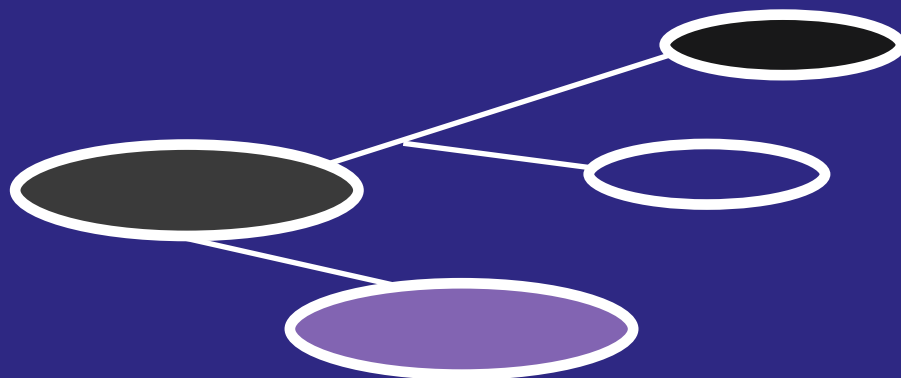


# COMMUNITY RENEWAL AND MENTAL HEALTH

Strengthening the links

Marsaili Cameron, Teresa Edmans, Angela Greatley  
and David Morris



*King's* Fund

**NHS**  
National Institute for  
Mental Health in England





# Community Renewal and Mental Health

STRENGTHENING THE LINKS



MARSAILI CAMERON, TERESA EDMANS, ANGELA GREATLEY, DAVID MORRIS



**King's Fund**

The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through grants. We are a major resource to people working in health, offering leadership and education courses; seminars and workshops; publications; information and library services; and conference and meeting facilities.

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# Outline

## **The guide at a glance** **1**

### **Section 1 Making the links** **7**



People living in disadvantaged areas often cite mental well-being as the issue of greatest concern to them. It is also clear that levels of mental health and well-being have a significant effect on the success or failure of a wide range of regeneration-funded activities. Yet, up to now, few localities have been able to offer an integrated approach to tackling the social exclusion often associated with mental illness. In the light of Government commitment to social inclusion and sustainable communities, this section discusses the need for new forms of collaboration between mental health services, regeneration partnerships, and community and voluntary organisations.

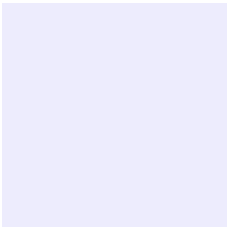
### **Section 2 What are we working with?** **17**

This section presents a highly visual guide to key policies, systems and partnerships that influence what agencies do and how they do it. It provides aerial views of:

- mental health services
- social exclusion in the context of policy on renewal and regeneration
- local strategic partnerships (LSPs).

### **Section 3 Where do you start?** **30**

Decisions affecting the mental health of communities are made at different levels every day. Sometimes the decision-makers are aware of the likely consequences of their decisions. Often they are not. The stigma associated with mental illness often contributes to public ‘invisibility’ of the issues involved. But it is only in discussion and negotiation – in and between organisations, agencies and partnerships – that change can be initiated and progress made. This section draws on discussion and debate across the country to present emerging ‘trigger points’ for change in question-and-answer form. It also introduces a visual continuum of community need, matched by a continuum of partnership and support.



#### **Section 4 Learning from other people's experience**

**38**

This section is designed to give an insight into what different people, organisations and partnerships have done to strengthen the links between community renewal and mental health, and how they have done it. The emphasis is on what they have learned – and on what you can learn from their experience. In particular, you are invited to explore your own assumptions about joint working in this complex area – and reflect on how four very different projects have dealt creatively with some of the different tensions involved.

#### **Section 5 Sources and resources**



**49**

This section contains a bibliography of references cited in the guide, and provides website links for many of the organisations mentioned in the publication. It also provides website links for sites that look at how mental health issues and social development affect each other. Some of the sites consider how change may be monitored and evaluated.



# Contents

<b>Foreword</b>	vii
<b>About the authors</b>	viii
<b>Acknowledgements</b>	ix
<b>The guide at a glance</b>	1
What is it for?	1
Where did it come from?	1
Who is it for?	1
How can you use it?	2
<b>Glossary</b>	3
<b>Abbreviations and acronyms</b>	6
<b>Section 1 Making the links</b>	7
Defining terms	7
The challenge	8
What is at stake?	10
Finding an effective response	12
<b>Section 2 What are we working with?</b>	17
How to use this section	17
Mental health services	19
Renewal, regeneration and social exclusion	22
Local strategic partnerships	28
<b>Section 3 Where do you start?</b>	30
Opening up constructive dialogue	30
If your focus is on renewal or regeneration	30
If your focus is on mental health services	32
If your focus is on the needs of your community	34
Fitting the pieces of the jigsaw together	35



<b>Section 4 Learning from other people's experience</b>	38
Assumptions and opportunities	38
Wise People's Project	40
First Step Trust	43
Lambeth Early Onset	45
Promoting Good Parenting	46
 <b>Section 5 Sources and resources</b>	 49
Sources	49
Websites	51

## List of figures

<b>Figure 1</b> The main determinants of health	11
<b>Figure 2</b> Mental health services – an aerial view	18
<b>Figure 3</b> Renewal, regeneration and social exclusion – an aerial view	21
<b>Figure 4</b> Local strategic partnerships – an aerial view	27
<b>Figure 5</b> Mental health in the community – meeting the full range of needs	36
<b>Figure 6</b> Learning from other people's experience	39



# Foreword

Policy-makers and people ‘at the sharp end’ do not always look at issues in the same way. Therefore, when similar concerns do emerge across Government departments, and across a wide range of different organisations, agencies and people at local level, there is real potential for constructive action.

A shared concern of this kind is being focused on the mental well-being of local communities. There is increased recognition that the social as well as physical costs of mental illness are huge – for individuals, families and whole communities; and there is growing awareness that there is nothing inevitable about this situation – it can be tackled and changed.

Steps can be taken to both reduce the incidence of mental health problems within communities and make a positive contribution to the community’s overall sense of itself as a place to live. Think, for example, of initiatives to tackle bullying in schools or to reduce fear of crime. Practical action on a variety of fronts can also enable those with severe mental health problems to live lives as rewarding as those of other citizens, playing a full part in their community.

Disadvantaged areas often contain high numbers of people with mental health problems. Complex cause-and-effect relationships underlie this situation. What is clear, however, is that the funds that renewal, regeneration and economic development programmes bring to areas of this kind need to contribute to the development of communities that are healthy, secure and confident. This can only happen if the flow of funds is allied with knowledge of mental health issues and in-depth understanding of local communities. In practice, this means developing imaginative, flexible and effective local partnership working. This is no small challenge. People and agencies who know relatively little of each other’s worlds need to learn about different perspectives and find innovative ways of using that learning to achieve goals of common purpose, such as making real inroads into health inequalities.

Two research findings underpin the need to make real progress in incorporating mental health issues into mainstream planning for social and economic development. First, evidence is clear that the success of regeneration and renewal initiatives depends on the active engagement and involvement of local people. Second, people living in disadvantaged areas care desperately about mental health issues and welcome the opportunity to work with others to address problems.

This guide maps some of the key elements of the different systems and funding streams involved, and highlights potential opportunities for creative joint working in the future. The voices of real people living in the real world are heard throughout the publication, asking questions, telling stories, and offering advice and encouragement. This is a tool crying out to be used – by people in the mental health and regeneration fields, and by representatives of communities.

**Louis Appleby** National Director for Mental Health  
**George Barlow** OBE, King’s Fund Senior Associate

# About the authors

**Marsaili Cameron** is an independent consultant and writer with particular interests in health and social care, community development, and professional education. She was a member of the core team carrying out, on behalf of the London Health Commission, health impact assessment of the Mayor of London's strategies. Publications for the London Region of the Department of Health include *Unlocking the Potential*; *Workforce and Development: Mapping the territory*; and *Employment Improves your Health*.

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**David Morris** leads the social inclusion programme at the National Institute for Mental Health in England, which links closely to the Social Exclusion Unit and Neighbourhood Renewal Units at the Office of the Deputy Prime Minister. Before this, he led the Citizenship and Community in Mental Health Programme at the Sainsbury Centre for Mental Health. He has worked in mental health in social care and health at national and regional levels, and holds a research post at the National Primary Care Centre at Manchester University where he is working on community engagement and primary care.

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- people in the organisations featured in Section 4 of the guide, who told us about their work and shared their learning from these initiatives
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# The guide at a glance

## What is it for?

The Government's commitment to social inclusion and the development of sustainable communities presents real opportunities for action to:

- reduce the incidence of mental health problems within communities
- make a positive contribution to each community's overall sense of itself as a place to live
- enable those with severe mental health problems to play a full part in the life of their communities.

This guide aims to promote imaginative, flexible and effective partnership working at local level to achieve these goals. In particular, it is designed to enable individuals and agencies to learn more about each other's perspectives, and to find innovative ways of using that learning to achieve common goals, such as reducing health inequalities.

## Where did it come from?

The idea of the guide emerged from discussions held in 2002 between the Citizenship and Community Programme at the Sainsbury Centre for Mental Health, together with regeneration and mental health specialists at the King's Fund. Key to these discussions was a desire to promote 'whole-systems thinking' in relation to mental health, social exclusion and regeneration. There was a need, it was agreed, for an accessible guide to give a wide range of people, organisations and partnerships the information and encouragement they needed to make the most of a time of real opportunity for change. This challenge was taken up by the National Institute for Mental Health in England (NIMHE), which agreed to co-publish the guide with the King's Fund.

## Who is it for?

The guide will be of particular interest to:

- agencies responsible for planning, commissioning and designing mental health services – such as mental health trusts, primary care trusts, strategic health authorities, local implementation teams and mental health development centres
- organisations and partnerships that have areas of common purpose with community-focused mental health services – such as renewal and regeneration partnerships, voluntary and community organisations, local authorities, regional government offices and local strategic partnerships (LSPs).

The guide is suitable for use by:

- individuals – for example, as a briefing guide and to find out sources of further information
- individuals and teams within departments – for example, for briefings, agenda setting, planning and review
- individuals, teams and groups from different departments, organisations, partnerships and networks – for example, for workshops, to help identify areas of common purpose and work out the practicalities of shared approaches.

## How can you use it?

- As a source of **information**, in words and diagrams, on current policies, systems and structures in mental health and regeneration.
- As a source of **new ideas** on what might be possible for your organisation, partnership or community – you are encouraged to explore your assumptions about basic issues and reflect constructively on the experience of those involved in pioneering initiatives.
- For **reference**, for **study** or for **review of current initiatives** – the structure of the guide makes it easy for you to choose appropriate sections depending on how you want to use it.

# Glossary

Below and overleaf are some terms used in the text that may be relatively unfamiliar to some readers. Note that several Government websites contain excellent 'jargonbusters' – for mental health, for example, see [www.nimhe.org.uk](http://www.nimhe.org.uk) and for regeneration, see [www.odpm.gov.uk](http://www.odpm.gov.uk)

**Area-based initiatives** Publicly-funded initiatives, targeted at areas of social or economic disadvantage, which aim to improve the quality of life of residents and/or their future life chances and those of their children.

**Assertive outreach** A way of organising intensive, user-centred community mental health support for people with long-term and serious problems who will not use services.

**Capacity building** Activity designed to enhance an organisation's ability to work effectively and efficiently.

**Care Programme Approach** The co-ordination and management of care for people of working age who are in contact with specialist mental health and social services.

**Career skills escalator** A dynamic approach to acquiring and using skills – and thus to recruiting, developing and retaining employees from a wide range of backgrounds.

**Community development** The sustained and meaningful engagement of an array of stakeholders so that people can take an active and informed role in the decisions that affect their lives.

**Community (Strategy) Plan** The Local Government Act 2000 placed a duty on local authorities to prepare a local strategy for promoting or improving the economic, social and environmental well-being of their area. This is often referred to locally as the Community Plan, and now forms the framework for local strategic partnerships.

**Gentrification** 'The rehabilitation of working-class and derelict housing and the consequent transformation of an area into a middle-class neighbourhood.' (Smith and Williams 1986)

**Local compact** The framework by which local statutory bodies and local voluntary and community organisations work together in partnership, and commission and deliver services.

**Local implementation team (LIT)** A team that monitors the implementation of the National Service Framework. Commissioners, providers and users of mental health services work through the teams to identify local needs and develop services to meet them.

**Local strategic partnership (LSP)** A non-statutory body that aims to bring together, at a local level, a range of stakeholders from the public, private, voluntary and community sectors. Local partners working through an LSP will be expected to take many of the major decisions about priorities and funding for their local area.

**Modernisation Agency** A new NHS agency that brings together health care improvement and leadership development in one place. The Agency co-ordinates work to modernise services to meet the needs of patients. It co-ordinates management and leadership development to foster leadership talent at all levels within the health service.

**National Service Framework (NSF)** 'A series of documents giving specific Government guidance in a number of key areas of joint working between health and local government, for example, NSFs for Older People, Mental Health and Coronary Heart Disease.' (Democratic Health Network)

**NHS Plan** A ten-year Government plan for investment in the NHS with sustained increases in funding and for reform with far-reaching changes across the NHS.

**Regeneration** 'Comprehensive and integrated vision and action that leads to the resolution of problems and that seeks to bring about a lasting improvement in the economic, physical and social environment of an area that has been subject to change.' (Adapted from Roberts 2000)

**Regeneration agencies** Those agencies developing policy and funding strategies at regional or sub-regional level, for example, regional development agencies, Government Offices, neighbourhood renewal teams, local authorities, local strategic partnerships (LSPs), and Learning and Skills Councils.

**Regeneration partnerships** Those involved in the delivery of regeneration schemes at local level. These are usually area-based initiatives, such as the Single Regeneration Budget (SRB), New Deal for Communities and some European-funded schemes.

**Renewal** The physical, economic and social recovery of a neighbourhood. This approach is currently reflected in the National Strategy for Neighbourhood Renewal, which is designed to tackle the problems of England's most deprived neighbourhoods and arises out of work undertaken by the Social Exclusion Unit. Its aim is to ensure that, in the next 10–20 years, no one is seriously disadvantaged by where they live.

**Social accounting and auditing** A way of measuring and reporting on an organisation's social and ethical performance. An organisation that takes on an audit makes itself accountable to its stakeholders and commits itself to following the audit's recommendations.

**Social exclusion** An umbrella term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high-crime environments, ill health and family breakdown.



**Sustainable communities** 'Thriving regions, cities, towns, villages and neighbourhoods are fundamental to quality of life. Strong economies, employment opportunities, good access to services, and attractive and safe surroundings are vital for their sustainable development. These must be achieved in ways that make good use of natural resources, protect the environment and promote social cohesion.' (Department of the Environment, Transport and the Regions 1999)

**Sustainable development** 'A framework for redefining progress and redirecting our economies to enable all people to meet their basic needs and improve their quality of life, while ensuring that the natural systems, resources and diversity upon which they depend are maintained and enhanced both for their benefit and for that of future generations.' (UK Sustainable Development Commission)

# Abbreviations and acronyms

ACU	Active Community Unit
CAMHS	Child and Adolescent Mental Health Services
CEF	Community Empowerment Fund
CEN	Community Empowerment Networks
CIC	Community Interest Company
CPA	Care Programme Approach
DDA	Disability Discrimination Act
DfES	Department for Education and Skills
DRC	Disability Rights Commission
DTI	Department for Trade and Industry
DWP	Department for Work and Pensions
EZ	Employment Zone
FRESA	Framework for Regional Employment and Skills Action
FST	First Step Trust
GO	Government Office
GOL	Government Office for London
GP	General practitioner
HAZ	Health Action Zone
HO	Home Office
HSE	Health and Safety Executive
IDeA	Improvement and Development Agency
LDA	London Development Agency
LEO	Lambeth Early Onset
LGIU	Local Government Information Unit
LIT	Local implementation team
LSC	Learning and Skills Council
LSP	Local strategic partnership
NACVS	National Association of Councils for Voluntary Service
NDC	New Deal for Communities
NHS	National health service
NIMHE	The National Institute for Mental Health in England
NRF	Neighbourhood Renewal Fund
NRU	Neighbourhood Renewal Unit
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister
PCT	Primary care trust
RCU	Regional Co-ordination Unit
RDA	Regional Development Agency
SCMH	Sainsbury Centre for Mental Health
SEC	Social Enterprise Coalition
SEU	Social Exclusion Unit
SRB	Single Regeneration Budget
WHO	World Health Organisation

# 1

## Making the links

**People living in disadvantaged areas often cite mental well-being as the issue of greatest concern to them. It is also clear that mental health and well-being have a significant effect on the success or failure of a wide range of regeneration-funded activities. Yet, up to now, few localities have been able to offer an integrated approach to tackling the social exclusion often associated with mental illness. In the light of Government commitment to social inclusion and sustainable communities, this section discusses the need for new forms of collaboration between mental health services, regeneration partnerships, and community and voluntary organisations.**

### Defining terms

This guide aims to encourage people from a range of sectors to explore other people's working reality – and, through doing so, to test out their own assumptions about the world. It seems sensible, therefore, to start with the basic elements of exchange – words. A glossary appears on pp 3–4. The focus here is on examining some key concepts and values.

### Mental health

We have adopted the following helpful framework from Heer and Woodhead (2002). As is implied in the quotation below, 'mental health' and 'mental well-being' come from different academic and professional traditions and territories. Accordingly, in reading this guide, some mental health professionals may find it disconcerting that severe mental health problems are discussed at times in the same breath as mental stress/distress. We invite these readers to suspend judgement while they reflect on the merits of our perspective. In particular, we ask readers to consider the potential benefits of sharing with people from different backgrounds the concept of a continuum of mental health problems – and a matching continuum of different sources of support.

*In common with the World Health Organisation (WHO 1946), '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 establish 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, 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.*

Heer and Woodhead 2002

## Mental health promotion

The Sainsbury Centre for Mental Health and Mentality (2001) offer an excellent definition and commentary on mental health promotion:

*There is a need to address the problem of language and conceptual frameworks in relation to mental health promotion, so that a meaningful debate can take place across professional and sector boundaries. Involving communities and taking account of lay perspectives could help to achieve this: the high priority given by residents to friendliness, community spirit, security, feeling safe from crime, and proximity to friends and family indicates that communities attach a central importance to feelings of mental well-being...*

*Mental health promotion is essentially concerned with:*

- *how individuals, families, organisations and communities think and feel*
- *the factors that influence how we think and feel, individually and collectively*
- *the impact that this has on overall health and well-being.*

## The challenge

*Quite often I see people in states that I would call mental distress. They're lonely, maybe, or depressed or stressed. Sometimes they're drinking too much or taking something else. They'd run a mile if they thought I came from the mental health services. But if they know I live quite near, they'll often think, "Maybe they'll understand what it's like", and they'll speak to me, and perhaps to someone else through me.*

Member of a community organisation

*Something I find difficult. As specialist professionals, we need to look after people who have serious illnesses and who are vulnerable because of that. We want to work with the community – but often the neighbours see themselves as directly threatened by the behaviour of ill people. So, I guess naturally enough, they often don't really want anything to do with us.*

Member of a local mental health team

These two quotations point to some of the key problems involved in promoting better mental well-being in local communities. Many of these stem from the fact that mental illness still often carries a burden of fear and shame. It tends to be seen as a frightening mystery, coming out of the blue, requiring special treatment, and bringing about a permanent separation between 'the ill' and 'the not ill'.

But the quotations also highlight some positive ways forward. For example, local community organisations are becoming increasingly aware of their ability to reach and support disadvantaged groups and individuals in ways that can be difficult for statutory services. They are also keen to explore how they can work in partnership with mental health professionals and others to tackle some of the factors that have been shown to harm people's mental well-being.

## Effective partnership can bring about change

There is a pressing need at all levels for effective partnership to bring about change. Heavy costs continue to be associated with the impact of mental illness. Individuals, families and communities suffer personal, social and economic hardship. Meanwhile, the country as a whole counts the cost, both in substantial bills for welfare benefits and in lost contributions of many kinds from people with mental health problems. People with mental health problems are less likely to be employed than any other group of people with disabilities. In the UK in 2001, people with mental health problems (including common and severe disorders) were almost three times more likely to be unemployed than all other groups of people with disabilities (Smith and Twomey 2002).

Yet if we can work together, we can help to transform this situation. In particular, practical steps can be taken to:

- ensure that people with mental health problems have access to a full range of opportunities and services, such as education and employment opportunities, as well as appropriate treatment and support – and the 1995 Disability Discrimination Act (DDA) is, of course, a powerful driver for service providers to make significant change in many areas (see Section 5 for details of the Disability Rights Commission website)
- reduce the incidence of mental health problems
- contribute positively to the mental well-being of individuals and communities.

Take, for example, initiatives to reduce stress in the workplace; to provide support to college students with mental health problems; to tackle bullying in schools; to increase access to green, open spaces; and to reduce fear of crime. Action of this kind can lead to health gain for individuals and communities and to the reduction of inequalities in health. The range of health and social benefits involved might include improved physical health, increased emotional resilience, greater social inclusion and participation, and higher productivity.

The role of regeneration partnerships will be vital in helping to design and support work of this kind. There is a well-established link between poverty, social and economic deprivation, and mental health problems. And there is a growing body of evidence on ways in which urban initiatives can affect quality of life and mental health – for better and worse.

A range of policies support partnership work to promote mental health and well-being. Effective partnership working of this kind is key to delivering Standard One of the National Service Framework in Mental Health (Department of Health 1999). This 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.*

The Government has made clear its commitment to tackling root causes of social exclusion. For example, in March 2003, Barbara Roche, then Minister for

Social Exclusion and Equality in the Office of the Deputy Prime Minister, announced a new focus on mental health and employment:

*Worklessness and mental health problems feature strongly in social exclusion... One in six adults has some form of mental health problem and this can lead to a cycle of disadvantage. Many want to work and participate fully in society but are being denied this opportunity and remain on the margins... We must act to prevent social exclusion happening in the first place, and reintegrate those who become excluded back into society.*

Across the country, local strategies are being developed to ‘join up’ initiatives that are key to sustaining communities. But many of the agencies involved in developing these strategies have expressed the desire to understand more clearly how the different pieces of the jigsaw might fit together in practical terms. In particular, they have indicated that it is a real challenge to:

- build up a clear picture of the benefits locally of working in this way – and the risks of not doing so
- explore opportunities for bending and shaping the procedures and structures of organisations, networks, partnerships and institutions in order to reflect and encourage different ways of working
- ensure that the different funding streams that flow into disadvantaged areas, and have health outcomes attached to them, support work to improve the mental well-being of local communities.

This guide aims to chart some of the territory that needs to be covered if this challenge is to be met. There are some fixed points and clear views (Bates 2002), but much of the landscape ahead lies in the future rather than in the past or present, and, as a result, as yet reveals no clear shape or pattern. This is a guide where the travellers themselves help to create what lies ahead.

## What is at stake?

It is now generally accepted that many different factors influence health. Health and social services make a contribution, but most of the key influences on health lie elsewhere. Figure 1 (right) presents the main factors in terms of layers of influence, starting with the individual and moving on to wider society.

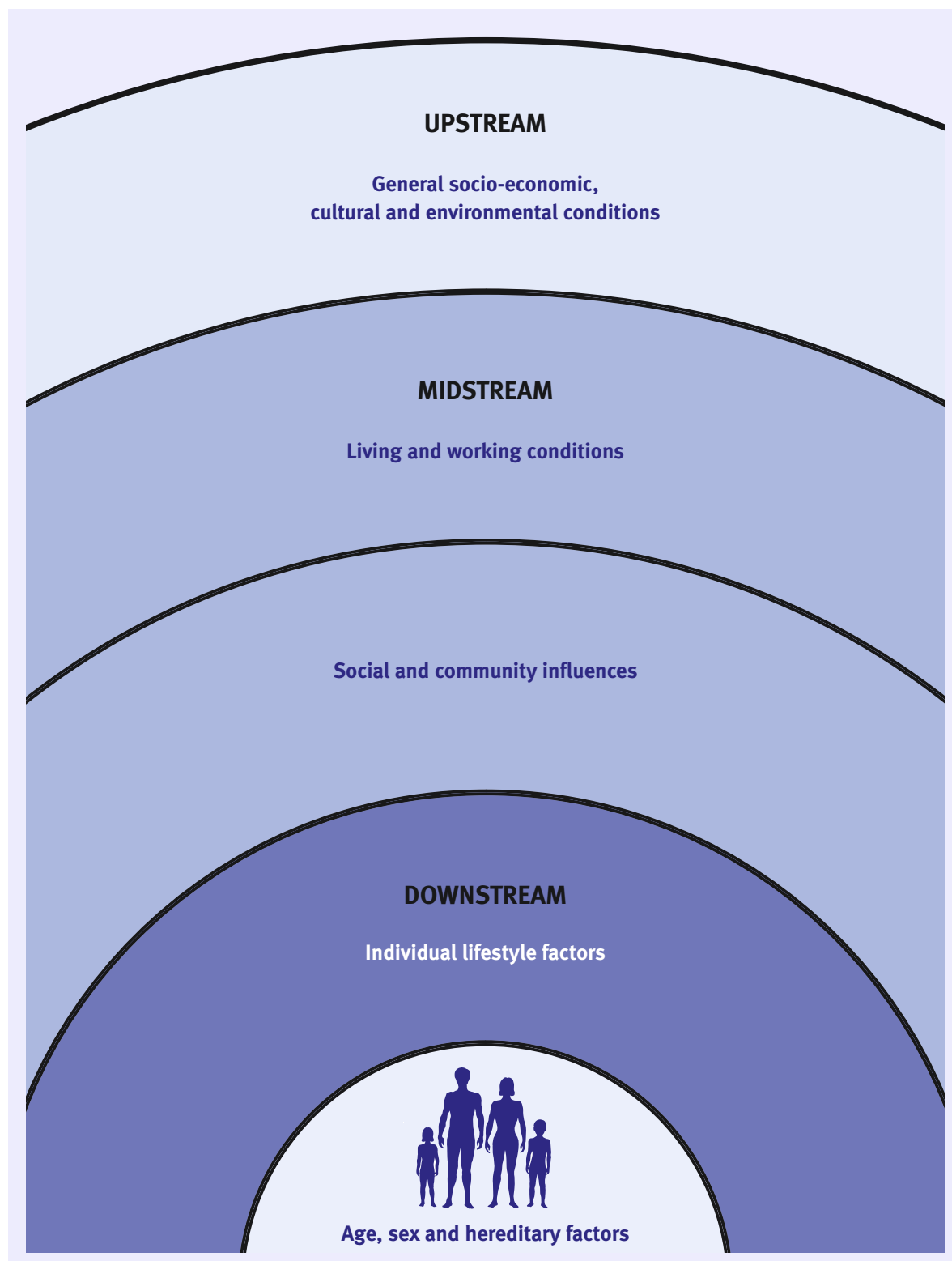
There is a growing awareness of the importance of factors of this kind in influencing mental as well as physical health – and thus going some way to explain differences in mental well-being between groups of people.

Heer and Woodhead (2002) draw some helpful distinctions in relation to this diagram.

*The general socio-economic, cultural and environmental conditions represented in the outer circle are referred to 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 lifestyle 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).*

**Figure 1:** The main determinants of health

This figure shows that most of the key determinants of health lie outside the direct influence of health and social care.



Source: Adapted from Dahlgren and Whitehead (1991).

What might these distinctions mean for the development of local strategies to promote mental health? Regeneration partnerships may be seen naturally to focus on ‘upstream’ and some ‘midstream’ factors, while mental health professionals may be seen to concentrate on ‘downstream’ factors. As will be seen shortly, the full range of ‘midstream’ factors has huge potential impact on mental health and well-being. The challenge now is for a wide range of agencies – including regeneration partnerships, community and voluntary groups and mental health services – to work together to create significant and sustainable opportunities in these areas.

## **Mental illness and deprivation**

There tend to be concentrations of people with mental health problems in areas of deprivation. There are three main reasons for this pattern:

- People with existing mental health problems may be moved into social housing in certain areas – they may be unemployed, for instance, or have a history of challenging behaviour.
- The mental well-being of people brought up or living in deprived areas may be adversely affected by factors like poor quality of education, lack of employment opportunities, and so on.
- Severe physical health problems, more common in disadvantaged communities, are associated with all kinds of challenges to mental health.

Poor mental well-being may be manifested in symptoms like depression, feelings of isolation, stress and lack of confidence. Clearly, symptoms of this kind have serious and ongoing consequences for individuals and their families – particularly, perhaps, where the families include young children. (Of course, people of any age group may experience such symptoms.) People living in disadvantaged areas often cite mental well-being as the issue of greatest concern to them.

Symptoms of mental distress also have a profound impact on life beyond the home. For example, depression and lack of confidence present invisible barriers to activities like accessing employment or training schemes, or taking part in community initiatives. This means that levels of mental health and well-being within deprived communities have a significant effect on the success or failure of a wide range of regeneration-funded activities. In some cases, as indicated in the quotation at the beginning of this section, mental health problems may underlie alcohol or substance abuse – both of which may damage individuals and families as well as the fabric of local communities.

## **Finding an effective response**

### **Past attempts**

Over the last 30 years or so, the challenges presented by mental health issues in local communities have been met – or, at times, left unmet – in a wide variety of ways by the different agencies and bodies concerned. Until recently, there has been little commitment to ‘joined-up’ initiatives.



The needs have always been great; the issues complex, making a clear focus difficult; resources scarce. Successive waves of policy-making in health and in regeneration – undertaken largely in isolation from each other – have washed over vulnerable people with legitimate needs.

## Mental health

Until the mid-1980s, there were examples in mental health of community mental health services using community development styles of working to build alliances with service users and local community groups. These were set up to develop agreed local services that linked neighbourhood concerns with the needs of people with mental health problems. The policies of the early 1990s became narrower in scope. They focused, for good reason, more on the needs of people with severe mental health problems, and did so in a community where there was low public tolerance and high anxiety (Hoggett *et al* 1999).

## Regeneration

In regeneration, the early focus was on physical regeneration, with an accompanying belief that renewing buildings and providing jobs would cure most communities' ills. The physical regeneration of areas resulted, in many cases, in the marginalisation of vulnerable people who, having been decanted from their housing, moved on to live in 'rings of deprivation' round the regenerated areas (Dear and Wolch 1987). This effect proved to be particularly marked where the regeneration was accompanied by gentrification.

The arrival of the Single Regeneration Budget (SRB) in the 1980s marked the point where it was acknowledged that resources had to be channelled to 'soft', 'people' initiatives designed to develop the capacities of local communities, at the same time as funding was allocated to 'hard', capital infrastructural projects in these areas. In rounds 5 and 6 of SRB, for example, some programmes funded innovative projects designed to promote mental well-being.

## What have we learned that can help us now?

Wherever there is renewal of areas, there is change; and where there is change, there are concerns to be anticipated, considered carefully and followed up. Experience also indicates that where there is change, there are also unplanned consequences. All the main agencies involved – including regeneration partnerships and providers of mental health services – need to look with the community at the positives, negatives and uncertainties of specific programmes of change, and work together on developing appropriate responses.

## Regeneration partnerships

It is still unusual for regeneration partnerships to place 'mental health' high on their list of priorities – despite the fact that the issue has a fundamental and continuing impact on the success of the local initiatives they fund. There are tangible benefits for regeneration partnerships, for example, in working towards providing co-ordinated support for people with mental health issues. Traditionally, activities associated with regeneration – like building new homes, creating jobs

and training – have been seen to exist on a different plane from people’s physical and mental well-being. But experience suggests that there are strong links between these areas. For instance, the high drop-out rate in regeneration-linked training/employment schemes has been shown to be associated with lack of confidence and self-esteem.

## Mental health professionals

For their part, mental health professionals may be accustomed to focusing on the individual using services rather than on the wider picture (in other words, on the ‘downstream’ rather than ‘upstream’ influences). But there is a growing awareness among professionals of the complex nature of the links between individual service users and their community – and of the opportunities available to them to work effectively at both levels. For example, the recently created Social Perspectives Network for Modern Mental Health (see Section 5 for contact details) addresses questions such as:

- How can professionals be helped to learn about users’ experiences of themselves in a way that shapes their practice?
- How can communities be strengthened and supported in their efforts to care for people with mental health problems?

Some professionals see the first step as being to re-focus on ‘respectful listening’, extending this from the individual patient to the community in which that patient lives. There is a continuing requirement to represent the interests of people with mental health problems, enabling them to advocate on their own behalf. But professionals also have an important emerging role in working with the community on concerns about people who are giving rise to anxiety.

## Identifying shared learning points

There is an opportunity here for constructive, ongoing partnership work that will have wide-ranging benefits. What broad learning points can regeneration agencies, mental health professionals and community organisations draw from past experience?

First of all, it is clear that there is an over-riding need for ‘capacity building’. It is equally clear that capacity needs to be built within the communities of mental health professionals and of regeneration and other agencies, as well as within the local communities to whom the phrase is usually applied. All those involved need to work together and separately in order to build their capacity to learn and develop. For example:

- Mental health professionals are well aware that working with groups in the community can require different skills from working at individual treatment level; and initiatives like the Social Perspectives Network for Modern Mental Health reflect a real desire to share and develop learning of this kind.
- Regeneration agencies and others could usefully build up their own networks to accelerate their learning about effective approaches to some of the complex issues facing them in this area.

Sections 2 to 5 of this guide aim to provide a basic framework for, and stimulus to, embarking on this challenge of capacity building within professional groups and agencies.

A second broad learning point is that attention must be paid to the full range of local communities' needs – including economic and social dimensions.

## Attending to the full range of needs

### Economic development to benefit all

Poverty tends to be bad for health. Being employed or having some other occupation tends to make people healthier. The hugely important 'upstream' determinants of health are associated with the economic development policies being pursued nationally and locally. It is vital, therefore, that lessons from the past are learned. It has been suggested that separation of 'hard' economic activity from 'soft' community-building activity contributes substantially to social and health inequalities. The process of social inclusion means that people who have been marginalised are enabled to move into the mainstream of society. This will happen only if there are structured opportunities for education, training and sustained employment.

### Building up 'social capital'

Both regeneration partnerships and mental health professionals, along with others, can be seen to have a vested interest in building up a good level of community spirit, where individuals and groups expect to give and receive according to their different abilities and needs.

Evidence suggests that urban initiatives intended to enhance quality of life or mental health need to promote security, increase leisure opportunities, foster 'social capital', and improve the image of the locality (Huxley and Evans 2001). Attention to building up social capital has been presented as a possible springboard for positive action to reduce health inequalities. Sometimes described as the 'glue' that holds societies together, social capital has been defined as follows:

*By 'social capital', I mean features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives.*

Putnam 1996, quoted in McKenzie *et al* 2002.

Social capital, then, refers to the accumulation and use of intangible but invaluable assets. Trust, for example, is explicitly present in the quotation on page 8 from the member of a community organisation. In many situations, community groups are likely to be in a better position than statutory services to invite and receive trust from local people. What might this mean in practice? Many people who know they need help may be reluctant to approach mental health services because of the potential stigma involved. They may be reluctant

to go to social services because of fear of the consequences. However, they may well be willing to approach voluntary or community organisations – particularly as they will be able to self-refer, an option not available in accessing many statutory services.

High levels of social capital are likely to benefit most members of that particular community; but it has been pointed out that minorities within the community may experience marginalisation and exclusion. It has been noted that the incidence of psychotic disorders rises among members of minority ethnic groups living in areas with lower proportions of such groups – known as the ‘ethnic density’ effect. The reason for this, it has been suggested, is that social capital within a given minority group diminishes as it becomes a smaller proportion of the population (McKenzie *et al* 2002).

Certainly, psychiatric illness rates are generally higher in minority ethnic groups. These groups also experience significant social adversity but have poorer social networks and support. For these reasons, the drive to bring about real reform in mental health services for people from black and minority ethnic communities in England includes giving priority to enhancing the capacity within these groups to deal with the burden of mental ill health and to tackle the inequalities in the services provided to them (NIMHE 2003).

Social capital is a rapidly developing area of social policy, and is attracting further research. In practical terms, what key lessons seem to be emerging? One piece of learning stands out: ‘healthy’ communities are characterised not only by close relationships between groups of residents of similar background, but also by acceptance of groups and individuals who live different kinds of lives. In other words, social inclusion seems to be good for the health of communities – and of all the people living within these communities.

# 2

## What are we working with?

**This section presents a highly visual guide to key policies, systems and partnerships that influence what agencies do and how they do it. It provides aerial views of:**

- **mental health services**
- **social exclusion in the context of policy on renewal and regeneration**
- **local strategic partnerships.**

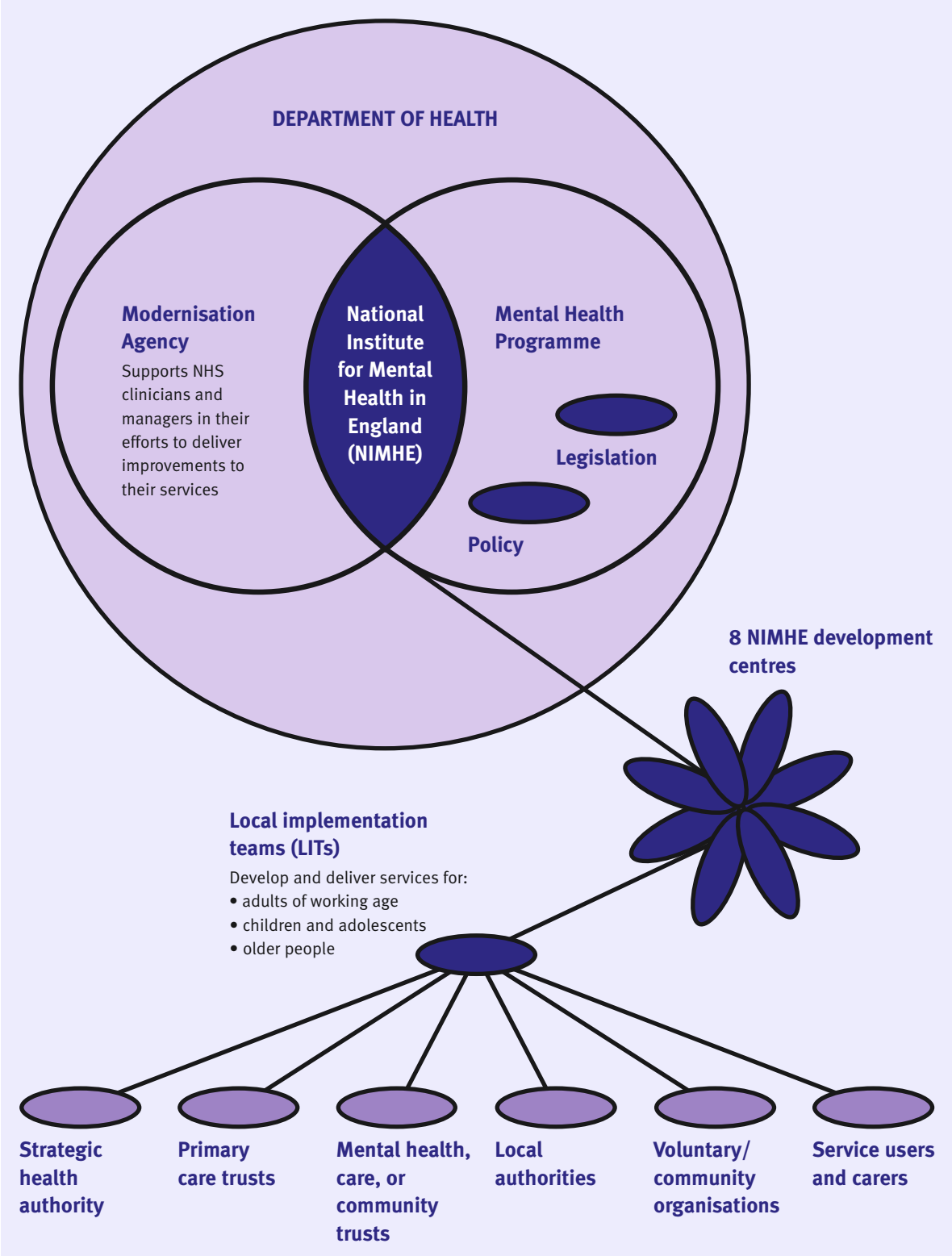
### How to use this section

The text and figures have been designed to work together to enable you to identify key aspects of the systems being described. You may find it helpful to look at the figures first, then read the accompanying text as glosses on the figures, broadening your understanding of the elements and relationships involved.

Every effort has been made to ensure that the information provided is accurate at the time of going to press. In this fast-moving area of work, however, information rapidly becomes outdated. You are advised to consult Section 5 for websites that will give access to the latest information.

**Figure 2: Mental health services – an aerial view**

This figure illustrates how commissioners, providers and users of mental health services work through local implementation teams (LITs) to identify local needs and develop services to meet them.



## Mental health services

### Who does what?

Figure 2 (opposite) focuses on the local implementation teams (LITs) through which commissioners, providers and users of mental health services work to identify local needs and develop services to meet them in line with the Mental Health National Service Framework.

Backing up the LITs are a range of agencies, organisations and programmes. The National Institute for Mental Health in England (NIMHE) has a leadership role in co-ordinating and facilitating change in mental health at national, regional and local levels. Working with the NHS and beyond it, NIMHE helps all those involved in mental health to implement change, providing a gateway to learning and development.

### Who plans and commissions mental health services?

- Strategic health authorities
- Primary care trusts
- Local authorities

### Who provides mental health services?

- NHS trusts, including mental health and community trusts
- Care trusts
- Primary care trusts
- Voluntary- and private-sector organisations
- Local-authority social services departments.

### Who is involved in mental health promotion?

- All health and social care services are involved in partnership with other groups and agencies (*see 'Key challenges' overleaf*).
- Local authorities are well placed to play an important role – for example, education departments may promote social inclusion initiatives in schools and environmental health departments may sponsor 'healthy city' initiatives.

### Who employs mental health workers?

- NHS mental health trusts employ a large proportion of the clinical staff working in different settings, for example:
  - inpatient facilities
  - day hospital/outpatient facilities
  - community teams: early intervention; home treatment; assertive outreach; community mental health teams
  - mental health promotion.
- Local authorities employ mental health social workers who work in community teams, Approved Social Workers who are empowered to implement the Mental Health Act, social workers and counsellors.

## Key drivers for change

- Core standards for mental health services, including mental health promotion, are contained in two National Service Frameworks – one for adults of working age, and one for older people. An NSF for children is currently being developed. These standards can be achieved only through closer working with agencies and organisations outside the NHS.
- NIMHE's Equalities Programme focuses on action to support implementation of the NSF at local level in respect of social inclusion, mental health promotion, and action on discrimination and stigma.
- Many aspects of the NHS Plan – such as the focus on improving working lives and action on health inequalities – support mental health promotion.
- In March 2003, the Government's Social Exclusion Unit highlighted mental health and employment as areas for major new projects.
- The National Workforce Programme includes a focus on occupational competencies and the development of new roles to work with communities. These roles include Support Time and Recovery Workers.
- NIMHE's Framework for Black and Minority Ethnic Mental Health (NIMHE 2003) proposes the development of 500 community development workers.

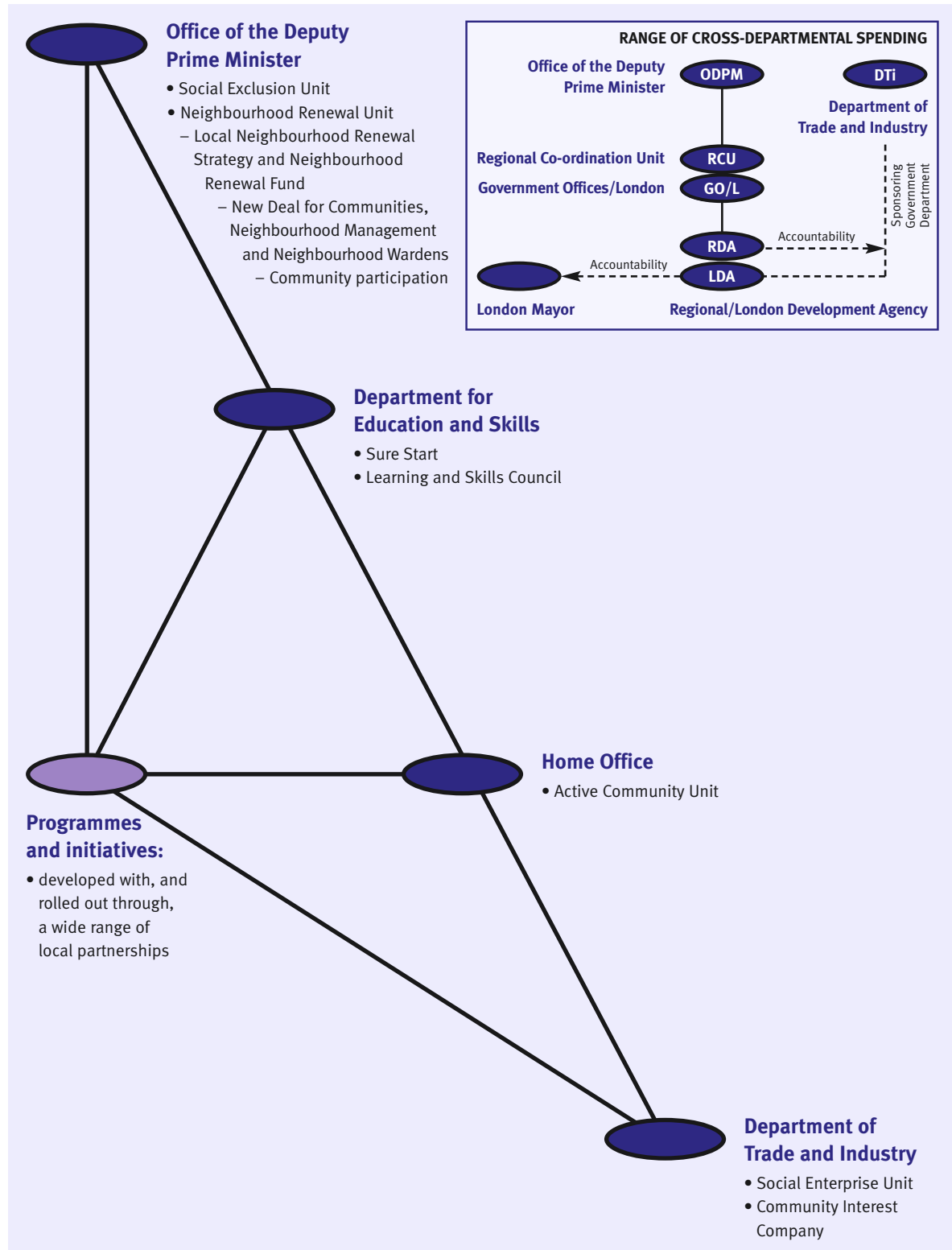
## Key challenges

- Mental health promotion needs to relate to the implementation of a wide range of policy initiatives, including social inclusion, neighbourhood renewal and health at work.
- A debate needs to be opened up on the 'public mental health' (Friedli 1999) in order to provide a framework for talking openly about the mental health needs of the whole community.



**Figure 3: Renewal, regeneration and social exclusion – an aerial view**

This figure shows the key thrusts of renewal and regeneration policy in relation to social exclusion. At the left of the diagram is the 'local reality' of programmes and initiatives; to the right are the key Government departments making policy relating to regeneration and social exclusion. The inset box shows the structure for cross-departmental spending on programmes of regeneration and economic development.



## Renewal, regeneration and social exclusion

### Who does what?

Like the world of mental health services shown in Figure 2, p 18, regeneration and renewal policy presents a complex picture. Figure 3, p 21, shows the key thrusts of renewal and regeneration policy in relation to social exclusion. On the left of the figure is the 'local reality' of programmes and initiatives; on the right are the key Government departments making policy relating to regeneration and social exclusion. The Office of the Deputy Prime Minister occupies a key linking position.

### The Office of the Deputy Prime Minister

- The Office includes important cross-cutting responsibilities for social exclusion, neighbourhood renewal, and the network of Government Offices for the Regions (*see more on Government Offices in Cross-departmental spend on programmes of regeneration and economic development, p 25*).
- It works across the Government and in partnership with others to build thriving, inclusive and sustainable communities in all regions.

### The Social Exclusion Unit (SEU)

- The SEU is involved in project-based work, as well as in developing other cross-Government policy relating to social exclusion.
- In March 2003, two major new projects were announced:
  - *Barriers to employment and enterprise in deprived areas*: the SEU will examine what more can be done to help people in England's most deprived areas move into jobs
  - *Mental health and social exclusion*: the SEU will address the barriers to opportunities faced by adults with mental health problems.

### Neighbourhood Renewal Unit

- The Neighbourhood Renewal Strategy Action Plan document sets out the Government's vision for narrowing the gap between deprived neighbourhoods and the rest of the country so that, within 10 to 20 years, no one should be seriously disadvantaged by where they live.
- At national level, the Action Plan is implemented by the Neighbourhood Renewal Unit (NRU).
- At regional level, neighbourhood renewal teams have been set up in the nine Government Offices to provide a direct channel of communication from neighbourhood/community groups to the NRU.

### *Local Neighbourhood Renewal Strategy and Neighbourhood Renewal Fund*

- These strategies aim to enable the 88 most deprived authorities, in collaboration with their local strategic partnership (LSP), to improve services, narrowing the gap between deprived areas and the rest of England.
- A key element of the Neighbourhood Renewal Strategy is the improvement of mainstream services to produce better outcomes in the most deprived areas. This means increased employment and improved economic performance, reduced crime, better educational attainment, improved health and better housing.
- To achieve these improvements, the Government, local authorities and other service providers need to reallocate resources in their mainstream programme to tackle deprivation more effectively.
- The 2002 Spending Review provides for further investment in the Government's priority areas and focuses on the key objectives of raising productivity, extending opportunity, promoting strong and secure communities, and seeking to maximise the opportunities for Britain in the world.
- The Government focus on communities confirms the commitment to renewal of the most deprived neighbourhoods, with the announcement of the continuation of NRF beyond 2003/04, with a further £450 million in 2004/05 and £525 million in 2005/06.
- All this is drawn together in a Local Neighbourhood Renewal Strategy, which is developed and monitored by the LSP.

### *New Deal for Communities, Neighbourhood Management and Neighbourhood Wardens*

- This is a key programme in the Government's strategy to tackle multiple deprivation in the most deprived neighbourhoods in the country.
- It gives some of the poorest communities the resources to tackle their problems in an intensive and co-ordinated way.

### *Community participation*

- Community participation provides a balance to business input on neighbourhood renewal. Local people know best what the priorities and needs of their local neighbourhoods are, and community participation gives local people the opportunity to participate in the regeneration of their own neighbourhoods.
- The Community Empowerment Fund was set up to help local community and voluntary sector groups get involved in decision-making through the local strategic partnerships. It will provide £60m over 2001–2006 to set up Community Empowerment Networks (CENs) in the 88 Neighbourhood Renewal Fund districts, to be administered by local community/voluntary sector 'lead organisations', allowing these groups to be involved in their LSP as influential and equal partners.
- The Community Chest programme gives accessible grants of £50–5,000 for projects to improve the quality of life in the 88 most deprived areas. Community Chests are administered by voluntary sector lead organisations and aim to enhance community activity in deprived areas.



For more information on these programmes, see [neighbourhoodrenewal@odpm.ggi.gov.uk](mailto:neighbourhoodrenewal@odpm.ggi.gov.uk)

- Community Learning Chests boost the Community Chest programme, providing small grants of £50–£5,000 to help residents in the 88 most deprived areas acquire the necessary skills and knowledge to play an active role in community renewal.

## Department for Education and Skills

### Sure Start

- The Government's programme to support children, parents and communities through the integration of early education, childcare, and health and family support services.
- Originally focused on disadvantaged communities, the programme has been expanded and extended and is now available to children, parents and communities across the country.

### Learning and Skills Council (LSC)

- The LSC is responsible for funding and planning education and training for those aged 16 and over in England.
- Its mission is to raise participation and attainment through high-quality education and training that puts learners first.
- The LSC is a national body and has 47 local offices.

## Home Office

### Active Community Unit (ACU)

- The ACU aims to promote the development of the voluntary and community sectors, and encourage people to become actively involved in their communities, particularly in deprived areas.

## Department of Trade and Industry

### Social Enterprise Unit

- Social enterprises are businesses operating in the social, not-for-profit sector. They aim to seek new solutions to social problems. This sector contains examples of successful ventures run by users of mental health services.
- The Social Enterprise Unit leads the Government's efforts to:
  - create an enabling environment for social enterprise
  - make social enterprises better businesses
  - establish the credibility of social enterprise.

### Community Interest Company

- There are proposals to establish a new type of company – the Community Interest Company (CIC).
- This form of company is designed for social enterprises that want to use their profits and assets for the public good. The intention is that CICs will be easy to set up, with all the flexibility and certainty of the company form, but with some special features to ensure they are working for the benefit of the community.

## Cross-departmental spend on programmes of regeneration and economic development

- Ten different Government departments allocate programme money for regeneration and economic development. These budgets are managed collectively by a corporate Regional Co-ordination Unit (RCU). The RCU allocates budgets to the nine regional Government Offices in England (GOs) and the one in London (GOL).
- Government Offices have two main functions:
  - to take a cross-departmental view of how Government programmes are working together
  - to spend £6 billion of programme money on behalf of the Government.
- Government Offices are responsible for agreeing contracts for the use of programme money and for ensuring that it is spent in accordance with the agreed terms. In this context, they sponsor Regional Development Agencies.
- Eight Regional Development Agencies (RDAs) were established in England in 1999 (with the London Development Agency (LDA) established in 2000). This pattern reflects the arrangement for Government Offices. The RDAs and the LDA are responsible for the co-ordination, delivery, support and monitoring of local programmes.
- The RDAs are accountable to the Department for Trade and Industry (DTI). The LDA is accountable to the Mayor of London and the DTI.
- The Single Regeneration Budget (SRB), which from 1994 brought together a number of programmes from several Government departments, was subsumed into the RDAs' Single Programme as from 1 April 2003.

## Key drivers for change

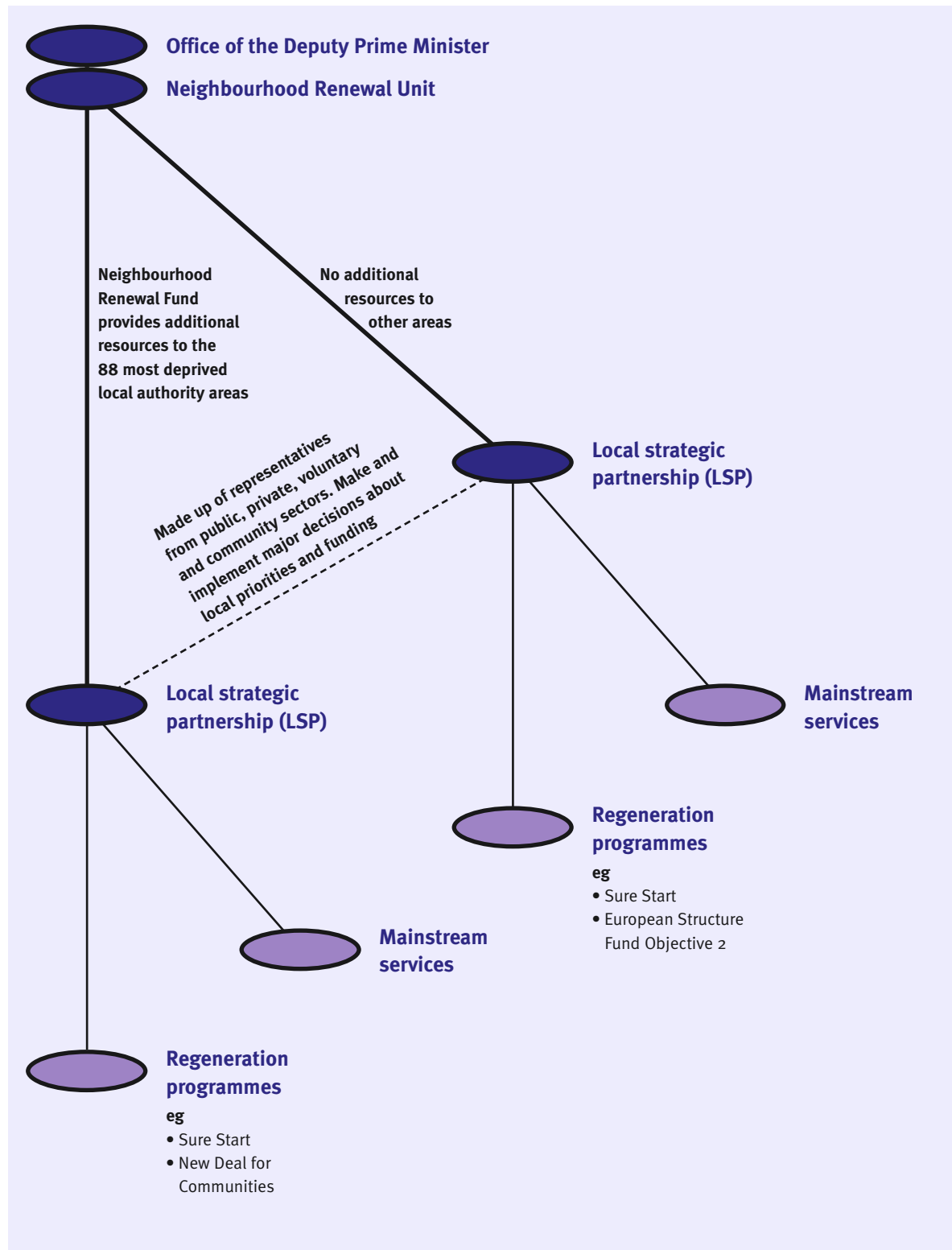
- Across Government, priority is placed on developing sustainable communities. This goal cannot be achieved without enabling health- and social-care professionals, individuals and communities to make real progress with mental health issues.
- In March 2003, the Government's Social Exclusion Unit highlighted mental health and employment as areas for major new projects.
- Learning and Skills Councils (LSCs) work closely with Government Offices and RDAs (and the LDA). Within a locally agreed Framework for Regional Employment and Skills Action (FRESA), each LSC has a remit to develop programmes specifically for people in disadvantaged circumstances, including those with mental health problems.
- Organisations and partnerships concerned with mental health issues may want to seek out opportunities to influence the roll-out of the Single Programme, controlled by the RDAs.

## Key challenges

- The needs and aspirations of vulnerable people need to be seen as a vital component of the needs and aspirations of the community as a whole.
- As citizens, vulnerable people need to have equal access to the decision-making processes that determine the flow of material and social benefits to their community.
- The Disability Rights Commission (DRC) argues that, in practice, people with mental illness are not afforded the same legal protection against discrimination as are other groups of people with disabilities (Disability Rights Commission 2003).
- Regeneration partnerships need to explore ways of improving the quality and consistency of the baseline data that they use in planning how to achieve social and health outcomes. Social audit may offer one useful model.

**Figure 4: Local strategic partnerships – an aerial view**

This figure shows how local strategic partnerships (LSPs) originate from the Neighbourhood Renewal Unit of the Office of the Deputy Prime Minister. Some forms of LSP attract additional resources; others do not. All LSPs make and implement major decisions about local priorities and funding.



## Local strategic partnerships

### What are they?

Figure 4, p 27, shows the origin of local strategic partnerships (LSPs) in the Neighbourhood Renewal Unit of the Office of the Deputy Prime Minister. As indicated in the diagram and explained in the text below, some forms of LSP attract additional resources; others do not.

- LSPs bring together, at a local level, a range of stakeholders from the public, private and voluntary sectors, including key providers of services. Local authorities, strategic health authorities and primary care trusts are expected to play a prominent role.
- Local implementation teams (see Figure 2, p 18) may have direct links to LSPs, or they may be linked through the representation of individual team members.
- Local partners working through an LSP are expected to make and implement many of the major decisions about priorities and funding for their local area.

### What are they for?

- These partnerships are central to the delivery of the national strategy, *New Commitment to Neighbourhood Renewal*. A key element in the strategy is the improvement of mainstream services to produce better outcomes in the most deprived areas, and to contribute to sustainable development.
- To achieve these improvements, the Government, local authorities and other service providers need to work together to allocate resources, and ‘bend’ their mainstream programmes to tackle deprivation more effectively.
- Key service providers are drawn into a single partnership with which the community is actively engaged. This means that communities have a greater say in the running and delivery of public services.
- LSPs work within a framework of community strategies and plans that local authorities have a duty to develop. There are clear, common aims, objectives and activities between the NHS and local government, many of which contribute to delivering NHS priorities, including in mental health.

### Is extra money involved?

- As Figure 4 shows, there are two different kinds of LSP. In the 88 most deprived local authority areas, LSPs have additional resources that can be spent in ways that tackle deprivation in the most disadvantaged neighbourhoods, and that contribute to sustainable development. Health goals are likely to be considered highly relevant to this scenario.
- In areas that have funding through New Deal for Communities (NDC), LSPs are expected to offer advice and support to the NDC partnership board.
- In all other areas, LSPs receive no additional resources. The expectation remains that they will pool resources and align activities to achieve the results required by the Neighbourhood Renewal Strategy.



## Key drivers for change

- A lack of joint working at local level has been one of the key reasons for lack of progress in delivering:
  - sustainable economic, social and physical regeneration
  - public services that meet the needs of local people.
- The Health and Social Care Act 2001 provides those local authorities which are key partners in LSPs with new powers to carry out health scrutiny. This power of scrutiny has potential both to increase democratic accountability in the NHS and to review the health impact of local authorities' own policies and practices.
- Local authorities have a duty to promote the well-being of people who live and work in their areas and to deliver a better quality of life through the development of sustainable communities.
- The Neighbourhood Renewal Fund aims to enable the 88 most deprived local authorities, in collaboration with their LSP, to improve services, narrowing the gap between deprived areas and the rest of England. 'Floor targets' are used – these set a minimum standard for disadvantaged groups or areas, or a narrowing of the gap between them and the rest of the country.

## Key challenges

- Mainstream services need to be re-designed to produce better outcomes in the most deprived areas and to contribute to sustainable development.
- Solutions to past difficulties in joint working at local level need to be found. Difficulties might be associated, for example, with different agencies working towards different targets or along different timescales. (Figure 6, p 39 offers a framework for exploring these issues further.)
- Too often, the availability of funding leads to rivalry rather than co-operative working. How can this situation be avoided locally?

# 3

## Where do you start?

**Decisions affecting the mental health of communities are made at different levels every day. Sometimes the decision-makers are aware of the likely consequences of their decisions. Often they are not. The stigma associated with mental illness often contributes to public ‘invisibility’ of the issues involved. But it is only in discussion and negotiation – in and between organisations, agencies and partnerships – that change can be initiated and progress made. This section draws on discussion and debate across the country to present emerging ‘trigger points’ for change in question-and-answer form. It also introduces a visual continuum of community need, matched by a continuum of partnership and support.**

### Opening up constructive dialogue

The prompts in this section are not necessarily straightforward and very few have a cut-and-dried answer. They are designed to encourage colleagues working in what can sometimes seem to be ‘parallel universes’ – including mental health, regeneration partnerships, and the community – to open up a constructive dialogue on assumptions, expectations and possible ways forward. The underpinning question is: how can renewal initiatives be matched with issues, such as employment, that need to be tackled if social inclusion goals are to be met for those affected by mental health problems? In particular, what areas of common purpose can be used to launch ‘win-win’ initiatives that provide benefits to all those involved?

### If your focus is on renewal or regeneration

**Q How many of the schemes you fund or run offer direct benefit to vulnerable groups, such as people with mental health needs?**

**A** You may want to think more broadly about the kind of schemes and initiatives that you’re supporting. For example, how many training or education programmes funded by regeneration agencies offer appropriate support to students with mental health problems? Might there be a case for expanding the number of community businesses or social enterprises developed and run by people with mental illness?

**Q What do you know about the specific needs of people with mental health problems in the areas covered by the regeneration schemes you fund or run?**

**A** If you are to achieve improved health outcomes, then you need to have a clear picture of the needs to be met within the local community or communities. As mentioned on p 26, you may need to review your approach to gaining baseline data relating to health. It is also important that you are aware of the types of

programmes that are needed to support people with mental health needs in securing employment. For instance, many people will choose a period of volunteer work or flexible and part-time work as an interim stage before they can tackle full-time work. (For more on employment issues, see the First Step Trust case study, p 43.) The local primary care trust or strategic health authority should be able to advise on these needs.

**Q Do you know what targets and performance indicators would be appropriate for schemes to support people with mental health needs?**

**A** Targets and performance indicators for schemes supporting people with mental health needs will have to fit the particular needs involved. Again, the local primary care trust or strategic health authority should be able to advise on these issues. They may also be able to relate these issues to the indicators used annually for self-assessment of progress in implementing the Mental Health National Service Framework (Glover and Barnes 2002).

**Q What health goals are associated with the schemes and programmes that you're currently supporting? Do goals and benefits relate to mental and emotional as well as physical health?**

**A** In thinking about these questions, you may have considered some of the 'upstream' and 'downstream' factors shown in Figure 1, p 11. For example, the link between employment and better family health is now well established. Not having a job increases the likelihood of ill health for both adults and their children. Therefore, consistently funded schemes that enable local people to develop the skills and confidence they need for meaningful work, and then support them into jobs, can do a great deal for the health of individuals, their families and the community as a whole. But are goals of this kind clearly embedded in the plans for the programmes?

**Q What health benefits are delivered by these schemes? How do you know? Do you know when innovations are worth funding?**

**A** The situation regarding evidence in this field is complex, particularly in relation to mental health promotion. Partly because of this, evaluation of schemes tends to be patchy and intermittent. Furthermore, related social issues, such as community safety, employment and mental health, are rarely looked at together. You might therefore consider it worthwhile to explore the possibilities for a strategic approach to evaluation. Benefits could include a shared resource of rigorous and relevant research – and a willingness to share learning across different agencies.

**Q Are the schemes and programmes you support making significant inroads into inequalities in mental health within local communities?**

**A** Some groups of people are more likely than others to experience mental illness or distress. For example:

- people living in poverty
- some minority ethnic groups, including African-Caribbean and Irish people
- asylum seekers and refugees
- people with disabilities or long-term illness

- homeless people, and people in poor housing
- people misusing substances
- people who have experienced abuse.

Many of these groups are also likely to suffer from discrimination and social exclusion, the focus of so much cross-Governmental effort. The links are complex. Poverty, for example, is both a cause and a consequence of poor mental and physical health (Payne 2000, Davis and Hill 2000, cited in Heer and Woodhead 2002). Investment in work to anticipate and meet mental health needs among these groups is likely to achieve a range of the objectives set for regeneration funding. Work with this focus can sometimes also usefully link into equal opportunities initiatives undertaken by local authorities and other agencies.

## If your focus is on mental health services

**Q What more could mental health and other commissioners and providers of mental health services do to open up structured training, career and volunteering opportunities for local people, including those affected by mental illness?**

**A** As a significant employer across the country – and with a particularly important place in many disadvantaged areas – the health- and social-care sector is well positioned to improve employment and volunteering opportunities in these areas, and, as a result, to improve people's health. Continuing staff shortages, along with requirements to make their workforce more representative of local communities, exert further pressure to extend local recruitment. The concept of the 'career skills escalator' is being increasingly used to provide a practical framework for development work in this area (Department of Health 2002, Coote 2002). There is also growing evidence of the success of approaches to employing mental health service users in trusts (Department of Health 2002). You might want to explore how these approaches could be used, or further developed, locally.

**Q Mental illness continues to be largely invisible to organisations involved in regeneration initiatives; and that can't be helpful to anyone. But, in practice, regeneration partnerships seem to exist in a separate dimension from mental health trusts and other commissioners and providers of mental health services. How might the two get to know each other better?**

**A** Mental health trusts and local implementation teams, along with mental health service users, can usefully consider becoming represented on the boards of regeneration partnerships. Primary care trusts are likely to have a presence there already, as will strategic health authorities. Even so, without specific representation, it is possible that the interests of users of mental services will be given less attention than is appropriate.

'To get some of the meal', observed one clinician experienced in partnership working, 'you need to be sitting at the table'. As indicated in Section 2, the world of regeneration presents a complex picture, with over 35 different types of initiative (Edmans and Tarifa 2001). As a mental health service professional, you might find it useful to start by seeking advice at local level – approaching the lead for regeneration in the local authority, for example, along with those responsible for public health in the primary care trust, strategic health authority and Government Office.

**Q** For mental health professionals, there are real issues involved in the move from engaging with individuals to engaging with wider communities. What's been shown to be helpful in making this move? And what's the role of a specialist organisation, like a mental health trust, in making links with the wider world?

**A** Delivering the mental health promotion standard of the National Service Framework for Mental Health involves major changes in thinking, working and communicating. As a clinician, for example, you may need to think about exploring your values and assumptions so as to be able to engage in meaningful debate across professional and sector boundaries. The National Institute for Mental Health in England (NIMHE) has initiated a project to look at promoting a values framework for mental health services: further information will be available on the NIMHE website (see Section 5). As discussed in Section 1, there is also a need for 'capacity building' for mental health professionals themselves. You are likely to need training and support in developing your skills. Section 4 will help you to explore these issues further.

**Q** How can I reallocate funds? It's hard enough to keep money in mental health in the first place.

**A** What does it really mean, 'to keep money in mental health'? The fact is that by funding voluntary and community organisations, statutory agencies can add tremendous value to their work. Funding of this kind can generate partnership working to support vital services like assertive outreach, early intervention teams, and neighbourhood-based social support networks. Voluntary and community agencies can also play an important role in addressing, at local level, the stigma of mental illness. NIMHE is developing approaches to engage local people and community agencies in these partnerships. In Bradford and Brighton, for example, the mental health services and community organisations are being brought together to pilot a 'community compact' for mental health. This offers a new form of collaboration and partnership between mental health services and community organisations. Work is also underway to apply a highly successful methodology for community engagement in mental health, developed by the Centre for Ethnicity and Health at the University of Central Lancashire.

**Q** With a focus on broader localities, how do we work to meet the needs of the most vulnerable and those currently least well served by the mental health services? Do we take a separate approach? If so, what message does that convey about inclusion?

**A** Some groups of people suffer high rates of mental illness and yet, for various reasons, find it difficult to access appropriate support. For example, homeless people, people with disabilities, and asylum seekers and refugees fall within this group. A key challenge in remedying this situation is effective partnership work at local level to knit together different strategies, initiatives and services in order to meet the particular needs of people excluded from community life through mental illness. Risk management presents a further slant on this issue. It is part of the job of mental health professionals to make sure that, in the widest sense, the mental health of communities is being safeguarded. This responsibility needs to be reconciled with the need to protect the interests of, and provide support to, those people who are most vulnerable and who have the most serious illnesses – often the illnesses that communities perceive as constituting a threat.

## If your focus is on the needs of your community

**Q** As community organisations, we're constantly being told that we're invaluable when it comes to supporting people with mental health problems. But we still always find ourselves struggling along on short-term funding.

**A** This problem has bedevilled many innovative schemes. However, as the role and value of community organisations in this field become more widely appreciated, the need for sustained funding is becoming more and more obvious. Why is the statutory sector often unable to commit funding for more than a year at a time? It is because, traditionally, budgets from the Government have been allocated on an annual basis, with little certainty about the following year's allocation. It has been common for budgets to be cut or priorities shifted from year to year. From April 2003, however, the Government has set in place arrangements for health funding to be planned over a longer period, by way of three-year local delivery plans. For their part, local authorities are using approaches such as community plans and compacts to enable groups to plan on a longer-term basis. Non-statutory funders are not bound by the same financial regulations as the statutory sector, so can be more flexible in the way they allocate their budgets.

**Q** Where we've got a particular focus on children and young people, what are likely to be the main issues involved, and to whom do we need to talk?

**A** Research carried out by the Mental Health Foundation (Mental Health Foundation 1999) estimates that one in five young people have mental health problems at any one time. The Samaritans (Samaritans 2003) also report that more than nine young people under 25 die by suicide every week in England.

However, mental health problems in young people are often misdiagnosed, unrecognised or underdiagnosed. Up to 23 per cent of children attending GP practices have emotional or psychological problems, but only 2 per cent of these are recognised by GPs (Department of Health 1996). There are few services for young people, and many of those that do exist require an adult to access them, such as a teacher, social worker, parent or doctor. Few services can be independently accessed by young people. Community or voluntary groups may be in a position to help fill this gap.

Many young people's projects funded through regeneration monies focus on tackling crime and drugs. Funding for health projects is geared towards sexual health and preventing teenage pregnancy. More could usefully be done to bring these two worlds together.

**Q** We're not interested in the traditional medical model of health. We want to take a more holistic approach. Is there any point in approaching mental health services?

**A** The voluntary sector is well positioned to be flexible, to tailor services to local need, and to respond quickly. Statutory services are often aware of these strengths and are open to funding services that meet client needs that they recognise but cannot meet themselves. That said, limited resources and statutory duties may restrict what can be done. From the point of view of individual voluntary or community organisations, there are a number of benefits associated with working in partnership with the statutory sector. One key benefit is that partnership working of this kind can strengthen applications for funding and unlock money from a number of sources.

**Q Who is our first port of call if we want to discuss how things might be done differently – is it the local GP?**

**A** To some extent the nature of your idea will determine the most suitable first port of call. You may have good links with your local primary care practice, in which case that might well be a good starting point. But there are other options. All local authorities, for example, have a department that takes the lead role in regeneration or economic development. In addition, there will be somebody who takes the lead in linking with community and voluntary organisations. Many primary care trusts (PCTs) have a person with a lead responsibility for regeneration, and the PCT's Public Health Department is also likely to be able to help. You could also consider making contact with the lead person for mental health promotion, social inclusion or equalities in NIMHE's Development Centre for your region.

## Fitting the pieces of the jigsaw together

**Q Locally, who is likely to be making decisions that will have a profound effect on the mental health of communities, and in what context will these decisions be made?**

**A** In disadvantaged areas, the boards of regeneration partnerships will make some decisions of this kind – although they may not be fully aware of the significance of these decisions as far as the community's mental well-being is concerned. Therefore those most concerned with mental health issues are encouraged (see above) to seek representation on the boards of major regeneration programmes, such as Sure Start or Neighbourhood Renewal. Involvement at regeneration board level has opened up creative space for many people – enabling them to cross boundaries both within and across organisations and thus see 'a bigger picture'. In all areas, local strategic partnerships (LSPs) will make decisions of great importance to the mental well-being of local communities.

**Q What real opportunities are presented by LSPs?**

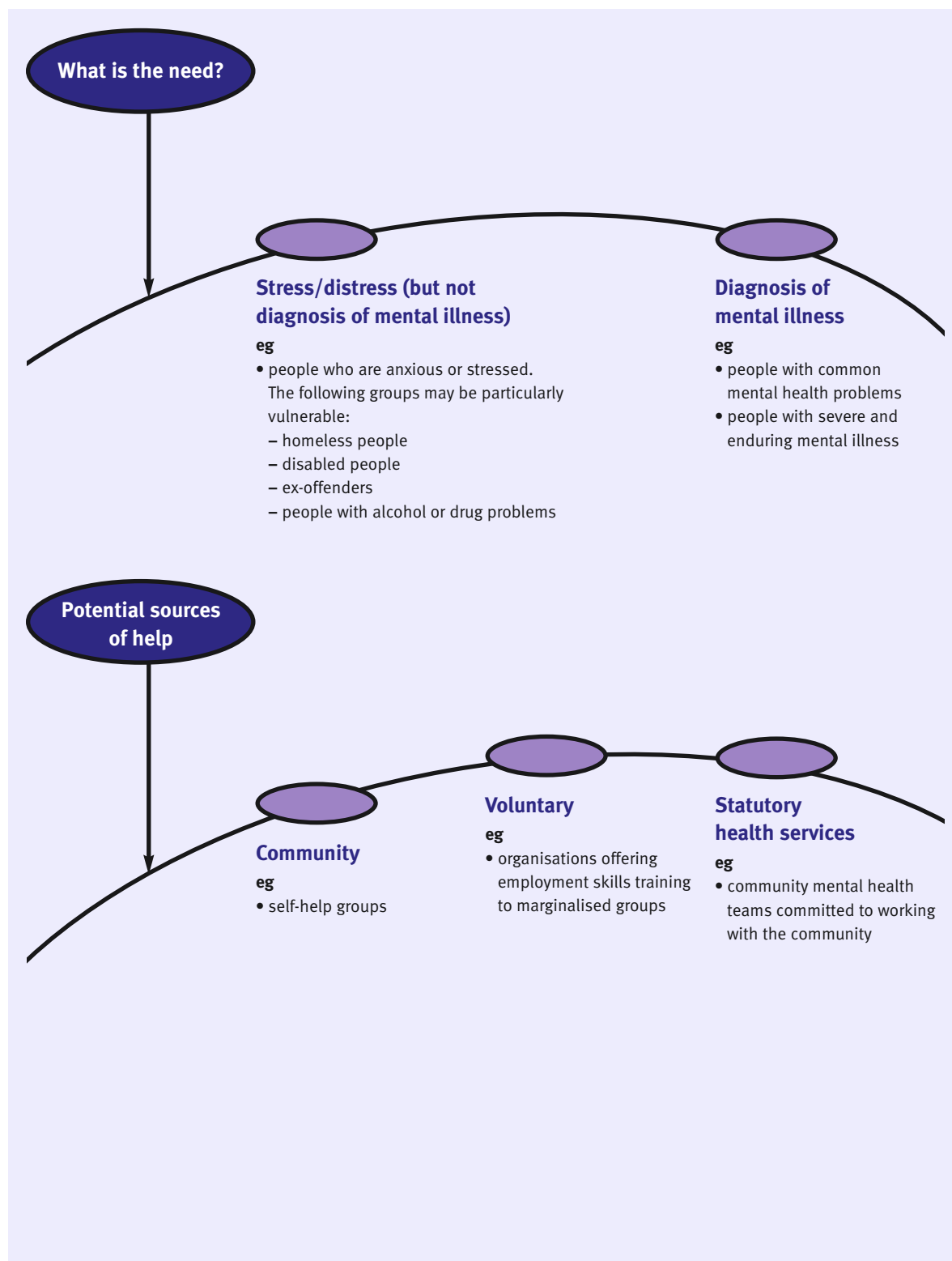
**A** LSPs (see Figure 4, p 27) provide an opportunity to bring together the agencies that can make a real difference to the mental well-being of the community and to patterns of social exclusion found there. Community and voluntary groups have a potentially key role in setting the agenda. Strong links need to be developed with local implementation teams (see Figure 2, p 18) and with primary care trusts. Charged with directing the flow of mainstream spending on public services, LSPs have a challenging and potentially very exciting brief – to look to the long term in shaping, developing and delivering services that will meet local needs.

**Q What about the challenges presented by LSPs?**

**A** A radical aspect of the LSP project is the prominence given to local people's voices – professionals are not assumed to know best. Many professionals welcome the opportunity to engage directly with local people on equal terms. Others, along with their middle and senior management, may need support in meeting the difficult challenge of reconciling the delivery of targets set centrally with the focus on local needs.

**Figure 5: Mental health in the community – meeting the full range of needs**

This figure illustrates two arcs, to be looked at together, which give a sense of the range of possibilities for meeting different mental health needs in the community. The arcs link key areas of need with key sources of support.





## Mapping needs and sources of support

Figure 5 (left) offers two arcs, to be looked at together to get a sense of the range of possibilities for meeting different mental health needs in the community. The map is neither a diagnostic nor an assessment tool. It is simply an attempt to put together in the same visual frame key areas of need and key sources of support.

One arc is labelled, 'What is the need?'; the other, 'Potential sources of help'. Each arc presents a continuum. The arcs do not neatly map on to each other, but they do demand to be viewed together. What creates need for support in terms of mental health is the complex mixture of life itself – personal experiences, the environment, heredity factors. No one reacts to this mixture in the same way. Accordingly, needs are not fixed – for individuals, families nor communities. And so the potential sources of help have to be similarly multi-faceted and flexible. The practical value of Figure 5, therefore, is to focus attention on the question, 'What elements of support can be put together from the "Potential sources of help" arc to meet the needs that are identified in the "What is the need?" arc?'.

# 4

## Learning from other people's experience

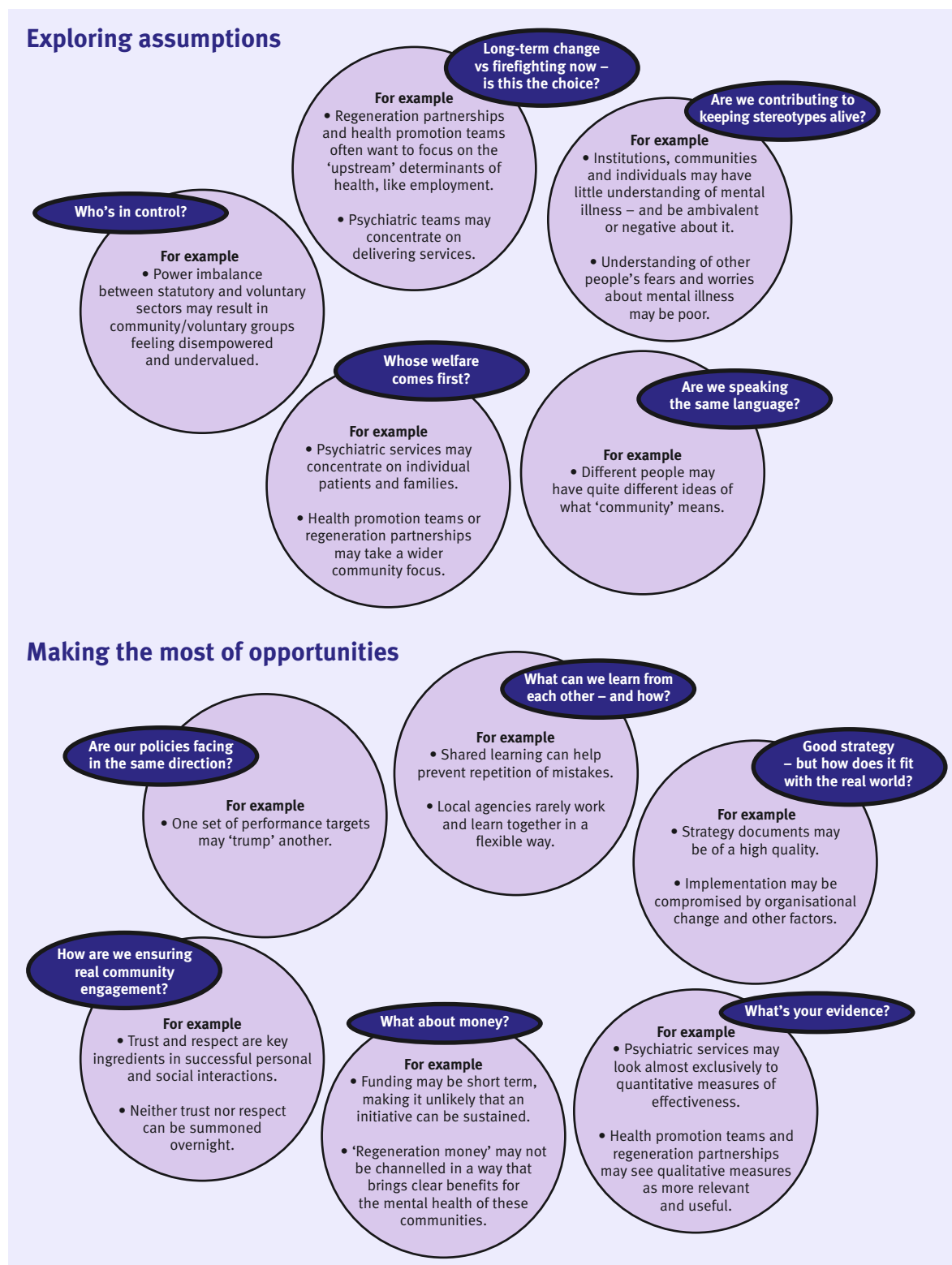
**This section is designed to give an insight into what different people, organisations and partnerships have done to strengthen the links between community renewal and mental health, and how they have done it. The emphasis is on what they have learned – and on what you can learn from their experience. In particular, you are invited to explore your own assumptions about joint working in this complex area – and reflect on how four very different projects have dealt creatively with some of the different tensions involved.**

### Assumptions and opportunities

Innovative work in any area is rarely straightforward – in how it begins or how it proceeds. Figure 6 (right) outlines the range of assumptions that may underlie partnership working associated with promoting mental health in local communities, and sketches out the kind of opportunities that may emerge in the course of joint working.

**Figure 6: Learning from other people's experience**

This figure outlines the range of assumptions that may underlie partnership working associated with promoting mental health in local communities, and sketches out the kind of opportunities that may emerge in the course of joint working.



The following positive practice examples give an idea of the range of possibilities to promote mental well-being in and across communities.

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## Wise People's Project

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### In short

**A survey revealed that stress was a big problem among residents of an estate in the north east. A group of local women approached the local mental health trust to see what could be done. The result was a pioneering initiative in partnership working.**

### The challenge... and the response

When a group of women on the deprived Cowgate estate, in Newcastle upon Tyne, surveyed 150 residents, 145 of them admitted to problems related to stress. The women went to the local mental health trust to ask for help.

The outcome is a grassroots initiative, thought to be the first of its kind, by which neighbours on the estate will help each other deal with emerging mental health difficulties. If it succeeds, the idea could be replicated in other communities vulnerable to stress-related problems.

Steve Shrubb, chief executive of the Newcastle, North Tyneside and Northumberland Mental Health Trust, says: 'I felt that here was an opportunity for the trust to move into a real partnership with some of the most deprived communities. So rather than just helping them when they were ill, there would be a preventive and positive relationship.'

Cowgate, in north-west Newcastle, has social issues typical of sprawling urban estates. The women's survey aimed to establish what improvements should be made. Unsurprisingly, getting rid of drug dealers was a top priority. Next came health concerns: the need for a GP practice on the estate, where there are no full-time, dedicated health workers; and a demand for some way of alleviating stress-related problems, reported in some degree by 97% of respondents.

The volunteers took their concerns, and their ideas, to the trust – known as the 'three Ns' trust. Shrubb soon realised that this was something worth developing. 'They were saying: "We don't just need your help, we want to have the skills and ability to help ourselves."'

Shrubb backed an initial package of training and support for what is provisionally called the Wise People's Project. Strictly speaking, it should be the Wise Women's Project; because though men are welcome, none have joined the core of 10 women. Of these, several have been on counselling and mediation courses and almost all have attended a series of six workshops and a residential weekend, arranged and funded by the trust.

At the workshops and weekend away, trust staff covered themes requested by the group. Gayle Bayes, a member of the trust's management team, says: 'They

specifically asked for some support with training. They didn't want training to become therapists, they just wanted it for background information so that they could support their own community better. We narrowed it down to issues of stress management, depression, anxiety, anger management – things that very much affected them on a daily basis.'

One of the project's prime movers is Rosalyn Skinner, a lone mother with two children, who was active in several community groups on Cowgate. With two friends, she initiated the original questionnaire. 'We'd had problems with depression ourselves and could relate to how other people were feeling,' she says. 'It's not just one thing, it's a cluster of things that make you feel low. So we decided we'd be helping ourselves, and helping others, by doing the survey.'

After presenting their findings to various local groups, the women took them to the trust. Skinner recalls: 'What we said to Shrubbs was: "Yes, you haven't got the money to provide estates with counsellors, psychiatric nurses and things, but what about tackling the problem before it comes and escalates, offering people support, employing local people?" He was impressed.'

Cowgate is a multi-tenured estate, with some housing that is very hard to let. There are streets where unemployment reaches down two or three generations. The Wise People know they will be taking on a difficult brief if they offer a frontline service.

But there are foundations on which to build. Lyndy Mountain, another core member, who has lived on Cowgate since she was a girl, says there is a strong network of community groups, which already run initiatives such as a healthy-eating group and a breakfast club for more than 60 children.

When the Wise People scheme starts, its volunteer counsellors will need some NHS professionals for back-up and support. The training the women have received so far has been of practical use, but the group has requested more sessions. Skinner has helped bereaved neighbours cope with their loss; and Mountain says the session of anger management came in useful when she intervened with a woman who was 'really losing it' with a group of youngsters.

Members of the group are clear about what they will not be doing: that is, replacing doctors, psychiatric nurses or psychiatrists. When the scheme starts early next year, volunteers will often be providing 'a cup of tea and a shoulder to cry on', as Mountain says. There will be drop-in sessions and an emergency out-of-hours phone line – both available several times a week.

If faced with serious cases of mental ill health, says Shrubbs, the volunteers will take action. 'They have said they will be able to recognise a low mood in someone who is seriously depressed; they'll know who to ring out of hours. And we've given them an awareness of the services out there, and how they function.'

Because it has evolved from the grassroots as an untried concept, the project has developed slowly. There are still big issues to be resolved before it becomes operational. One of these is to find a permanent base and secure funding – though running costs should be minimal and the hope is to find space at the local primary

school, which is due to receive about £850,000 to become an 'extended school' – that is, one offering a full range of community facilities.

Another challenge is to set up the group formally as a voluntary organisation and to discuss clear – and legally-approved – guidelines under which the volunteers can operate. As discussions between health bodies and the volunteers continue, the limits of the project will become defined. Shrubb says: 'What we're offering is moral support, and expertise, to increase their own self-awareness. But they'll come across a lot of moral dilemmas, on issues such as confidentiality, for example. They'll have to have a constitution and rules to abide by.'

So far, there has been nothing but co-operation from clinical psychologists, other specialists and nurses involved in the training and support sessions for the group. Shrubb does not anticipate hostility from NHS staff, but says it is still uncharted territory.

He sees an analogy between the Wise People and St John Ambulance. 'They're not ambulance people in the NHS, but they provide a really important source of first aid and a gateway into the bigger NHS,' Shrubb says. 'It wouldn't be sensible for them to end up being mini-psychologists. What they offer to the community is quite unique – and couldn't and shouldn't be seen as replacing the role of a nurse or a psychologist.'

Source: Cunningham (2002) © Guardian

## Update

As of May 2003, the 'Wise People' initiative is developing its pilot phase. With a new base in the local community school, the initiative is backed by a health partnership group that involves the city council and the mental health trust.

## What might you learn from our experience?

*You could describe us as 'the community helping the community'. If you're thinking of doing something similar, our advice is to keep going – even when you don't think it'll work. And keep expressing your views – to anyone who will listen. People do listen. Remember that all big organisations are not the same. Some may be patronising, but others will take you seriously. And the people inside organisations are very different, too – like the rest of us in the community. You absolutely have to have support – like we had from the trust – and you need to know the individuals you can turn to for advice. Financial support is important, of course, but in our experience, psychological support is even more important.*

Members of the 'Wise People' group

*I think it's very hard for professionals to recognise that their workload needs to change in permanent and fundamental ways. A lot of support is needed to enable people to get to grips with what is, in many ways, a whole new world. Everybody needs encouragement when it comes to really focusing thoughts and efforts in a new way. Take capacity building in the community, for example. So often, that seems a completely abstract idea to health professionals – it's a bit like looking at big stars in the sky. You need to make it real and actionable in some way, linked to other activities that people do know about.*

Steve Shrubb, Chief Executive, Newcastle, North Tyneside and Northumberland Mental Health Trust

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*Personal politics matter when you are working with the 'Wise People'. I have had to suspend my analytical mind and 'see what happens' in supporting the project. Working in a different way (with a lot of support from colleagues) has kept me both hopeful and humble.*

Dr Denise Barulis, Clinical Psychologist, Newcastle Primary Care Trust

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## First Step Trust

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### In short

**First Step Trust (FST) provides work opportunities for people with mental health problems and other disabilities or disadvantages. The organisation also assists people in moving towards employment in the open market. All activities, implicitly or explicitly, challenge some of the prevalent attitudes towards disability. A clear emphasis on commercial trading creates a real work environment, with workers experiencing the pressures and stresses of everyday working life.**

### The challenge... and the response

*Before I started work, my confidence was non-existent. It's helping me change my life for the better.*

In these words, a worker for First Step Trust (FST) sums up the difference that 'real work' can make to people who have been disadvantaged through multiple and complex needs, such as mental health problems, learning disabilities, and alcohol and drug-related problems.

A registered charity, established in 1994, FST develops and manages small, 'not-for-profit' businesses delivering services to the general public, and to local statutory services. Work undertaken in projects in both urban and rural settings across the UK includes gardening, removals, printing and decorating.

The projects receive core funding from local health and social services. They cover their remaining costs through trading. All income from the work is invested back into the projects. With well-established projects, this can amount to 40 per cent of total income. As partners of FST, statutory agencies offer more than money. They also support the work by enabling FST to compete for contracts for grounds maintenance, minor works, database design, and so on.

The projects generate around £250,000 a year through their trading. This income ensures stability for the projects, despite the pressures of short-term funding. The flow of funds also contributes to the economic regeneration of the areas in which they are located.

FST sees its projects as an effective way of providing work experience, work training and rehabilitation to people with multiple and complex needs. Over the last four years, 26 people have moved from welfare benefits on to salaried employment within FST, while 150 people have made successful moves to salaried employment elsewhere or to college.

Despite working with people who may be coping with serious mental health problems, FST is clear that it is not about treatment. Instead, it sees its role as complementary to mental health services. It provides what any good employer would – support for its workers to enable them to achieve in their jobs. At the same time, FST works closely with mental health professionals to encourage people to seek clinical assistance when needed. The underlying values are clear – and the organisation sees them as intrinsic to its continuing success. In particular, any person with mental ill health can make a valuable contribution if given real responsibility and access to work. In this way, people manage their difficulties to achieve a greater quality of life.

‘Real responsibility’ can be a heavy burden – but it is precisely that emphasis on meeting their responsibilities, the project team believes, which enables people to turn their lives around. People are integrated into the community in two key ways:

- They are challenged with the pressures of a real workplace – including deadlines, standards, responsibility, reliability, behaving appropriately and responding to management – and supported in learning to cope with these pressures.
- The work is carried out in the community, in the houses and gardens of the general public. This has a dual effect. First, the worker develops an identity as a provider of services instead of being a service user. Second, through meeting people in their capacity as service providers, members of the public get a chance to overcome their own potential anxieties and ignorance about mental illness.

### What might you learn from our experience?

*The importance of employment for people’s mental well-being is well researched and demonstrated, but not everyone is ready to move on to open employment. What still needs to be understood is the process whereby a person is assisted to move from years of dependency on services to the ability to cope with the demands of working life – and with a fair chance of sustaining that success over time.*

*First Step Trust believes the key to this is the provision of a work environment where people with mental health problems are supported and challenged to cope with pressure and responsibility. It is not enough to assert the right to employment. Work is both a right and a responsibility, and to be truly included in society, people with mental health problems need the opportunity to develop the means to carry real responsibility within the community.*

Carole Furnivall, Joint Chief Executive Officer, First Step Trust

### Exploring assumptions

Figure 6, p 39, can be used to explore assumptions and prompt constructive discussion among partner organisations. Carole Furnivall of First Step Trust offers the following thoughts.

#### **‘Whose welfare comes first?’**

*Psychiatric services have been focused on illness and dysfunction rather than on capabilities and ability to deal with ordinary living. This emphasis is beginning to change – but it is still very early days.*



*There is no agency bridging the gap between the wider focus of regeneration and individual focus of psychiatric services – in other words, creating services that are integrated into the community but genuinely accessible by people with mental health problems. This is the gap the First Step Trust tries to fill.*

#### **'Who's in control?'**

*Service users seem to be missing. The service-user movement has done an invaluable job in representing the views of those who receive services. The effects of their involvement can be seen, for example, in changes to the ways in which services are designed, planned and evaluated. But there is still a danger that service users remain marginalised within the wider community outside mental health services. In my view, the movement needs a wider focus that looks beyond issues relating to existing services and addresses the need for people to take on a share in real responsibility in the community – for example, through work.*

#### **'Are we contributing to keeping stereotypes alive?'**

*The most damaging and most prevalent stereotype is the assumption that people with mental health problems will spend the rest of their lives on benefits, dependent on the state and unable to contribute in a positive way to society.*

#### **'Long-term change versus firefighting now – is this the choice?'**

*Regeneration funding is in danger of forcing a focus on the short term through its emphasis on simplistic, quantifiable outputs, such as numbers gaining qualifications, obtaining employment within the funding year, and so on. It is important that voluntary agencies are accountable for the public monies they receive. But this approach to monitoring inhibits use of the funding to support people with longer-term mental health problems. They are capable of working, but they need more time to get there.*



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## **Lambeth Early Onset**

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### **In short**

**Lambeth Early Onset (LEO) is an assertive outreach service that focuses on people in the London Borough of Lambeth aged from 16 to 35. Special emphasis is put on work to preserve and strengthen clients' support networks.**

### **The challenge... and the response**

There was recognition locally of a need to develop better services for younger people who had developed serious mental health problems. A consortium of organisations got together to develop a new service that would work to reduce the trauma of early contacts with mental health services and to promote the clients' recovery and social integration.

Organisations involved included mental health, primary care, housing agencies, voluntary groups from the black community, the Lambeth Health Action Zone, the police and the probation service. Some initial funding was received from the King's Fund, the Sainsbury Centre for Mental Health and the Department of Health.

Special emphasis was put on offering information and support to carers and families, with the aim of keeping younger people in contact with their support networks. The project also aimed to foster positive community responses and to play a part in improving the health of the community – working, in particular, to develop education, training and work opportunities.

Unusually, the team included a development worker who did not have a client caseload. Her role, seen as crucial, was to support working relationships across the team and to develop wider partnerships. These partnerships included work with the following:

- Local churches and parish workers. Mental health professionals made themselves available to discuss general issues; in some cases, they also introduced clients to what became a network of community support.
- The local college. A new staff member had been recruited to support students with disabilities. In discussion with the team, it was agreed that this portfolio included mental health. The team also worked with the local Mind group to provide a mental health awareness programme for all tutors at the college, not just those working in special needs.
- The local vocational strategy group. LEO's development worker played an important role in this group, which addressed practical employment issues in Lambeth.

Source: Based on Greatley and Ford (2002)

### What might you learn from our experience?

*The team has evolved since its inception – staff have come and gone, and caseloads have risen. Because we are a clinical team, there is huge pressure to use all staff as care co-ordinators. So, when the development worker left, her post was changed into a 'general' care co-ordinator's post. We are now in the fortunate position of being able to use some finances to fund a one-year, fixed-term development worker's post – something I think is essential in enabling our clients to have access to work and a wide variety of meaningful daytime activity.*

*It's important, I think, to stay realistic with initiatives of this kind – to reflect the demand on the service, and adapt as needed in terms of team structure, service development, and so on. Keep evolving, and don't stand still in terms of a 'finished product'.*

*It's essential to involve carers and users as much as possible. We have recently started an 'introduction to service' evening where we go through the things that many staff take as read that people know – explaining, for example, about the Care Programme Approach and the structure of services.*

*We also have an open day for anyone who is interested in local services. People from other services come to this, and carers too. Being genuinely 'open' helps enormously in building links with local services and with raising the profile of LEO and mental health.*

Jim O'Donnell, Team Leader, LEO Community Team



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## Promoting Good Parenting

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### In short

**Promoting Good Parenting is a multi-agency project that supports the ability of parents, carers and staff to understand, and respond appropriately to, the needs of infants. Part of the Sure Start initiative in the London Borough of Haringey, the project is based on robust evidence that:**

- **the quality of early interaction between parent and child has a significant and lasting influence on the neurological, social and psychological development of the child**
- **parents experiencing socio-economic deprivation are significantly more at risk of developing difficulties in interacting with their babies.**

### The challenge... and the response

'If you're serious about reducing levels of crime, prostitution and psychiatric disorders in future generations, then you should be taking practical steps towards promoting good parenting – and helping others to do this too', says Wendy Lanham, who is Mental Health Lead on this Sure Start initiative, and who developed the initiative jointly with Jennifer Alexander, a Sure Start midwife.

Supported by statutory and voluntary agencies across Haringey, the project includes the ante-natal identification of psycho-social risk factors in families; a range of direct interventions with families; evidence-based parenting programmes; and a College Link Programme that supports adults with mental health difficulties into education and employment. Crucially, the project also involves a major training programme for staff from a range of professional backgrounds and agencies, supported by senior management across organisations.

The rationale is explicit and clear. Bringing about sustainable improvement in the mental well-being of families in disadvantaged communities depends on the following:

- Professional staff from adult and child services, who work with parents, developing their observational skills and understanding of the interaction between the adult and infant, and offering early intervention if there is a perceived risk of poor bonding. The type of intervention offered will depend on the needs of each adult-child pair and the role and skills of the member of staff. Some parents may be helped to move into education or employment; others may take part in parenting programmes; others may take up an offer of counselling.
- Organisations across the health, social care and education systems learning about the importance of parent/child bonding, and then embedding this understanding in policies and procedures. Because families with young children often come into contact with a wide range of public services, the whole system needs to 'speak the same language' and work to common priorities.

The project's approach to 'promoting good parenting' recognises that parents' need for support will exceed the supply of healthcare professionals available. The

project therefore uses a model of ‘cascade’ learning in which professionals share expertise widely across the system, including involving members of the community.

### What might you learn from our experience?

*When you’re dealing with an issue that involves the whole family – the welfare of young children, for example – you have to find ways of getting round the limitations of age-based services. This needs proper discussion and agreement by senior management within and across organisations – it cannot be left to individual practitioners to make all the running.*

*It’s a hard thing to identify problems with other people’s children. You may be afraid of opening up a ‘Pandora’s Box’ where everything gets out of control. In sensitive territory like this, you can expect to meet opposition and avoidance. It’s very important, therefore, that senior management are willing and able to provide support.*

*This type of initiative takes time. Senior management needs to allocate time to set up an initiative such as this and to train staff in the necessary knowledge and skills.*

Wendy Lanham, Mental Health Lead, Sure Start project, Promoting Good Parenting

### Exploring assumptions and making the most of opportunities

Figure 6, p 39, can be used to promote constructive discussion among partner organisations. Wendy Lanham of Promoting Good Parenting offers the following thoughts.

#### **‘Are we contributing to keeping stereotypes alive?’**

*There can be a temptation to assign categories – and then prioritise these categories. For example, a clear split is often made between ‘the worried well’ and ‘those with severe and enduring mental illness’. A corresponding division can be made between mental health promotion (‘the soft stuff’) and the delivery of mental health services to those with severe illness (‘the hard stuff’). But our everyday reality is that we work with people from across the spectrum of mental distress and illness. Even if you’ve got severe and enduring mental illness, you can still interact with a baby in a way that supports that baby’s development – or you can learn to do this. Conversely, your baby may be at risk of impaired social, psychological and/or cognitive functioning even though your mental health difficulties do not meet the threshold that would allow you to access traditional mental health services.*

#### **‘What about money?’**

*There’s a need to explore locally how money flows can be channelled in ways that really meet the needs of the local population.*

#### **i**

##### **Contacts**

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# 5

## Sources and resources

**This section contains a bibliography of references cited in the guide, and provides website links for many of the organisations mentioned in the publication. It also provides website links for sites that look at how mental health issues and social development affect each other. Some of the sites consider how change may be monitored and evaluated.**

### Sources

*An essential paper-based guide to the world of regeneration is The Regeneration Maze Revisited, by Teresa Edmans and Grisel Tarifa, published by the King's Fund in 2001.*

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## Websites

This section provides website details of many of the organisations mentioned in the guide. It is not an exhaustive list of all organisations working in mental health and regeneration; rather it offers a springboard for further action. Many of the organisations have excellent links pages that are valuable sources of current information.

## Government departments

### Central Government

**CABINET OFFICE** [www.cabinet-office.gov.uk](http://www.cabinet-office.gov.uk)

**Strategy Unit** [www.strategy.gov.uk](http://www.strategy.gov.uk)

**DEPARTMENT FOR EDUCATION AND SKILLS** [www.dfes.gov.uk](http://www.dfes.gov.uk)

**Learning and Skills Councils** [www.lsc.gov.uk](http://www.lsc.gov.uk)

### DEPARTMENT OF HEALTH

**Children and Adolescent Mental Health Services (CAMHS)**

[www.nhs.uk/nhsupdate/news\\_focus\\_children\\_mental\\_health\\_main.asp](http://www.nhs.uk/nhsupdate/news_focus_children_mental_health_main.asp)

**healthaction** [www.healthaction.nhs.uk](http://www.healthaction.nhs.uk)

**Health Development Agency** [www.hda-online.org.uk](http://www.hda-online.org.uk)

**Mental health-related sites** [www.doh.gov.uk/mentalhealth](http://www.doh.gov.uk/mentalhealth)

**NHS Plan: A plan for investment – a plan for reform**

[www.doh.gov.uk/nhsplan/nhsplan.htm](http://www.doh.gov.uk/nhsplan/nhsplan.htm)

**National Institute for Mental Health (NIMHE)** [www.nimhe.org.uk](http://www.nimhe.org.uk)

**National Service Frameworks (NSF)**

*Mental health* [www.doh.gov.uk/nsf/mentalhealth.htm](http://www.doh.gov.uk/nsf/mentalhealth.htm)

*Older people* [www.doh.gov.uk/nsf/olderpeople/index.htm](http://www.doh.gov.uk/nsf/olderpeople/index.htm)

**Saving lives: our healthier nation**

[www.archive.official-documents.co.uk/document/cm43/4386/4386-o8.htm](http://www.archive.official-documents.co.uk/document/cm43/4386/4386-o8.htm)

**DEPARTMENT FOR TRADE AND INDUSTRY** [www.dti.gov.uk](http://www.dti.gov.uk)

**Social Enterprise Unit** [www.dti.gov.uk/socialenterprise](http://www.dti.gov.uk/socialenterprise)

**HOME OFFICE** [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk)

**Active Community Unit (ACU)**

[www.homeoffice.gov.uk/inside/org/dob/direct/accu.html](http://www.homeoffice.gov.uk/inside/org/dob/direct/accu.html)

**OFFICE OF THE DEPUTY PRIME MINISTER** [www.odpm.gov.uk](http://www.odpm.gov.uk)

**Social Exclusion Unit** [www.socialexclusionunit.gov.uk](http://www.socialexclusionunit.gov.uk)

**Neighbourhood Renewal Unit** [www.neighbourhood.gov.uk](http://www.neighbourhood.gov.uk)

**Regional Development Agencies (RDAs)**

[www.local-regions.odpm.gov.uk/rda/info](http://www.local-regions.odpm.gov.uk/rda/info)

**Government Offices** [www.government-offices.gov.uk](http://www.government-offices.gov.uk)

## Local Government

**Improvement and Development Agency (IDeA)** [www.idea.gov.uk](http://www.idea.gov.uk)

**Local Government Association** [www.lga.gov.uk](http://www.lga.gov.uk)

**Local Government Information Unit (LGIU)** [www.lgiu.gov.uk](http://www.lgiu.gov.uk)

## Other links

**Centre for Ethnicity and Health, University of Central Lancashire**

[www.ethnicity.org.uk](http://www.ethnicity.org.uk)

**Democratic Health Network** [www.dhn.org.uk](http://www.dhn.org.uk)

**Disability Rights Commission (DRC)** [www.drc-gb.org](http://www.drc-gb.org)

**First Step Trust** [www.fst.org.uk/fstintro.htm](http://www.fst.org.uk/fstintro.htm)

**Health and Safety Executive** [www.hse.gov.uk](http://www.hse.gov.uk)

**King's Fund** [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

**Mentality** [www.mentality.org.uk](http://www.mentality.org.uk)

**Mind** [www.mind.org.uk](http://www.mind.org.uk)

**National Association of Councils for Voluntary Service (NACVS)**

[www.nacvs.org.uk](http://www.nacvs.org.uk)

**Revolving Doors Agency** [www.revolving-doors.co.uk](http://www.revolving-doors.co.uk)

**Sainsbury Centre for Mental Health (SCMH)** [www.scmh.org.uk](http://www.scmh.org.uk)

**Social Enterprise Coalition (SEC)** [www.socialenterprise.org.uk](http://www.socialenterprise.org.uk)

**Social Perspectives Network for Modern Mental Health**

[www.spn.org.uk](http://www.spn.org.uk)

[www.topss.org.uk/uk\\_eng/news/modsoc\\_model.pdf](http://www.topss.org.uk/uk_eng/news/modsoc_model.pdf)

**UK Sustainable Development Commission** [www.sd-commission.gov.uk](http://www.sd-commission.gov.uk)

**YoungMinds** [www.youngminds.org.uk](http://www.youngminds.org.uk)



## Evidence and methods

The following websites consider how mental health issues and social development affect each other. Some of the sites look at how change may be monitored and evaluated.

### **NHS Centre for Reviews and Dissemination**

A National Contract on Mental Health  
[www.york.ac.uk/inst/crd/contents4.htm](http://www.york.ac.uk/inst/crd/contents4.htm)

### **Health and neighbourhood renewal**

Guidance from the Department of Health and the Neighbourhood Renewal Unit  
[www.doh.gov.uk/healthinequalities/healthandneighbourhood.pdf](http://www.doh.gov.uk/healthinequalities/healthandneighbourhood.pdf)

### **Health Development Agency**

Effectiveness of mental health promotion interventions  
[www.hda-online.org.uk/html%5Cresearch%5Ceffectivenessreviews%5Ceffective4b.html](http://www.hda-online.org.uk/html%5Cresearch%5Ceffectivenessreviews%5Ceffective4b.html)

### **Monitoring regeneration: a health-indicators toolbox for practitioners**

Executive summary available to download. Full report available on request.  
[www.lho.org.uk/holp/regen.htm](http://www.lho.org.uk/holp/regen.htm)

### **Selected evidence: Volume 2 Guide to health-impact assessment for regeneration projects**

Evidence review looking at urban regeneration and health change.  
[www.geog.qmul.ac.uk/health/guide.html](http://www.geog.qmul.ac.uk/health/guide.html)

Poor mental health has serious impacts on the lives of individuals and communities – whatever the social context. For people living in disadvantaged areas, depression, stress, feelings of isolation, and relationship problems are all major health challenges that can exacerbate wider social exclusion.

The commitment across Government departments to policies promoting social inclusion, and to the development of sustainable communities, presents real opportunities for change ‘at the sharp end’. The immediate need is for funding flows to be allied with knowledge of mental health issues and an in-depth understanding of local communities. In practice, this means developing imaginative, flexible and effective local partnership working between agencies and partnerships that design and implement renewal and regeneration programmes, mental health professionals, and community and voluntary organisations.

The potential benefits from bringing these different worlds together are enormous. For example, steps can be taken that both reduce the incidence of mental health problems within communities and make a positive contribution to the community’s overall sense of itself as a place to live.

This guide is designed to enable a wide range of individuals and agencies to learn more about each other’s perspectives, and to find innovative ways of using that learning to achieve common goals, such as reducing health inequalities.

It will be of particular interest to:

- agencies responsible for planning, commissioning and designing mental health services – such as primary care trusts, strategic health authorities, local implementation teams and mental health development centres
- organisations and partnerships that have areas of common purpose with community-focused mental health services – such as renewal and regeneration partnerships, voluntary and community organisations, regional Government Offices and local strategic partnerships.

*‘For once the real issues are here. Mental health professionals have their way of looking at things. Local people usually see things quite differently. How can constructive links be made between different worlds?’*

Steve Shrubbs, Chief Executive, Newcastle, North Tyneside and Northumberland Mental Health Trust

