incomes. Look for any grants that may be available or offer income-based charging scales. Consider ways in which you could get people to connect with each other and share the costs, or let people pay 'in kind', by contributing in some other way
- **Transport.** Consider how people will get to your group or activity, ensure there is access to good public transport, look into transport schemes in your area or organise lift sharing, this has the added benefit of putting people in contact with each other
- **Someone to go with.** Half of our respondents said they'd like someone to accompany them the first time they attend a group. Where appropriate, allow people to bring a friend to the first session, or support them to find someone who can accompany them. Befriending schemes are useful in matching up people in need of support with someone who can help
- **Be welcoming.** Train your staff and volunteers to be welcoming, friendly and non-judgemental and encourage them to explain the group clearly to newcomers.

A few years ago I was much more timid. Still helps now to make contact with the person running a new group, nice to know what it's about, what to expect, talk to someone on the phone. With my own group I offer to transport or accompany new people because I think it's important and can be terrifying.

Offering any potential newcomers a lift in this way this solves several problems all in one go, transport, the need for someone to go with and an introduction to the group.

Finding out about available services and activities is such an important potential barrier that we separated it out into a section of its own. We asked our respondents to tell us where they go to find out about things to do.

We found that one in ten respondents had no idea where to look for information about things to do and by far the most common way to find out was at groups or places the individual is already attending. Although, as

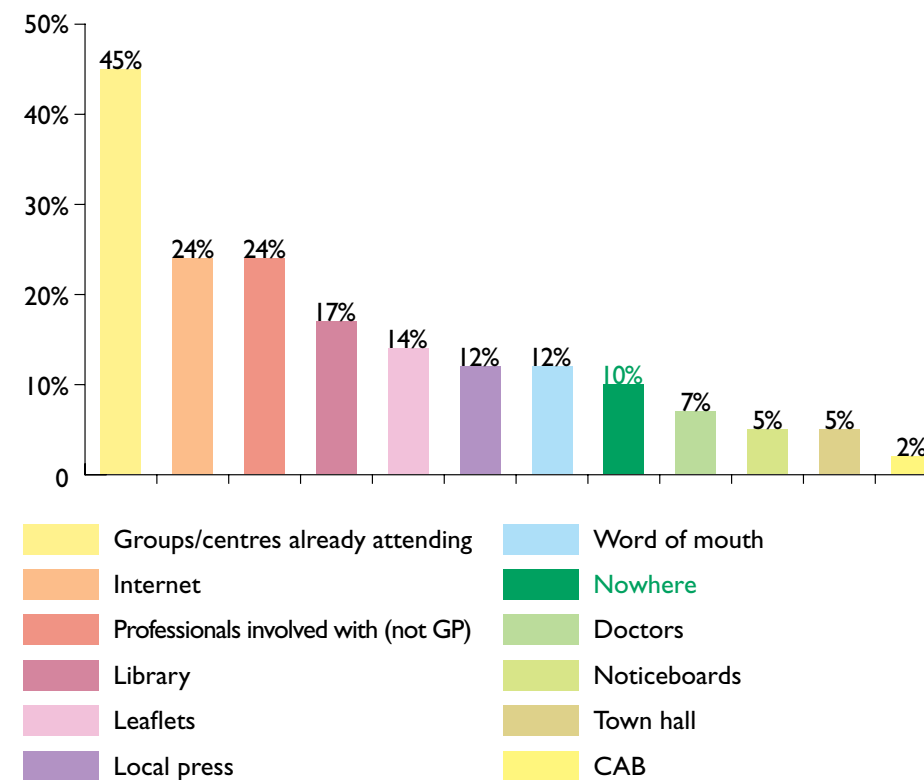
these are very much the kinds of activities that this project is looking at, it does rather beg the question of how people found out about *them* in the first place. We assume that it was through some of the other means mentioned – support professionals, the internet, library, leaflets, press/ leaflets and their doctors.

Looking more closely at this information, we also found that person-to-person delivery of information seemed to work best, especially as people with mental health issues may not actively seek information.

Things are put in front of me rather than me seeking it and this means I mostly meet other people with mental health issues. Pros and cons.

Once again we see the essential need for connections with other people – we see 'word of mouth' and 'professionals' on our list and we can be fairly sure that a lot of the information-passing-on that people get in drop-ins and other groups is personally presented rather than just picked up on a poster. And our categories hide

Where do people find out about things to do



⁹ For example <http://www.bathnes.gov.uk/healthandsocial/communitytransport/Pages/MiniBusSchemes.aspx>

some of the other ways in which people need other people to find out about activities – for example, one person said they ‘get others to check the internet’. Carers need information about activities too (for themselves and the person they care for) – it is no good offering information just to the ill person if it will never get to their carer.

Some interviewees expanded further on problems they’d encountered finding information:

Things are hidden away in pamphlets where nobody ever gets to them.

Not really anywhere for Mind, could call at head office. No drop-in centre [for information] really – could go to Hayhill if you knew about it.

Tried voluntary bureau in library but not very helpful. Internet is best bet (Lets Get to It).

The use of the internet is an interesting area – clearly not the most popular but used by about a quarter of respondents (24%). We asked a specific question about whether respondents have ever used a database on the internet called WellAware¹⁰ which aims to provide information about local services. 98% of respondents had never

used it, although three people had heard of it. The one person who had used it found it wooden.

The implications for service providers is that simply providing leaflets in information bureaux etc is not likely to reach potential users with mental health issues, more creative ways are needed.

Recommendations for informing people about services

- People find out about groups and activities from other people. Ensure that information about your service is available. Encourage word of mouth, perhaps by encouraging existing members to talk about their experiences at different places
- Do not rely exclusively on any one format, and particularly not the internet. Leaflets, noticeboards and local press are definitely useful but limited in their reach
- People very frequently find out about groups and activities at the places they already attend, and from professionals involved in their support – target these
- Remember that people with mental health issues may not proactively seek out information at all, they may only react to information provided to them. Don’t always expect people to look for information about your service/group, get out there and deliver it to them
- Make sure your information reaches carers too.

¹⁰ <http://www.wellaware.org.uk/> Accessed 19/6/12

Conclusion

This report aimed to find out what needs to be done to build bridges between people with mental health issues in B&NES and services, groups and activities that could support improvements in their wellbeing.

Through the peer research process and interviews with 42 service users (including some carers) we established the issues and came up with recommendations for solutions.

We organised our findings around six ‘gaps’; areas where there was clearly room for improvement. In summary the gaps were:

1. **Improving wellbeing.**
2. **Connections between people.**
3. **Statutory services.**
4. **Motivation**
5. **Accessing services**
6. **Finding out about services**

The research showed that what may not be a barrier to someone without a mental health issue in accessing a service may present a significant obstacle to someone with a mental health issue

because their motivation might be low and therefore they do not have the requisite inner resources to overcome it.

What we also found was that the gaps are all intertwined with each other; in particular, a strong theme which came out of the data is that overarching all of the ‘gaps’ is the need to improve connections between people. There are many, many things we can and should be doing towards improving wellbeing for those affected by mental health issues in B&NES but building social relationships, networks and ties underpins anything else you might do.

We found that people are motivated by interest, by enjoying something and by getting something out of it (including a very strong desire to ‘put something back’ into society). Offering opportunities for people to do things they are interested in, and building ways for as many people as possible to access them, is working towards improving wellbeing.

In conclusion, we say that our study found below-optimum wellbeing amongst our study population and identified many areas where changes could be made to achieve better wellbeing. We found that there is no magic silver bullet which will instantly transform people’s lives; instead a wide and deep ranging approach is needed, reaching across ‘service’ boundaries and being prepared to delve into profound topics such as loneliness, friendships, community, motivation, client involvement, what really works and what wellbeing actually means. Whilst there are no quick-fixes there are undoubtedly things that can be done in the short-term, quickly and cheaply, which would work towards wellbeing goals. And, in addition, there are medium-to-long-term adjustments which need to be made to systems, structures and attitudes which will make the lasting difference. Our evidence suggests that the benefits of making these changes and building the bridges to wellbeing would be immense.



St Mungo's Bridges to Wellbeing

The Bridges to Wellbeing service works with people with low to moderate mental health needs in Bath and NE Somerset. The aim is to enable people to have more independent and fulfilling lives by developing peer support networks and groups. It supports and collaborates with:

New Hope

A forum for those who have been affected by mental health issues (inclusive of clients, carers and supporters) who are involved in improving local groups and services and reducing stigma surrounding mental health.

Mission: To reduce stigma surrounding mental health issues and to be actively involved in improving local services used by those effected by mental health issues.

Aim: To use the skills and talents of group members to improve the experience of living with mental health issues in B&NES, empowering those who get involved and inspiring others

Together New Hope and St Mungo's Bridges to Wellbeing provide:

- **Training** – including recovery and recovery star, safeguarding, boundaries, self development, facilitation and mentoring skills. Wherever possible this is co-delivered.
- **Grants** – Anyone affected by mental health issues can apply for funding to set up a group. The clients, staff and commissioner panel, have allocated £4000 to five groups – Tiny Monuments, 12 O'clock club, Speaking Circles training, Creative Individuals, Mulberry House FC. Other groups in development include: Keep Safe Keep Sane for carers, Personality Disorder Support and Surfing.
- **Volunteering opportunities** – Including: Planning and delivering World Mental Health day; Peer research; Designing and running a What's On website; Peer mentoring; Co-facilitation of groups, meetings and events.
- **Support** – One to one and group support to clients setting up groups, activities and delivering training and all clients involved in New Hope.

To find out more or get involved

Tel: 07825 115 775 **Email:** rlillywhite@mungos.org

For more information please contact:

St Mungo's, Griffin House, 161 Hammersmith Road,
London W6 8BS

Tel: 020 8762 5500 **Fax:** 020 8762 5501

Email: info@mungos.org www.mungos.org

Registered Charity No. 1149085
Company No. 8225808
Housing Association No. LH0279

St Mungo's 