Communities and Local Government

Digital Exclusion Profiling of Vulnerable Groups

Adults with Mental Health Problems: A Profile

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Citizens Online and National Centre for Social Research
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Department for Communities and Local Government

The findings and recommendations in this report are those of the authors and do not necessarily represent the views of the Department for Communities and Local Government

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Section 1

About the profile

This profile considers adults with mental health problems. It aims to understand group members' actual and potential interaction with technology. The starting point of the profile is to understand the life circumstances of group members through desk-based research. Our understanding of group members' (potential) engagement with technology has been developed largely through primary research. In particular, focus groups were set up with group members and professionals working with the group.

Detailed findings from the primary research as well as further background to this profile are available from the Department for Communities and Local Government[1].

[1] www.communities.gov.uk/corporate/contact.

Section 2

Who does this profile include?

This profile covers adults with mental health problems accessing secondary health services. Various definitions of good mental health exist. The most common definition of good mental health is a state characterised by the absence of mental disorder. The American Psychiatric Association defines mental disorder as:

"A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (eg a painful symptom) or disability (ie impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability or an important loss of freedom." (American Psychiatric Association 1994)[2].

Other definitions focus on positive characteristics that reflect good mental health. The Mental Health Foundation's definition refers to individuals who:

- develop emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
- face problems, resolve them and learn from them
- are confident and assertive
- are aware of others and empathise with them
- use and enjoy solitude
- play and have fun
- laugh, both at themselves and at the world.

(Mental Health Foundation 2005)[3].

The Department of Health reflects the government's view of good mental health as:

"The emotional and spiritual resilience which enables enjoyment of life, and the ability to survive pain, disappointment and sadness; and as a positive sense of wellbeing and an underlying belief in our own and other's dignity and worth."

(Department of Health 2001)[4].

[2] American Psychiatric Association (1994), *Diagnostic and statistical manual of mental disorders*, Fourth edition (DSM-IV), Washington DC: American Psychiatric Association.

[3] Mental Health Foundation (2005), *Problems and treatments – what is mental health?* www.mentalhealth.org.uk

[4] Department of Health (2001), *Making it happen: a guide to developing mental health promotion*, Department of Health.

It is worth noting that definitions do not focus just on individual attributes, such as coping skills or resilience, but also include environmental and social conditions.

The focus of this profile is narrowed by two constraints. It considers adults, defined as those of working age, and those accessing secondary health services.

Primary mental health care services include treatment at a GP surgery, local hospital, or walk-in centre. Drug treatment, counselling services, and advice and information may be provided from a primary service. People with more severe mental health problems may be referred to specialist mental health services. This is called secondary care, and involves community-based treatment, usually provided by mental health trusts. Depending on the type of service, treatment can be accessed through a day hospital, inpatient clinic, home visits, 24-hour help lines, crisis centres, voluntary drop-in centres, and day-care centres.

Lastly, it is worth noting a categorization of mental health problems that is used in the data[5] and followed in this profile. *Common mental health problems* include problems such as anxiety, depression, phobias, obsessive compulsive and panic disorders. *Severe and enduring mental health problems* include those mental health problems such as psychotic disorders (including schizophrenia) and bipolar affective disorder (manic depression).

[5] See, for example, London Health Observatory at: www.lho.org.uk/viewResource.aspx?id=9558.

Section 3

Mental health – why does it matter?

Achieving good mental health is important not just for those experiencing mental health problems, but for wider society. This section puts forward some key facts and figures that bring home the severity of the problem.

At any given time, one in six adults has a mental health problem of varying severity[6]. One person in four will experience some kind of mental health problem in the course of a year[7].

It is estimated that the annual cost of mental illness in England is £77.4bn[8]. This comprises:

- £12.5bn for care provided by the NHS, local authorities, privately funded services, family and friends
- £23.1bn in lost output to the economy caused by people being unable to work (paid and unpaid)
- £41.8bn in the human costs of reduced quality of life (and loss of life) among those experiencing a mental health problem.

State benefits for adults with mental health problems add an estimated £9.5bn to the figures mentioned above.

Only 24 per cent of adults with a long-term mental health problem are in work[9].

People with mental health problems are at more than double the risk of losing their job than those without[10].

Carers providing someone with substantial support are significantly more likely to have mental health problems[11].

The first episode of mental health problems is often experienced by people in their late teens or early twenties. This can have serious consequences for their education and employment prospects[12].

6 Office for National Statistics (2000), *Survey of psychiatric morbidity among adults living in private households*, HMSO.

7 Mental Health Foundation (1999), *The fundamental facts*, Mental Health Foundation.

8 Sainsbury Centre for Mental Health (2003), *The economic and social costs of mental illness*, Sainsbury Centre for Mental Health.

9 Office for National Statistics (2003), *Labour force survey*, Office for National Statistics.

10 T Burchadt (2003), *Employment retention and the onset of sickness or disability: Evidence from the Labour Force Survey longitudinal datasets, in-house report no. 109*, Department for Work and Pensions.

11 Singleton N, Maung NA, Cowie A et al. (2002), *Mental health of carers*, The Stationery Office.

12 J Kim-Cohen (2003), 'Prior Juvenile Diagnoses in Adults with Mental Disorder', *Archives of General Psychiatry*, 60 (7).

People with mental health problems are nearly three times more likely to be in debt[13].

One in four tenants with mental health problems has serious rent arrears and is at risk of losing their home[14].

An estimated 6,000 to 17,000 children and young people care for an adult with mental health problems[15].

13 H Meltzer, N Singleton, A Lee, P Bebbington, T Brugha and R Jenkins (2002), *The Social and Economic Circumstances of Adults with Mental Disorders*, The Stationery Office.

14 Shelter (2003), *House Keeping: Preventing homelessness through tackling rent arrears in social housing*, Shelter.

15 J Aldridge and S Becker (2003), *Children caring for parents with mental illness: perspectives of young carers, parents and professional*, The Policy Press.

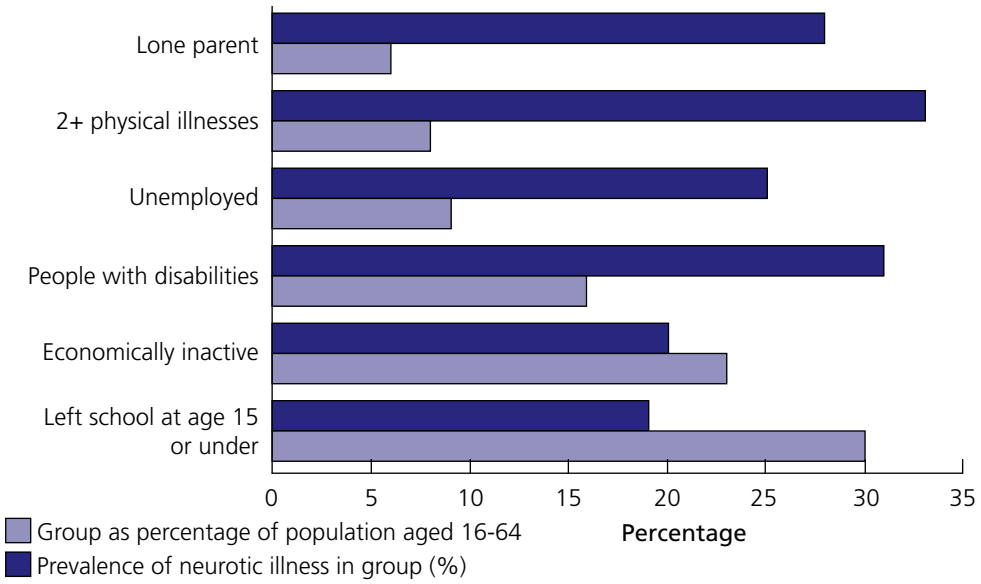
Section 4

Who makes up the group?

Mental health problems touch almost all parts of society and are found across varying age groups, ethnicities, occupations and geography. In this section we highlight those groups that are more likely to be at risk of experiencing mental health problems[16].

Melzer et al (2004) identify a number of groups that are at high risk of experiencing mental health problems through considering factors such as family structure and educational achievement. Their results are summarised below[17]:

High-risk subgroups as a percentage of the general population aged 16-64, and the prevalence of neurotic disorder in each group (note: group membership overlaps).



Source: D Melzer, T Fryers and R Jenkins (Eds) *Social Inequalities and the Distribution of the Common Mental Disorders, Maudsley Monograph 44*, (Hove, Psychology Press, 2004).

Other studies have highlighted further subgroups likely to experience mental health problems. These are summarised below by relevant group characteristic.

[16] This section borrows heavily from the report *Mental Health and Social Exclusion*, Social Exclusion Unit (2004).

[17] Figure taken from *Mental Health and Social Exclusion*, Social Exclusion Unit (2004).

4.1 Age

The statistics tell an interesting story regarding when we can expect to see mental health problems. In particular, they dismiss the idea that mental health problems occur late in life. The average age of onset of psychotic symptoms is at the young age of 22[18] with up to half of all adult mental health problems beginning in childhood[19].

Common mental health problems peak for men aged 45-49 years and for women from 50-54 years[20].

Young men aged 25-34 are a particularly high risk group for suicide[21].

4.2 Gender

Women have higher rates of common mental health problems than men. They are also more likely to experience longer-term episodes of depression, with greater likelihood of recurrence[22].

4.3 Ethnicity

Severe and enduring mental health problems are more likely to be found amongst ethnic minority groups. Rates of diagnosed psychotic disorders are estimated twice as high among African Caribbean people than white people[23] and individuals belonging to ethnic minority groups are six times more likely to be detained under the Mental Health Act than white people[24].

The prevalence of common mental health problems is fairly similar across different ethnic groups, although rates are higher for Irish men and Pakistani women and lower for Bangladeshi women[25].

18 Department of Health (2001), *The Mental Health Policy Implementation Guide*, Department of Health.

19 J Kim-Cohen (2003), 'Prior Juvenile Diagnoses in Adults with Mental Disorder', *Archives of General Psychiatry*, 60 (7).

20 N Singleton, R Bumpstead, M O'Brien, A Lee and H Meltzer (2001), *Psychiatric Morbidity Among Adults Living in Private Households*, The Stationery Office.

21 Department of Health (1998), *Our Healthier Nation: A contract for health – a consultation paper*, The Stationery Office.

22 Department of Health (1998), *Our Healthier Nation: A contract for health – a consultation paper*, The Stationery Office.

23 K Spronston and J Nazroo (2002), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, The Stationery Office.

24 B Audini and P Lelliott (2003), *Age, gender and ethnicity of those detained under Part II of the Mental Health Act 1983*, British Journal of Psychiatry.

25 K Spronston and J Nazroo (2002), *Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) – Quantitative Report*, The Stationery Office.

4.4 Parents and carers

Both lone parents and carers show above average rates of mental health problems. An estimated 28 per cent of lone parents have common mental health problems[26]. The figures for carers are more disturbing. Carers providing someone with substantial support are twice as likely to have mental health problems as non-carers[27]. There are an estimated 420,000 people in the UK who care for someone with a mental health problem[28], including 6,000 to 17,000 young carers[29].

4.5 Occupation

The wellbeing of today's workforce is a key area of attention and Dame Carol Black's review[30] is one of the many studies on this area. The total cost to employers of mental health problems among their staff is estimated at nearly £26bn each year[31]. That is equivalent to £1,035 for every employee in the UK workforce.

While mental health is an issue for all occupations, there are certain occupations within which employees report a higher prevalence. Teachers, nurses and managers are most likely to report high levels of stress[32]. People working in the medical and farming professions are at greatest risk of suicide[33]. An estimated one in five firefighters[34] and one in seven young people in the armed forces with significant combat experience[35] are likely to suffer from post-traumatic stress disorder.

4.6 Location

Mental health problems are more likely to be found in deprived areas and remote rural districts[36]. A similar result is displayed when examining suicide rates[37].

[26] D Melzer, T Fryers and R Jenkins (eds.) (2004), *Social Inequalities and the Distribution of the Common Mental Disorders*, Maudsley Monograph 44, Psychology Press.

[27] Singleton N, Maung NA, Cowie A et al. (2002), *Mental health of carers*, The Stationery Office.

[28] J Maher and H Green (2000), *General Household Survey – Carers 2000*, Office for National Statistics. Note, the category of 'mental disability' used in the survey includes people with a learning disability and is therefore an overestimate.

[29] J Aldridge and S Becker (2003), *Children caring for parents with mental illness: perspectives of young carers, parents and professional*, The Policy Press.

[30] Dame Carol Black (2008), *Working for a Healthier Tomorrow*, TSO.

[31] The Sainsbury Centre for Mental Health (2007), *Mental Health at Work*, http://website.scmh.org.uk/80256FBD004F6342/vWeb/pcKHAL79TMF9.

[32] A Smith, C Brice, A Collins, V Matthews and R McNamara (2000), *The scale of occupational stress: A further analysis of the impact of demographic factors and type of job*. Contract Research report 311/2000, Suffolk, Health & Safety Executive.

[33] Samaritans (2003), *Information Resource Pack 2003* www.samaritans.org/know/pdf/InfoResourcePack2003web.pdf

[34] Patient UK website, Patient Information Publications, Post Traumatic Stress Disorder (PTSD), www.patient.co.uk/showdoc.asp?doc=27000223.

[35] A Braidwood (ed.) (2000), *Psychological Injury, Understanding and Supporting Proceedings of DSS War Pensions Agency Conference*, The Stationery Office.

[36] Office for National Statistics (2001), *Geographic Variations in Health*, Office for National Statistics, The Stationery Office.

[37] D Melzer, T Fryers and R Jenkins (eds.) (2004), *Social Inequalities and the Distribution of the Common Mental Disorders*, Maudsley Monograph 44, Psychology Press.

4.7 Complex needs

An important step forward in understanding subgroups has been to consider individual with complex needs. The Social Exclusion Unit[38] highlighted a variety of groups at particular risk of mental health problems. The common thread amongst these groups is their complexity of need resulting in a poor service being delivered to them through statutory agencies. The groups identified are:

- Drug misuse – an estimated 30 to 50 per cent of those misusing drugs have a mental health problem[39]. Approximately 50 per cent of adults dependent on alcohol reported a mental health problem[40].
- Prisoners – the prison population exhibits very high rates of mental health problems. Seventy-two per cent of male and 70 per cent of female sentenced prisoners have two or more mental health disorders[41]. Prevalence rates for psychotic disorders are also high. The prevalence rates for any functional psychosis in the past year were seven per cent for male sentenced, 10 per cent for male remand and 14 per cent for female prisoners. This compares to the rate of 0.4 per cent in the general population[42]. Attempted suicide rates were also higher amongst prisoners with 20 per cent of males and 37 per cent of females having attempted suicide[43].
- Homelessness – One in four deaths amongst homeless people is due to suicide[44]. The data shows that and estimated 30 to 50 per cent of rough sleepers have mental health problems[45].
- Refugees – refugees experience higher rates of both common and severe mental health problems. Studies show two-thirds of refugees experience depression or anxiety[46]. Rates of psychosis among white people migrating to predominantly white communities are twice as high as the general population, and four times as high among black people[47].
- Learning disabilities – approximately 25-40 per cent of people with learning disabilities experience risk factors associated with mental health problems[48].

[38] Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

[39] B Iddon (1999), Chairman of All Party Parliamentary Drugs Misuse Group, in Hansard, part 2 July 1999 Column 567.

[40] Turning Point (2003), *Waiting for Change: Treatment delays and the damage to drinkers*, Turning Point.

[41] Social Exclusion Unit (2003), *Reducing re-offending by ex-prisoner*s, Social Exclusion Unit.

[42] N Singleton, H Meltzer, R Gatward, J Coid and D Deasy (1998), Psychiatric Morbidity among Prisoners in England and Wales, *Office for National Statistics*, The Stationery office.

[43] N Singleton, H Meltzer, R Gatward, J Coid and D Deasy (1998), *Psychiatric Morbidity among Prisoners in England and Wales*, Office for National Statistics, The Stationery office.

[44] Mental Health Foundation (1997), *Fundamental Facts: Suicide And Deliberate Self-Harm, Briefing No. 1*, Mental Health Foundation,.

[45] S Griffiths (2002), *Addressing the Health Needs of Rough Sleepers*, Office of the Deputy Prime Minister.

[46] A Burnett and M Peel (2001), 'Health Needs of Asylum Seekers and Refugees', *British Medical Journal*, 322: 544-547.

[47] E Cantor Graae and JP Selten (2004), 'Schizophrenia and Migration: A Meta-Analysis', *Schizophrenia Research*, 67 (1): 63.

[48] The Foundation for People with Learning Disabilities (2003), *Statistics on Learning Disabilities*, accessed at: www.learningdisabilities.org.uk/page.cfm?pagecode=ISST.

Section 5

What are the causes?

There are many possible causes of mental health problems. These can range from difficult family background to stressful life events such as divorce[49]. To pinpoint a single cause is often difficult as it is not just the event but the following environment which can move an individual from a difficult period to a common mental health problem and possibly even further to a severe mental health problem.

To understand the causes of mental health problems it is therefore important to consider both individual and environmental factors. This is approach is reflected in the model put forward by MacDonald and O'Hara[50] (see below) which pairs risk and protective factors.

Ten Elements of Mental Health[51]

Environmental quality	+	Self-esteem	+	Emotional processing	+	Self-management	+	Social skills participation
Environmental deprivation	+	Emotional abuse	+	Emotional negligence	+	Stress	+	Social exclusion

The Social Exclusion Unit[52] has identified more specific environmental factors that cause poor mental health and/or lead to more severe problems. These are:

- Mental health problems being inaccurately diagnosed or missed.
- A lack of time, training or local contacts to help people move into work or participate in their local communities.
- A lack of effective joint-up working to meet individual needs.
- Stigma and discrimination – actual or fear of rejection from the community resulting in people wanting to stay in the safety of mental health services rather than engaging in wider society.
- A lack of clear responsibility for improving vocational and social outcomes for adults with mental health problems.

[49] Mind (2007), *Understanding mental illness* www.mind.org.uk/Information/Booklets/Understanding/Understanding+mental+illness.htm

[50] MacDonald G, O'Hara K (1998), *Ten elements of mental health, its promotion and demotion: implications for practice*, Society of Health Education and Promotion Specialists.

[51] Figure taken from: NICE (2007), *Public health interventions to promote positive mental health and prevent mental health disorders among adults*, NICE.

[52] Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

Section 6

What barriers do group members face?

People experiencing mental health problems face a number of barriers which prevent them from getting their lives back on track. In this section we highlight key barriers faced by the group.

6.1 Stigma

The stigma attached to mental health problems is a huge barrier. It decreases the chances of early identification of problems as individuals are weary of reporting 'mental health problems'. It also dissuades those diagnosed with a mental health problem from openly engaging with mainstream society due to the negative feedback that this can bring.

What is particularly worrying is that survey data shows the situation is worsening. The Shift anti-stigma campaign recently commissioned a survey of public attitudes towards people with mental health problems. The number of respondents agreeing that "We need to adopt a far more tolerant attitude toward people with mental illness in our society" decreased by eight per cent from 92 per cent in 1994, to 84 per cent in 2007[53].

A survey in 2008 commissioned by the Department of Health[54] confirms the hardening of attitudes found by the Shift survey. It reports:

- One in eight people would not want to live next door to someone who has been mentally ill.
- Nearly six out of ten people describe a person with a mental illness as "someone who has to be kept in a psychiatric or mental hospital".
- One third of people think that people with mental health problems should not have the same rights to a job as everyone else.
- Only 31 per cent of people think that mental hospitals are an outdated means of treating people.

[53] TNS Global (2007), *Attitudes to Mental Illness 2007 Report*, Shift/CSIP.

[54] Department of Health (2008), *Attitudes to Mental Illness*, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_084478.

6.2 Work

There is a growing consensus that work is an effective route through which people experiencing mental health problems can improve their wellbeing[55]. Furthermore, research shows that the majority of people with mental health conditions want to work[56]. Experts in the field have highlighted three key barriers[57] that prevent the desire to work from becoming a reality.

The first is stigma. Less than four in ten employers say they would recruit someone with a mental health problem[58]. This discrimination is clearly felt by people with mental health problems. In a survey of 400 service users by the Mental Health Foundation, over half believed that they had definitely or possibly been turned down for a job in the past because of their mental health problems. Furthermore, only one third of service users felt confident in disclosing their experience of mental health problems on job application forms[59].

The second barrier to returning to work relates to financial disincentives. The proportion of people on incapacity benefit recorded as having a mental health problem has increased from 25 per cent in the mid-1990s to nearly 40 per cent in 2005[60]. Incapacity benefits are there to provide support for those with long-term ill health who are unable to work. However the system has created financial disincentives for those aiming to return to work. Those currently on benefits fear they will lose their entitlement before they can cope with an ordinary job, and be left with a lower income on jobseekers' allowance or basic income support[61].

More recent government interventions are seeking to overcome this. The Employment and Support Allowance (ESA) and the roll out of Pathways to Work in the recent Welfare Reform Act offer some additional financial incentives to return to work.

The last barrier to returning to work is the low expectation by health care staff of what people with mental health problems can achieve[62] and a lack of resources to make this a reality. Staff can focus on continuing treatment rather than on a plan of recovery which takes the patient back to an independent life. With respect to a lack of resources, talking therapies are a good example. Cognitive behavioural therapy (CBT) can play an important

[55] See, for example, NICE (2007), *Public health interventions to promote positive mental health and prevent mental health disorders among adults*, NICE.

[56] Grove, B., Secker, J. & Seebohm, P. (eds) (2005), *New Thinking about Mental Health and employment*, Radcliffe.

[57] The Sainsbury Centre for Mental Health (2007), *Mental Health and Employment, Briefing 33*, www.scmh.org.uk/publications/mh+employment.aspx?ID=531

[58] Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

[59] Warner, L. (2002), *Out at Work: A survey of the experiences of people with mental health problems within the workplace*, Mental Health Foundation.

[60] Department for Work & Pensions (2006), *A New Deal for Welfare: Empowering people to work*, The Stationery Office.

[61] The Sainsbury Centre for Mental Health (2004), *Benefits and work for people with mental health problems: a briefing for mental health workers, Briefing 27*.

[62] Sainsbury Centre for Mental Health (2006), *Leading by Example: Making the NHS an exemplar employer of people with mental health problems*.

role in helping people to remain in work, but just under 60 per cent of GPs say that local access to CBT is poor and many prescribe antidepressant medications due to lack of access to CBT[63].

6.3 Debt

The lack of work opportunities coupled with a decreased ability to deal as effectively with financial issues during a period of poor mental health can quickly result in individuals being placed under the extra burden of debt. This financial pressure can lead to a worsening of mental health as well as further disadvantage such as homelessness.

The Office for National Statistics reports that people with mental health problems are three times more likely to be in debt than the general population[64]. This is evidence is supported by a recent study published by Mind[65]. It found that debt was a significant factor in worsening mental health. The study showed the adverse impact of debt included:

- 91 per cent said debt has worsened mental health.
- 87 per cent rely on credit to pay for food and everyday costs.
- 83 per cent reported harassment by creditors when unwell.

The clear impact of debt is brought out in other studies also. The charity Shelter found that one in four tenants with mental health problems has serious rent arrears and is at risk of losing his or her home[66]. In an analysis of expenditure, Melzer et al (2002) find adults with severe and enduring mental health problems are over five times, and those with common mental health problems over three times more likely to cut down on use of the telephone, gas, electricity and water than the general population[67].

6.4 Views from primary research

The primary research probed members of the group and professionals working with them to further understand barriers and issues facing adults with mental health problems.

Professionals described mental health service users as an extremely diverse group. Accordingly, their needs are also very diverse. It is for this reason that professionals working with secondary mental health service users invariably described undertaking some type of needs assessment with people who are newly referred to their service. They emphasised that needs assessment should focus on specific skills and capabilities of the client as well as specific problems they have.

63 Hairon, N. (2006), 'Survey exposes GP frustration at dire access to depression services', *Pulse*, 2 March, 14–15.

64 Office for National Statistics (2002), *The Social and Economic Circumstances of Adults with Mental Disorders*, Office for National Statistics.

65 Mind (2008), *In the red: debt and mental health*, www.mind.org.uk/mindweek/report.

66 Shelter (2003), *House Keeping: Preventing homelessness through tackling rent arrears in social housing*, Shelter.

67 H Meltzer, N Singleton, A Lee, P Bebbington, T Brugha and R Jenkins (2002), *The Social and Economic Circumstances of Adults with Mental Disorders*, The Stationery Office.

Key issues which they did highlight as of relevance to most users of secondary mental health services are:

Emotional problems such as anxieties or depression which may lead to other barriers to daily functioning like fear of leaving the house or using public transport. The specific symptoms of mental illness vary from person to person and their specific needs in helping to cope with these symptoms will also vary.

Social stigma and social isolation associated with mental illness. Social prejudices and fears of people with mental illness are compounded by lack of education about mental health issues among the general public and negative media coverage of people with mental health problems. This leads to isolation of people with mental health problems from the mainstream communities in which they live. Their isolation may become more entrenched if their social interaction is based primarily or exclusively on interaction with other mental health service users. Some professionals described this as 'ghettoisation' of service provision and felt that service users should be actively encouraged to engage more widely in activities in their community. Lengthy hospital stays may also mean that people become 'disengaged' from their communities, and possibly also from friends and previous sources of social support.

Ongoing engagement with mental health professionals. In many cases, mental health service users continue to require medication and support to stay well. This means that they may need help to take their medication appropriately and on time, and they may need reminders and support to attend appointments.

Figure 1 provides an overview of key issues facing secondary mental health service users as identified both by professionals and service users. It shows how varied their needs may be.

Figure 1: Key issues facing secondary mental health service users

Mental/emotional state

- Anxieties/phobias (eg worried about leaving the house- agoraphobia)
- difficulties associated with symptoms (eg, hearing voices) or medication side-effects (eg shaking) or both

Complex/over-lapping social and health issues

- mental health problems may be accompanied by substance or alcohol abuse
- mental health problems may be accompanied by physical ill health
- links between mental illness and offending behaviour/time in prison
- links between refugee status or homelessness and mental/physical ill health

Figure 1: Key issues facing secondary mental health service users *(continued)*

Societal prejudice, stereotypes, 'stigma'

- Negative media images of people with mental health problems
- Stigmatisation is linked to difficulty accepting/living with diagnosis

Social isolation and separation from community linked to…

- hospitalisation
- own anxieties (agoraphobia, etc)
- social prejudice against and fear of people with mental health problems

Housing

- may be homeless
- may be living in a hostel, shelter, care home or supported housing
- may be living with family members
- may live on their own in a flat, bedsit or house
- may need help finding appropriate accommodation after release from hospital, prison, psychiatric care homes that have closed down, etc.

Benefits

- May need help with benefits claims (eg, Incapacity Benefit, etc)

Ongoing contact with mental health services

- Likely to be on Care Programme Approach (CPA) or Enhanced CPA involving an integrated individual plan including social workers, GPs, CPN, etc.
- regular appointments with psychiatrists, counsellors, other health staff may be required
- may need support/encouragement/reminders to attend appointments
- may need encouragement/reminders/help to take medication

Key life issues/perspectives:

- desire to 'get out of the house'/avoid isolation/overcome boredom
- desire to live/socialise in settled, stable, calm environment
- desire to socialise with others with similar problems: peer support so don't feel 'you're the only one'
- need/desire to develop confidence to enable greater independence
- may need help developing social skills/interacting with others effectively
- unemployment/out of work a long time/vocational skills may have lapsed

Section 7

What do the numbers tell us?

In this section we give a picture of the group through numbers[68]. We take directly from the Mind website which provides various statistical factsheets on people with mental health problems[69].

7.1 How many people in Britain experience mental health problems?[70]

Estimates of the prevalence of mental distress in Britain vary. The Office for National Statistics (ONS) puts the figure at one in six adults at any one time[71]. Another major survey that is frequently quoted puts the figure at one in four[72]. The one in six figure given by the ONS represents those people defined as having 'significant' mental health problems, whilst the latter survey uses a wider definition of mental health problems. The breakdown below gives an overview of what treatment those who experience mental health problems are likely to seek and get[73]:

- around 300 people out of 1,000 will experience mental health problems every year in Britain
- 230 of these will visit a GP
- 102 of these will be diagnosed as having a mental health problem
- 24 of these will be referred to a specialist psychiatric service
- six will become inpatients in psychiatric hospitals.

[68] Some of the information here repeats that given in other sections but provides further details.

[69] See the Mind website: www.mind.org.uk/Information/Factsheets/#S.

[70] © 2008 Mind, reprinted from 'Statistics 1: How common is mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[71] Office of National Statistics (2000), *Psychiatric morbidity among adults living in private households in Great Britain*, ONS.

[72] Goldberg, D. & Huxley, P. (1992), *Common mental disorders a bio-social model*, Routledge.

[73] Based on figures from Goldberg, D. & Huxley, P (1992), *Common mental disorders a bio-social model*, Routledge.

7.2 What is the most common form of mental distress?[74]

Mixed anxiety and depression, according to the ONS 2000 survey[75], is experienced by 9.2 per cent of adults in Britain. This is followed by general anxiety at 4.7 per cent and depression (without the symptoms of anxiety) at 2.8 per cent. The figures show an increase (from 1993 to 2000) in the prevalence of mixed anxiety with depression of 1.4 per cent (from 7.8 per cent to 9.2 per cent).

7.3 What is the least common form of mental distress?[76]

The least common disorder in the ONS survey is panic disorder, affecting 0.7 per cent of the population of Britain. In 2000 there was a slight decrease, 0.5 per cent, in the prevalence of obsessive compulsive disorder compared with the figures for 1993.

7.4 Prevalence of mental health problems by gender[77]

The below chart gives the prevalence of mental health problems for people aged between 16 to 64 years. All figures are percentages[78].

Diagnosis and rate (past week)	**Female**		**Male**		**All**	
	1993	**2000**	**1993**	**2000**	**1993**	**2000**
Mixed anxiety and depression	10.1	11.2	5.5	7.2	**7.8**	**9.2**
Generalised anxiety disorder	5.3	4.8	4.0	4.6	**4.6**	**4.7**
Depressive episode	2.8	3.0	1.9	2.6	**2.3**	**2.8**
Phobias	2.6	2.4	1.3	1.5	**1.9**	**1.9**
Obsessive compulsive disorder	2.1	1.5	1.2	1.0	**1.7**	**1.2**
Panic disorder	1.0	0.7	0.9	0.8	**1.0**	**0.7**
Any neurotic disorder	19.9	20.2	12.6	14.4	**16.3**	**17.3**

Source: ONS, 2000, *Psychiatric morbidity among adults living in private households in Great Britain*.

[74] © 2008 Mind, reprinted from 'Statistics 1: How common is mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[75] Office of National Statistics (2000), *Psychiatric morbidity among adults living in private households in Great Britain*, ONS.

[76] © 2008 Mind, reprinted from 'Statistics 1: How common is mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[77] © 2008 Mind, reprinted from 'Statistics 1: How common is mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[78] Note: People may have more than one type of neurotic disorder, so the percentage with any disorder is not the sum of those with specific disorders.

7.5 Prevalence of neurotic symptoms by gender[79]

The table below shows the prevalence of different neurotic symptoms for people aged between 16 to 64 years. All figures are percentages.

Diagnosis and rate (past week)	Female		Male		All	
	1993	2000	1993	2000	1993	2000
Sleep problems	28	34	21	24	**25**	**29**
Fatigue	33	33	21	23	**27**	**28**
Irritability	25	24	19	20	**22**	**22**
Worry	23	23	17	18	**20**	**20**
Depression	11	12	8	11	**10**	**12**
Concentration and forgetfulness	10	11	6	9	**8**	**10**
Depressive ideas	11	12	7	9	**9**	**10**
Anxiety	11	10	8	9	**10**	**9**
Somatic symptoms	10	9	5	6	**8**	**7**
Worry about physical health	5	7	4	7	**5**	**7**
Obsessions	12	4	7	5	**9**	**6**
Phobias	7	6	3	4	**5**	**5**
Compulsions	8	4	5	3	**6**	**3**
Panic	3	2	2	2	**3**	**2**

Source: ONS, 2000, *Psychiatric morbidity among adults living in private households in Great Britain*.

7.6 Ethnicity, rates of mental illness and admission to psychiatric hospitals[80]

Both past and recent research suggests that some groups – notably black Caribbean, black African and other black groups – are over-represented in psychiatric hospitals[81].

The high numbers of African Caribbean people being diagnosed with schizophrenia is well documented, with some studies reporting between two to eight times higher rates of diagnosis compared to the white population[82].

[79] © 2008 Mind, reprinted from 'Statistics 1: How common is mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[80] © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[81] Commission for Healthcare Audit and Inspection (2005) *Count me in, Results of a national census of inpatients in mental health hospitals and facilities in England and Wales.*

[82] Harrison, G. (2002), 'Ethnic minorities and the Mental Health Act', *The British Journal of Psychiatry*, 180: 198-199.

Data from the 2001 Census showed that men from black and white/black mixed groups had the highest rates of admission to psychiatric hospitals. They were three or more times likely than the general population to be admitted. Women from the black and mixed white/black groups were two or more times likely than the general population to be admitted to psychiatric hospitals. White British, Chinese and Indian men were less likely than the average population to be admitted.

Men from black Caribbean, black African, and other black groups were more likely than other groups to have been detained under the Mental Health Act 1983.

Studies have shown that Irish people have higher rates of mental illness than the general population[83]. The Irish are often overlooked because they are white. Yet studies have found that Irish-born people living in the UK have a higher rate of suicide than any other minority ethnic group living in the country[84].

7.7 Employment and mental health[85]

Employment issues surrounding poor mental health are a serious issue:

- It is estimated that stress related illness is costing the NHS between £300 and £400m every year[86].
- Around 6.8 million people of working age in the UK are disabled[87]. This is around 20 per cent of the working age population.
- More than 2.5 million individuals receive incapacity benefit and/or severe disability allowance[88].
- Close to one million people are claiming incapacity benefit due to mental ill health[89].

Many people with mental health problems want to work. The Department of health suggests that 40 per cent of people who claim incapacity benefit have a mental health problem. They also suggest that most of them want to work[90].

[83] Fitzpatrick, M. (2005), 'Profiling mental health needs: what about your Irish patients?', *British Journal of General Practice*, October.

[84] NIMH (2003), *Inside outside, improving mental health services for black and minority ethnic communities in England*, Department of Health.

[85] © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[86] TAEN (2006), *Key Facts, Health, Employment and Age*, TAEN.

[87] Disability Rights Commission (2006), *Disability Briefing, Making Rights a Reality*.

[88] DWP (2006), Incapacity Benefit/Severe Disablement Allowance Caseload: Working Age/Pension Age split by IB ICD (disease) summary code, Time Series, Aug 2006.

[89] NIMH (2005), *Making it possible, Improving Mental Health and Well-being in England*.

[90] Government News Network (2007), downloaded March 2007 from www.gnn.gov.uk/Content/Detail.asp?ReleaseID=260250andNewsAreaID=2.

Unfortunately one survey shows that only around 37 per cent of employers are willing to take on someone with a mental health problem[91]. In contrast, more than Sixty per cent of employers are willing to take on someone with a physical disability. The Social Exclusion Unit suggests that 75 per cent of employers would not consider employing anyone who had a diagnosis of schizophrenia[92]. The Social Exclusion Unit also found that 55 per cent of people with a mental health problem found that stigma was a barrier to employment.

7.8 Gender and mental health[93]

Statistically, women are more likely than men to experience mental and emotional distress (where psychotic elements are not present). Research by the Office for National Statistics shows that 20 per cent of all adult women between the ages of 16 to 65 have 'significant mental health problems', as compared with 14 per cent of men between these ages[94].

Gender differences in mental health have been widely debated, and a number of explanations are commonly given: that these reflect the greater stresses that many women face in society; that women are more likely to admit to mental health problems and seek help; and that psychiatrists are much more likely to diagnose women as suffering from a mental health problem than men[95].

For psychosis, which affects 0.5 per cent of the population, there are no significant gender differences in prevalence rates. However, for schizophrenia, the onset of illness is, on average, later in women and women are more likely to make a full recovery[96].

7.9 Urban and rural environments and mental health[97]

Studies indicate that people who live in rural areas are likely to experience slightly better mental health than people living in urban areas[98].

However, studies show that farmers are among the occupational groups with the highest risk of suicide in England and Wales[99]. This is compounded by the fact that farmers are less likely to report feeling depressed than then general population.

91 Disability Rights Commission (2003), *Coming together – mental health service users and disability rights*.

92 ODPM (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

93 © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

94 Office of National Statistics (2001), *Psychiatric Morbidity in Great Britain, 2000, Prevalence of Psychiatric Morbidity Among Adults Living in Private Households*.

95 Miles, A. (1987), *The Mentally Ill In Contemporary Society, 2nd Edition*, Basil Blackwell.

96 Warner, R. (1994), *Recovery From Schizophrenia – Psychiatry and Political Economy*, Routledge.

97 © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

98 Weich, S, Twigg, L, and Lewis, G (2006), 'Rural/non-rural differences in rates of common mental disorders in Britain', *The British Journal of Psychiatry*, 188: 51-57.

99 Thomas, HV, Lewis G, Thomas, D Rh, Salmon, Chalmers, RM, Coleman, TJ, Kench, SM, Morgan-Capner, P, Meadows, D, Sillis, M, and Softley, P (2003), 'Mental Health of British Farmers', *Occupational and Environmental Medicine*, 60:181-186.

One study indicates that the rate of mental health problems may be higher than the figures indicate[100]. There are significantly fewer health services in rural areas compared to urban areas. If an individual with a mental health problem lives in a rural area they may be left with two choices; to stay where they are and not get the treatment they need or move to a more urban area where help is available.

7.10 Social class and mental health[101]

Studies from Britain and other countries have consistently suggested that people from lower socio-economic groups have higher levels of common mental health problems, such as depression and anxiety, than people from higher socio-economic groups[102].

7.11 Links between mental health, housing and homelessness[103]

Homelessness and housing problems increase a person's chances of physical and mental ill health. Homeless people are more likely to experience physical, mental and emotional problems than the general population[104]. Around nine per cent of households accepted as unintentionally homeless are in priority need due to mental illness[105].

Many homeless people find it difficult to register with a GP. As being registered with a GP is often the first step towards getting support, homeless people often fall outside the system and get no help[106]. This is particularly worrying as around 30-40 per cent of rough sleepers have mental health problems. Some have suggested that as many as 70 per cent of homeless people experience some form of mental health problem[107].

One in five people say that mental health problems were a reason for becoming homeless. One survey suggests that 94 per cent of homeless men and 90 percent of homeless women developed mental health problems before they became homeless[108].

[100] Smith, A.J. and Ramana, R (1998), 'Mental health in rural areas: experience in South Cambridgeshire', *Psychiatric Bulletin*, 22, pp 280-284.

[101] © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[102] Fryers, T, Meltzer, D, Jenkins, R, and Brugha, T (2005), 'The distribution of common mental disorders; social inequalities in Europe', *Clinical Practice and Epidemiology in Mental Health*, 1:14,.

[103] © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[104] Office of the Deputy Prime Minister (2004), *Homelessness Statistics December 2003 and Addressing the Health Needs of Homeless People, Policy Briefing 7*, Homelessness and Housing Support and DH.

[105] Office of the Deputy Prime Minister (2004), *Homelessness Statistics December 2003 and Addressing the Health Needs of Homeless People, Policy Briefing 7*, Homelessness and Housing Support and DH.

[106] Office of the Deputy Prime Minister (2004), *Homelessness Statistics December 2003 and Addressing the Health Needs of Homeless People, Policy Briefing 7*, Homelessness and Housing Support and DH.

[107] Broadway (2004), *Homelessness and Mental Health Factsheet*.

[108] Dr Dean, R and Prof Craig, T (1999), *Pressure points: Why people with mental health problems become homeless*, Crisis.

Mental ill health is also a major contributor to homelessness among young people. A study in London found that more than 18 per cent of young homeless people had received a psychiatric diagnosis including schizophrenia, bipolar disorder and clinical depression[109]. The diagnoses were made before they became homeless.

7.12 Carers of people with mental health problems[110]

Every year over two million people become carers[111]. According to Carers UK, the number of informal carers is around 6 million[112]. This means that approximately one in eight adults are carers. As many as three in five is likely to become a carer in their lifetime. As many as 1.25 million carers provide 50 or more hours of care per week. Between 1.7 million and 1.9 million carers provide 20 or more hours of care per week. The majority of carers (58 per cent) are women, and women are more likely to carry the main responsibility for caring, where there is more than one person with some responsibility[113]. Carers UK has estimated that home care saves the country at least £57bn a year[114].

Around half of those with severe mental illness live with family or friends, and are likely to receive considerable support from them[115]. Unfortunately many of these carers feel that they do not get the support that they need. Since 1996 carers have had a right to request a carers assessment. The Social Services Inspectorate found that the number of assessments done was particularly low for carers of people with mental health problems and carers from minority ethnic communities[116].

Carers of people with mental health problems report higher levels of mental distress than other carers since becoming a carer[117]. Many are treated for anxiety, depression and stress. Carers of people with mental health problems were less likely than other groups to get increased levels of support after having had a carer's assessment. Only 25 per cent of carers who reported unmet needs got more support after an assessment. This was in spite of the fact that 75 per cent of carers of people with mental health problems reported unmet needs[118].

[109] Mental Health Foundation (2006), *Making the link between mental health and youth homelessness – A pan-London study*.

[110] © 2008 Mind, reprinted from 'Statistics 6: The social context of mental distress' by permission of Mind (National Association for Mental Health) www.mind.org.uk

[111] Carers UK (2004), Ten facts about caring.

[112] Carers UK (2002), Without Us...? Calculating the value of carers' support.

[113] Carers UK (2005), Facts about Carers.

[114] Carers UK (2002), Without Us...? Calculating the value of carers' support.

[115] H.M. Government (1999), *Caring about Carers: A National Strategy for Carers*, HMSO.

[116] Carers UK (2003), Missed Opportunities, The impact of new rights for carers.

[117] Carers UK (2003), Missed Opportunities, The impact of new rights for carers.

[118] Carers UK (2003), Missed Opportunities, The impact of new rights for carers.

Not surprisingly, surveys find that those providing 50 hours or more care per week were more likely than others to experience ill health including mental health problems[119]. Due to eight out of ten carers being of working age (between 16-65) many combine full-time work with many hours of caring every week. Around 400,000 carers in the UK combine full-time work with caring for 20 or more hours per week[120].

Many carers find that they have to give up work. Consequently many will experience loss of earnings and financial difficulties[121], which in turn can increase levels of stress and other mental health problems.

119 Carers UK (2005), Facts About Carers.

120 Carers UK (2005), Facts About Carers.

121 Carers UK (2005), Facts About Carers.

Section 8

Who provides support to the group?

People experiencing mental health problems and accessing secondary health care could receive support from a number of organisations spanning the statutory, voluntary and private sectors. The statutory sector includes the NHS and local authorities (local, city or regional councils). The voluntary sector provides a variety of community-based services. These may be funded through public donations or commissioned by the local authority social services department. The private sector is profit making, and provides a range of hospital and community-based mental health services.

We outline below individuals, teams and institutions people with mental health problems accessing secondary health care may be in contact with[122].

Care co-ordinator

The Care Programme Approach (CPA) is the framework for assessment and care planning. It attempts to bring together the relevant individuals and organisations needed to address the needs of people using specialist mental health services[123]. The care plan should be drawn up in consultation with the individual and, as appropriate, their carer. It should then be regularly reviewed and updated as necessary. A central figure is appointed, the care co-ordinator, to keep in close contact with the individual and ensure appropriate care is provided.

The CPA operates at two levels: standard and enhanced. The Standard CPA is for people who require the support of only one agency. Such individuals pose no danger to themselves or to others and will not be at high risk if they lose contact with services. In this case only one or two members of the multidisciplinary community mental health team will be required. Mind (2002) offer an example[124]:

An example of standard CPA might be someone who has been assessed as needing a fortnightly visit by a community mental health nurse (CMHN) plus an appointment with the psychiatrist at the out-patient clinic every three months. The CMHN will be the care co-ordinator; the care plan will be the fortnightly visit, the outpatient appointment and any treatment (such as medication or counselling) (Mind 2002).

[122] For a more detailed history and the legal requirements of service delivery see: Mind (2002), Community care 2 – Systems for delivering mental health services, www.mind.org.uk/Information/Factsheets/Community+care/Community+Care+2+-+The+Care+Programme+Approach.htm

[123] Department of Health (1990), The Care Programme Approach was introduced by joint Health and Social Services circular, HC(90)23/LASSL(90)11, London.

[124] Mind (2002), Community care 2 – Systems for delivering mental health services, www.mind.org.uk/Information/Factsheets/Community+care/Community+Care+2+-+The+Care+Programme+Approach.htm

The enhanced CPA is for people with complex mental health needs who generally need a range of community care services and community mental health care services. This may be due to, for example, more than one clinical condition and or due to difficulties in maintaining contact with the service user. Enhanced CPA tends to apply to people with more severe mental health problems (eg schizophrenia or manic depression) and some people on enhanced CPA are thought to pose a risk if they lost contact with services.

Community Mental Health Teams

Multi-disciplinary Community Mental Health Teams (CMHTs) are the central hub of adult mental health services. Mental health professionals including social workers, community psychiatric nurses, occupational therapists, psychiatrists and psychologists make up the team. Their role is to offer support to those experiencing complex mental health problems and their families when their needs cannot be met by GPs or generic social services. Patients are referred back to their GP when their condition has improved. CMHTs also provide long-term care of people with enduring mental health problems.

The team will appoint a care coordinator for each individual service user. The care coordinator should ensure that the service user's care plan is being carried out and should report any problems or issues back to the team. The role of care coordinator is taken on by any member of the team and is not a separate profession in its own right.

The care manager focuses on assessing a person's social care needs and arranging the delivery of community care services within available resources. They are often Approved Social Workers or other social workers with a range of therapeutic skills.

Specialist teams

A number of specialist teams were introduced to secondary care by The NHS Plan. The aim was to build in a stronger emphasis on vocational and social issues. The teams are:

- **Early intervention teams** provide community-based treatment and support to young people aged 14-35 years with first episode psychosis. This should include ensuring that involvement in education and work is maintained, and future prospects are not put at risk.
- **Assertive outreach teams** target adults aged 18-65 years with severe and enduring mental health problems as well as additional complex needs such as homelessness, self-harm or neglect, or high levels of disability. Assertive outreach can achieve better outcomes than standard community care on accommodation status, employment and patient satisfaction[125].

[125] For further details see: M Marshall and A Lockwood (1998), ACT for people with severe mental disorders, Cochrane review, Issue 3, The Cochrane library.

- **Crisis resolution teams** aim to prevent the need for adults having an acute psychiatric crisis to be hospitalised by providing 24-hour community-based treatment until the crisis is resolved.

Day services

The aim of day care is to provide recreation, therapy and rehabilitation. They are particularly effective at overcoming the isolation that often accompanies mental health problems. Day services are usually provided by social services or voluntary agencies.

Acute psychiatric inpatient services

This service is for people who cannot be treated and supported at home or in a less restrictive setting[126]. Staff are expected to note if people are in employment or education at the time of admission, maintain contact with families, and help resolve any financial issues.

Alternative services

Statutory providers (the NHS and social services departments) are not the only agencies providing health and social care in the community. Voluntary organisations offer a range of different services for people with mental health problems, such as day centres, employment projects and befriending schemes.

Hospital care

Psychiatric hospitals/units may be managed by general NHS trusts or by specialist mental health trusts. The emphasis is on treatment and most people stay in hospital only for as long as is considered necessary. In hospitals there is a heavy reliance on medication, but some also provide talking treatments, such as counselling or group therapy and some form of occupational therapy.

[126] For further details see: Department of Health (2002), *Mental Health Policy Implementation Guide: Adult acute inpatient care provision*, Department of Health.

Section 9

Access to helping services

Professionals noted that most of their clients have already been in touch with some other helping service. Those who have accessed secondary mental health services generally have a Care Plan (linked to the Care Programme Approach) and as part of this, they will also have a Care Co-ordinator. Their Care Co-ordinator may be one of a number of different professionals such as an Occupational Therapist, a doctor, a social worker or a nurse. Care Plans are updated every six weeks in a meeting attended by all the relevant professionals involved with the client. The purpose of the meeting is to discuss progress and assess how well current services are working to support the client and to adjust their support where required.

The Care Programme Approach context implies that secondary mental health service users should be directly in touch with at least one helping professional on a regular basis. Among those attending the focus groups, there appeared to be a mixture of reliance on intermediaries to help with accessing services and self-reliance in seeking out new sources of help, advice and guidance. This diversity of needs and abilities among mental health service users is something that professionals emphasised. Specifically, they highlighted the importance of assessing each individual's needs (and strengths) and offering help tailored to this. Professionals themselves use a variety of tools for assessing clients' needs and attempt to use this assessment as their starting point for service delivery.

9.1 Barriers and facilitators to accessing services

As noted, mental health service users have a diverse range of needs and abilities. It is therefore difficult to create a comprehensive list of the key issues that may hinder or encourage service use as this will vary from person to person. However, Figure 2 provides an overview of the issues discussed by clients and professionals in these focus groups as factors that may influence service use. The barriers listed here are issues which may present immediate obstacles to accessing services, but with the help of an intermediary, could be overcome.

Professionals and clients also noted that the help they receive from service providers is ultimately to assist them in becoming more independent and more engaged with the community in which they live. Intermediaries are therefore perhaps most crucial in offering support to access services earlier on in the journey to recovery (ie, after leaving hospital, after experiencing an acute episode of mental ill health, etc). As people become more well, they may also become increasingly able to access services independently.

Figure 2: Barriers and facilitators to service use among secondary mental health service users

Barriers

- May not have **access to a telephone** (intermediaries may be principal means of communication with others)
- Possible **difficulties using telephone** (lacking confidence, 'hearing voices'- leads to confusion; possibly English as additional language)
- Possible **anxieties** about leaving their home, using public transport, attending meetings/appointments without a helper
- If living at home, **may lack access to a computer and/Internet**
- Perceived **lack of knowledge/skill/confidence** in using computers
- **Fears associated with using computers** (possibly linked to illness, possibly just 'fear of the unknown')
- Lack of confidence about **social interaction** (because of stigma of mental illness, lack of understanding among general public and service providers about mental illness)

Facilitators

- **Intermediaries** who work with and for the client to help access services, eg,
  - a key worker or helper goes along with the client to meetings/appointments; helps to ensure that medication is taken appropriately ; rings up the Benefits Office, Housing Association, etc. on behalf of the client
- **Signposting** and advice about services in places normally visited (e.g. libraries, day centres)
- **Willingness to seek out/engage with helping services** (eg, Citizens Advice Bureau, Samaritans, MIND, SaneLine)
- **Access to computers, Internet, connectivity, digital TV** via service providers (eg day centres, care homes, etc)

9.2 Preferred methods of accessing services

Those participating in the research noted a range of ways in which they could find out about services. This suggests that they are aware of a wide range of potential sources of help and support. However, an important and recurrent issue was that a key worker or social worker is often viewed as the principal reference point for finding out about things and helping to make things happen in their lives. Although they may be aware of more direct methods of accessing services, there was often a preference for working through these intermediaries and a reluctance to engage directly with services. For example,

one person suggested that you can get information about jobs from the JobCentre, but rather than visiting the JobCentre, they preferred to ask their support worker to ring the JobCentre on their behalf. This appeared to be related to a lack of confidence in dealing directly with other unknown service providers.

Others appeared more confident about accessing services without the help of an intermediary and suggested that they might phone service providers directly (for example about benefits). Several people in the groups had used telephone helplines for people experiencing mental health difficulties such as the Samaritans or SaneLine. Additionally, the library was commonly noted as a source of information about services and is a place that some mental health service users visited regularly (for books, music, Internet access, etc).

Figure 3 provides an overview of 'contact points' used by the mental health service users who attended the focus groups. These are venues which are visited by people with mental health problems and could be used for advertising or accessing services of relevance to them.

Figure 3: Contact points for mental health service users/people with mental health problems

Venues:

GP surgeries

Day Centres/'drop in centres'

Libraries

Leisure centres

Parks

Voluntary workplaces (eg, community gardening projects, animal shelters, charity shops, etc)

Community colleges/FE colleges

Local arts centres

JobCentre

Social housing association offices/facilities

Psychiatric care homes

Institutions where help with resettlement may be available:

- Hospitals
- Prisons
- Refugee centres
- Hostels/shelters

Figure 3: Contact points for mental health service users/people with mental health problems *(continued)*

Intermediaries who may help with accessing services:

'Key worker'/'support worker' (at a helping organisation)

Occupational Therapist (OT)

GP

Social worker

Community Psychiatric Nurse (CPN)

Librarian

Helplines such as SANE, Samaritans

Local offices of national organisations (eg MIND)

Citizens Advice Bureau

Section 10

Views about and use of ICT among clients

10.1 ypes of ICT used by clients

There were varying levels of comfort and skills in using ICT among those attending the focus groups. Some were extremely able and confident users of IT, using computers and the Internet in voluntary or paid work, as part of adult education courses or for leisure purposes. However, others felt they lacked computer skills and said they 'didn't like computers' or described themselves as a 'technophobe'. Some were currently attending courses to learn how to use IT.

Figure 5 provides an overview of the forms and uses of ICT among secondary mental health service users attending these groups.

10.1.1 Access to computers and the Internet

Professionals noted that their clients were unlikely to have a computer at home or an Internet connection as this is too expensive. However, the organisations included in this research generally provided access to computers and the Internet to their clients and this was freely available at places like hostels, psychiatric care homes and day centres. They also provide support in using these facilities (ie, a staff member will show a client how to use the Internet or help them if they have a problem with it). Some of these helping organisations also ran IT skills courses themselves or referred clients to other local providers who offered such courses (ie libraries).

Some professionals noted that people with mental health problems may feel more comfortable accessing this type of learning with other people with similar problems. They felt that training offered specifically to mental health service users may help to overcome people's anxieties about learning by enabling them to do the course in a 'safe' environment where others are less likely to be critical of them.

Where clients accessed external training in ICT, they noted that obtaining basic skills in ICT use was more important than having a certificate at the end of the course. Some felt that UK Online centres focus too much on acquiring specific skills to obtain the certificate at the end and it was also necessary for an intermediary to help register a client on the course. These created barriers to using that service. Libraries, which offer a similar type of training but were more easily accessible were the preferred option.

10.1.2 Mobile phones as a primary contact point

Professionals highlighted the importance of mobiles phones in helping to ensure that their clients are safe, both in terms of them phoning for help if required and others phoning them if they have not recently been in contact. As mental health service users may not be living in their own homes, they may not have a landline and this means that mobile phones are particularly important as a means of maintaining contact and sharing information. However, they stressed that some mental health service users do not have mobile phones and this makes contacting them more difficult. In such cases, the principal point of contact is generally an intermediary (such as a key worker at a hostel or psychiatric care home). Messages are then passed along via this intermediary.

Mental health service users themselves also noted a variety of ways in which having a mobile phone can be particularly helpful to them. This included:

- enabling ongoing social support and contact even while in hospital
- enabling private conversations while living in shared accommodation (as in psychiatric care home)
- enabling close contact with helpers/provides security of ongoing contact with helpers

"I'm used to keeping a tight hold of people who are helping me, and that's one good thing with the mobile phone…"

Those who had mobile phones sometimes felt that using it for calls was too expensive. They therefore used them primarily for texting or for incoming phone calls, but this still enabled them to keep in touch (with others phoning them, for example). However, not everyone in the groups did feel comfortable with texting and some preferred the more personalised contact of a phone conversation.

It was less common for people attending these groups to have phones with a variety of sophisticated capabilities (eg MP3 player, internet access) although there were examples of this. Instead, the emphasis among those in the focus groups tended to be on the phone as a principal means of contact rather than an accessory. Those who did have more expensive phones also described not being able to afford to use more sophisticated features like Internet access from their mobile. Lack of kudos associated with an inexpensive phone did not appear to be a major concern among those attending these groups (in contrast, for example, to young NEETs).

10.1.3 Use of computers and the Internet

As noted above, there was variation among group members with some using computers and the Internet regularly and others not at all. Among those who did use computers, this was for a range of purposes, encompassing vocational, educational and leisure uses.

10.1.4 Digital television

Digitial television was commonly available to those attending these groups, and, like computers and the Internet, it was accessed via service providers (ie, at day centres, in psychiatric care homes, etc). Those attending the groups were favourably inclined to 'press the red button' and described using this for news, weather, sports, and music.

Figure 5: Forms and nature of ICT use among secondary mental health service users

Mobile phones are used for:

- Phone calls to keep in touch with family, friends, key workers, other helpers
- Enable ongoing contacts/social support even if hospitalised
- Some unable to afford phone calls/phone used primarily for incoming calls
- Phoning about appointments
- Calling 999 in an emergency

Data storage

- Useful for storing contacts information

Texting

- Cheaper than phone calls (free texts as part of calling packages)
- Quicker than phoning

MP3 player

- Listening to music while away from home (not commonly mentioned)

Bluetooth

- sending images or jokes to family/friends via Bluetooth on a mobile phone (not commonly mentioned)

Internet

- too expensive to use via mobile phone

Figure 5: Forms and nature of ICT use among secondary mental health service users *(continued)*

Computers are used for:

- E-mail (for sending messages to helpers at DayCentre, college, etc)
- Internet
  - Google searches for information (eg, medication, info about illness, family history)
  - Fan clubs
  - Social networking: Facebook, Skype
  - Online survey participation
  - Jobs information
- Educational contexts (ie. for general coursework, design courses, IT skills courses)
- Word processing (typing up letters, CVs, coursework)
- Graphics, artwork

Games consoles (Playstation) for entertainment

Digital TV ('the red button') for:

- Watching news
- Having more choice over what to watch (sports, etc)
- Weather
- Music channels

IPOD/MP3 players (less commonly discussed) for:

- music

DVD players

- Watching comedies when feeling down
- Possibly used via laptops

10.2 Factors affecting clients' views and use of ICT

10.2.1 Skills

Although some of those attending the focus groups said they lacked ICT skills and cited this as a reason for not using ICT, there were also current non-users of ICT who described having previously used computers, for example in a former job. The issue with skills may therefore be either lack of any basic IT skills or lack of recent ICT skills. Others noted problems with looking at the screen exacerbating conditions like epilepsy or causing difficulties with their eyes. Underlying these issues, however, some non-users noted that the principal barrier was that they hadn't had the opportunity to develop or refresh their IT skills and they would need help in doing so.

10.2.2 Training

Some of those attending these focus groups had taken IT courses hosted by the organisation or had been referred to external courses by the organisation. This suggests that courses are available if people seek them out or express an interest in this type of learning to a key worker.

This point was reinforced by professionals who noted that if an individual does express a desire to learn about computers, for example, this is something that would be noted in their Care Plan and taken forward. They also noted that staff are available to help if people want to learn to use the Internet, for example, and they can show them the basic steps involved.

10.2.3 Motivation

Professionals emphasised the importance of finding a source of motivation to encourage people to learn about ICT. That is, although the professionals may consider IT to be a necessary basic skill now, people need to see the benefits of using ICT as a tool to do something they want to do, rather than as an end in itself.

They suggested that people would be motivated to learn about ICT for specific purposes, such as to enable less expensive methods of staying in touch by e-mail rather than by phone. Also, mental health service users may be encouraged by seeing others using the Internet, for example, and then develop a greater sense of confidence that they too might be able to use it. They suggested that peer group support as part of learning about ICT would be useful for their clients.

10.3 ICT access and skills among professionals

One theory explored in the research is that frontline professionals working with secondary mental health service users may lack access to technology and ICT skills themselves. If this were the case, it would limit the extent to which these professionals were able to help their clients to engage with and use ICT. As noted earlier, this research is qualitative, so cannot provide any indication of the prevalence of ICT use and skills among service providers working with mental health service users.

However, among those organisations with staff participating in the focus groups and telephone interviews, ICT appeared to be widely used by staff. It was extensively used in their administrative work for the organisation and in order to stay in touch with colleagues and in some cases, clients. Types of ICT commonly used by staff included: mobile phones, PCs, e-mail, Internet, and lone worker badge or phone systems. Less commonly, some also used digital phones (ie, linked to computers) and Blackberries.

Those attending the focus groups generally felt that people join organisations with a range of IT skills already, particularly in relation to standard Microsoft programmes. Training is also commonly available in these organisations in the use of specific programmes like Access and Powerpoint. There are also more specific programmes used by these organisations, such as web-based needs assessment tools and databases for which specific training is also provided to new joiners.

Some organisations had their own IT departements or specialist IT staff while others, particularly smaller organisations, did not.

10.4 Factors affecting service providers' views and use of ICT

Service providers described a range of ways in which ICT was used in their work.

Key factors identified as encouraging ICT use among professionals were:

- The need to use databases to record client details and progress as part of funding (ie, linked to Supporting People, CPA monitoring)
- The imperative to assess clients' needs and the search for the most appropriate tools to do this (ie, web-based analytical tools were used in some cases)
- The importance of ICT in communicating with other organisations in relation to client referrals
- The need to ensure staff safety (via lone worker ID badge systems or mobile security phone systems)

- The need to keep in touch with remote workers
- The need for information for client referrals and support (via the Internet)

Factors which are currently hinder ICT use were also noted. These included:

- System down-time in relation to databases means cannot rely totally on them. Need to back-up with paper records to avoid disruption to work.
- Some services do not have enough computers for each staff member. Paper records are therefore relied on in preference to solely computer-based data storage.
- Lack of resources for a dedicated IT department so support may be limited if problems arise
- Other referral organisations do not use ICT (ie reliant on fax and paper notes)

Interestingly, there were also situations in which service providers choose not to use the ICT available to them. For example, some mobile phones to keep in touch with clients, either with phone calls or texting, while others made a policy of only communicating via office landlines in order to preserve 'work/life' boundaries.

10.5 What works?

In relation to the use of ICT, the following are the key messages from mental health service users and providers of helping services:

- Provide support in learning about ICT and using it
- Peer group support when learning to use ICT may be helpful
- Provide an incentive to learn (ie, ICT as a tool to do something you really want to do)
- Make computers/Internet available widely and at no cost
- Provide ICT in a 'safe' environment
- With website design, make it simple/easy/quick to find what looking for

Mental health service users were also asked to think about the types of services that they had used and found particularly helpful. A summary of their responses is provided in Figure 6.

Figure 6: Examples of what works in delivering services to secondary mental health service users

Inexpensive **mobile phones** to enable contact/prevent isolation

ICT courses available at the **library** (gets people out in the community; no need for a certificate at the end, can have free Internet access at the library afterwards)

Time bank – voluntary work for organisation paid with credits that can be used towards complementary therapies.

Telephone **helplines** –MIND, SaneLine, Samaritans, NHS Direct: used and considered helpful by participants (helped with signposting, referrals, direct advice, 'just listening')

Citizens Advice Bureau – local offices, someone to talk to personally about a problem

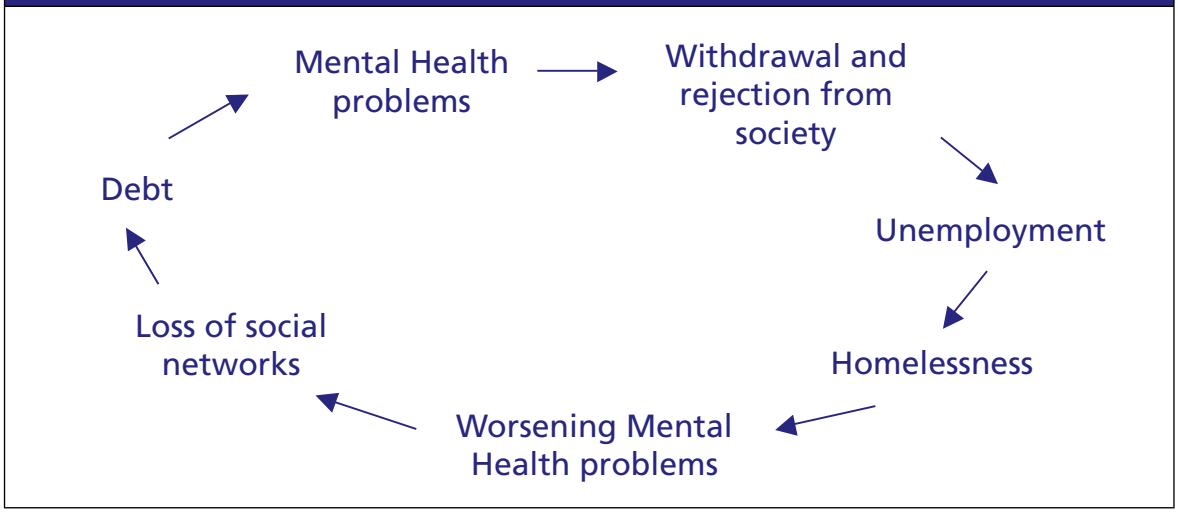
Vocational **training incorporating paid work** with third sector organisations for 10 weeks, followed by a job guarantee at the end of the training

Section 11

When is the best time to help?

The Social Exclusion Unit put forward a strong argument for early and continued intervention[127]. The data shows that mental health problems if detected early have a better chance of being overcome. However, if left unabated, even relatively short periods of difficulty can quickly spiral into a cycle of exclusion. The diagram below shows the key stages in this cycle.

Poor Mental Health: A Cycle of Exclusion



Intervention must therefore be preventative with schemes to promote good mental health from an early age. At the same time intervention must tackle each stage of the cycle that can lead to a worsening of the problem, for example the stigma attached to mental health problems which can lead to a missed opportunity of early treatment.

[127] Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

Section 12

What is the Government doing?

12.1 Policies and programmes

The mental health policy landscape has been shaped by two central aims that are common across public services. The first is a policy shift from top-down to customer-centric policy design with the aim of delivering more personalised and responsive services. This has led to a shift in the parameters of the debate: providers no longer dispute the right of users to be involved, but discuss the best mechanisms for ensuring that user involvement is meaningful. The second goal is social inclusion for those experiencing multiple deprivation.

While these goals are common across public services, policy that hopes to achieve good mental health must also tackle the stigma and myth surrounding mental health problems. Thus the context within which policy must succeed is more complicated.

We summarise here government initiatives as well as key policy and guidance documents for England. Given the longevity of such documents we cover documents produced over the last 10 years[128].

Saving Lives: Our Healthier Nation (1999)[129]

The white paper *Saving Lives: Our Healthier Nation* identified good mental health as a key work area for government. It argued that mental health problems are a 'a major cause of ill-health, disability and mortality' and set a target to 'Reduce the death rate from suicide and undetermined injury by at least a fifth by 2010 – saving up to 4000 lives in total.'

Although the white paper is largely concerned with suicide reduction it does offer a vision for good mental health for all.

National Service Framework for Mental Health (1999)[130]

At the centre of mental health policy is the National Service Framework (NSF). It is a ten year plan which sets out national standards for users with all kinds of mental health problems. The seven standards set out are:

- Standard one addresses mental health promotion and the discrimination and social exclusion associated with mental health problems.

[128] This section relies heavily on NICE (2007), *Public health interventions to promote positive mental health and prevent mental health disorders among adults*; and IPPR (2004), Developments and Trends in Mental Health Policy.

[129] Department of Health (1999), *Saving Lives: Our Healthier Nation*, Stationery Office.

[130] Department of Health (1999), *National Service Framework for Mental Health*, Department of Health.

- Standards two and three cover primary care and access to services for anyone who may have a mental health problem.
- Standards four and five cover effective services for people with severe mental illness.
- Standard six relates to individuals who care for people with mental health problems.
- Standard seven draws together the action necessary to achieve the target to reduce suicides as set out in Saving lives: Our Healthier Nation.

The Department of Health updated the NSF in 2004[131].

The NHS plan (2000)[132]

The NHS Plan pledged that over £300m would be made available to 'fast forward' the National Service Framework. The plan introduced Early Intervention Teams as part of the new wave of specialist services. Along with Crisis Resolution Teams and Assertive Outreach Services, they constitute a network of active community services in severe mental illness.

Choosing Health (2004)[133]

A joined-up approach to mental health was stressed by the white paper *Choosing Health*. The paper argues for a health-promoting NHS that is coherent in approach to mental health promotion. Three key levels of work were suggested:

- Strengthening individuals: increasing emotional resilience through acting to promote self-esteem, and developing life skills such as communicating, negotiating and relationship and parenting skills.
- Strengthening communities: increasing social support, inclusion and participation helps to protect mental wellbeing. Tackling the stigma and discrimination associated with mental health will be critical to promoting this increased participation.
- Reducing structural barriers to good mental health: increasing access to opportunities such as employment that protect mental wellbeing.

Two other key areas covered by the white paper were:

- Day services – the Department of Health would work, through the National Institute for Mental Health in England, to ensure that day services for people with severe mental health problems offer support for employment and mainstream social contact beyond the mental health system.
- Physical health inequalities – such inequalities experienced by people with mental health problems will be an early priority for the National Institute for Mental Health in England's stigma and discrimination programme.

[131] Department of Health (2004), *The National Framework for Mental Health – five years on*, Department of Health. This document also includes information on progress made up to 2004

[132] Department of Health (2000), *The NHS Plan: a plan for investment, a plan for reform*, Department of Health.

[133] Department of Health (2004), *Choosing Health: making healthy choices easier*, Department of Health.

Mental health and social exclusion (2004)[134]

In spring 2003, the Social Exclusion Unit considered what more could be done to reduce social exclusion among adults with mental health problems. The project focused on people of working age, and considered two main questions:

- What more can be done to enable adults with mental health problems to enter and retain work?
- How can adults with mental health problems secure the same opportunities for social participation and access to services as the general population?

The report sets out a 27-point action plan to bring together the work of government departments and other organisations in a concerted effort to challenge attitudes, enable people to fulfil their aspirations, and significantly improve opportunities and outcomes for this excluded group.

Action falls into six categories:

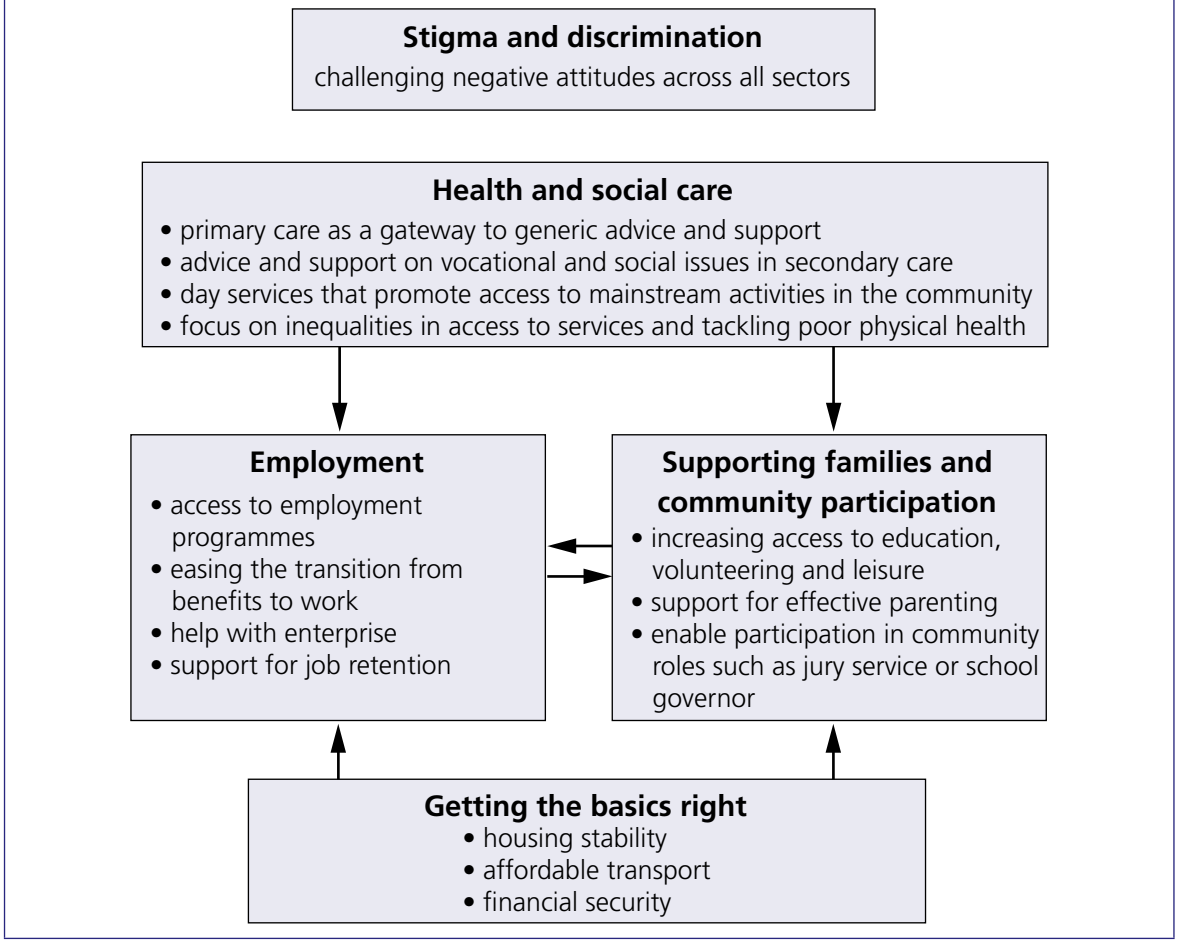
- Stigma and discrimination – a sustained programme to challenge negative attitudes and promote awareness of people's rights
- The role of health and social care in tackling social exclusion – implementing evidence-based practice in vocational services and enabling reintegration into the community
- Employment – giving people with mental health problems a real chance of sustained paid work reflecting their skills and experience
- Taking part in the local community – enabling people to lead fulfilling lives the way they choose
- Getting the basics right – access to decent homes, financial advice and transport
- Making it happen – clear arrangements for leading this programme and maintaining momentum.

The diagram below[135] summarises their framework for change and how the different areas of action will be linked.

[134] Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

[135] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*, Social Exclusion Unit.

A framework for change



Following on from the report, a further publication of 12 fact sheets Action on *Mental Health* was launched in October 2004[136] to offer practical tips to improve opportunities and outcomes for people.

Discrimination Act of 2005

To help prevent discrimination against disabled people with a mental illness the requirement of the 1995 Disability Discrimination Act – that a mental illness should be clinically well-recognised – was taken out of the Disability Discrimination Act of 2005.

As well as the above, there have been specific policy and programmes directed at sub-groups with particular needs. These include the following.

National Service Framework for Older People (2001)[137]

In support of the mental health well being of older people, Standard 7 of the *National Service Framework for Older People* states that:

[136] Social Exclusion Unit (2004), *Action on mental health. A guide to promoting social inclusion*, Office of the Deputy Prime Minister.

[137] Department of Health (2001), *National Service Framework for Older People*, Department of Health.

'Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers.' (Department of Health 2001)

This work area is supported by the Association of Directors of Social Services (ADSS) and the Local Government Association (LGA) in their joint publication *All Our Tomorrows*[138]. In it they state their commitment to improve the quality of life of older people and to engage them in the development of services as part of their statutory duty.

Mainstreaming gender and women's mental health. Implementation guidance (2003)

This paper sets out implementation guidance from the Department of Health on tailoring services to needs of women. It aims to help those planning and delivering mental health services to understand better what is meant by being 'sensitive to the needs of women' and ensure that women feel better served by the mental health care system in terms of their individual experience.

Delivering Race Equality in Mental Health Care (2005)[139]

In January 2005, the Department of Health published a five-year action plan, Delivering Race Equality (DRE) in Mental Health Care. DRE aims to help mental health services provide care that fully meets the needs of BME patients and build stronger links with diverse communities.

The programme is built on three key areas of work:

- More appropriate and responsive services – achieved through action to develop organisations and the workforce, to improve clinical services and services for specific groups.
- Community engagement – delivered through healthier communities and by action to engage communities in planning services.
- Better information – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services.

12.2 Measures and targets

Government targets for the groups are structured around Public Service Agreements (PSAs) and Departmental Strategic Objectives (DSO). These high-level objectives steer local government targets through the system of Local Area Agreements (LAAs). The key targets for the group are summarised below.

[138] Association of Directors of Social Services and Local Government Association (2003), *All our tomorrows*, Association of Directors of Social Services.

[139] Department of Health (2005), *Delivering Race Equality in Mental Health Care*, Department of Health.

PSA 16 aims to increase the proportion of socially excluded adults in settled accommodation and employment, education or training. This leads on to two very relevant LAA targets for the group:

- LAA 149: Adults receiving secondary mental health services in settled accommodation.
- LAA 150: Adults receiving secondary mental health services in employment.

The above two measures will help to provide stability in the life of someone experiencing mental health problems to help prevent a worsening of the condition. Employment also offers a positive route through which mental health may be improved.

The Department for Work and Pension's DSO *Maximise employment opportunity for all*, leads onto the LAA target measured by *Flows on to incapacity benefits from employment*. This again provides an incentive to help those suffering from mental health problems back into employment.

The Department for Children Schools and Families' DSO *Secure the well-being and health of children and young people* recognises the importance of good mental health. From it we have the LAA target measured by *Effectiveness of child and adolescent mental health services* (CAMHS). This feeds into the preventative model of intervention.

The Department of Health's DSO *Ensure better care for all* has implications for carers. In particular the LAA 135 is measured by *Carers receiving needs assessment or review and a specific carer's service, or advice and information*. This reflects the need to support carers in order to deliver effective care as well as the need to promote the good mental health of carers.

Further details on all 198 LAAs and their relation to PSAs and DSOs can be found in the spreadsheet *Targets and Measures*. This document summarises the relevance of each target to the group and collects further information, where available, on the rational behind the indicator, its precise definition, what data is collected and by whom.

Section 13

Case studies

13.1 SANEmail[140]

SANEmail is a new email support service for those experiencing mental health problems. It is run by the mental health charity SANE and funded by The Vodafone UK Foundation. SANEmail runs alongside their national mental health helpline, SANEline, to provide an additional channel of support to those affected by mental health issues.

Anyone can email, but in particular, the SANEmail service aims to support:

- Young people affected by mental health problems who may feel more comfortable using email to gain support rather than the helpline.
- Those with a physical disability or mental illness that prevents them from using the helpline.

13.2 Open Up[141]

Mental Health Media has launched Open Up, a project that provides a 'toolkit' of training, support and resources to enable people with experience of mental health problems to take positive action against discrimination in local communities. Open Up has set up five development areas across England and Wales, and offers free anti-discrimination courses and local co-ordinators in those areas. A website with resources and networking tools www.openuptoolkit.net provides online support, and a complete set of multimedia resources will be launched in July 2004. Open Up was launched in 2002 with £500,000 in grants.

13.3 Software to support good mental health

An increasing number of software packages are becoming recognised as positive routes to promote good mental health. The National Institute for Health and Clinical Excellence recently recommended that two computer programmes *Blues* and *FearFighter*, which offer computerised cognitive behaviour therapy, be offered as treatment for mild and moderate depression, panic and phobia. These represent self-service therapy as early intervention

[140] See www.sane.org.uk/SANEmail.

[141] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

to prevent problems from becoming more severe. Other examples include *MoodGymn*[142] (Australia), and *Living Life to the Full*[143] (Scotland).

13.4 Victoria's story – breaking the cycle of social exclusion[144]

Victoria had a variety of successful but stressful jobs and coped with the stress by harming herself. She became agoraphobic and started using cocaine to give her courage to leave the house. Scared of the psychiatric system, she refused help until she was in a crisis. While in hospital, she was evicted from her flat and was then discharged to a hostel where she lived for seven months while waiting for council housing. For the first time she relied on benefits, but not only was she too ashamed to ask for advice, she didn't know where to find it. She used her Incapacity Benefit to pay council tax, not knowing that she was entitled to Council Tax Benefit or that she could apply for Disability Living Allowance.

Victoria's debts mounted and she received a court summons, making her even more anxious and depressed. She was referred to the Cawley Centre, a therapeutic community in London, where she received intensive psychotherapy as well as practical and emotional support. A welfare adviser helped her claim the correct benefits and negotiate a repayment plan with creditors, and an occupational therapist went with her to make the payments. A weekly 'Future Prospects' group encouraged her to start going out on her own, and a volunteer group called Sabre encouraged her to start thinking about a future career and advised her about permitted work rules. She now volunteers as a classroom assistant at a local primary school for two mornings a week and attends evening classes once a week.

"I spent years in a cycle of hospital admissions because of suicide attempts and self-harm, and I didn't believe that could change. It took more than just therapy – it took practical support and the right advice and encouragement – to show me the future really can be different. I owe my life to the Cawley Centre."

13.5 Chinese Outreach Service, the Kinhon Project, Sheffield[145]

The four primary care trusts in Sheffield provide an outreach service to their Chinese population, as members of the community are often reluctant to access mainstream services, and half cannot speak English. The project provides a women's drop-in centre and advocacy/translation services, and helps identify high-risk groups. They would like to expand to provide more accessible drop-in facilities, a telephone helpline and an outreach worker for men.

142 http://moodgym.anu.edu.au/

143 www.livinglifetothefull.com/

144 Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

145 Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

13.6 Liz's story – overcoming stigma and discrimination[146]

Liz worked as a journalist but experienced severe bouts of depression. She was worried about anyone finding out about her mental health problem, and stopped seeing her doctor because she didn't want to take time off work. She would explain occasional manic episodes as simply working too hard.

Liz was eventually hospitalised several times. When she tried to go back to work, she couldn't get a job interview because of her mental health history. This triggered serious depression and she was detained under the Mental Health Act, and later became homeless.

While recovering she started to use her skills in the mental health field – writing, training journalists, speaking to the media and consulting with the voluntary sector. In 2002, she received the Mental Health Media Survivor Award. She joined the Social Exclusion Unit's mental health team in 2003 and is helping to set up the National Institute for Mental Health in England's programme to tackle stigma and discrimination.

While she still experiences symptoms of manic depression, she has learned to cope with the support of occupational therapists and a psychologist, as well as a supportive GP and regular appointments with psychiatrists.

"Just two years ago I felt my life was over. I couldn't see any way of getting back to how I used to be, and I felt useless. Being back at work, having a secure home and having the confidence to see my friends again has transformed my life. And I know that support is there when I need it – at work, from my psychologist and from my friends and family."

13.7 Public education programme, London[147]

A study of local attitudes around a new community-based group home for people with mental health problems in South London found that local residents were willing to help, but lacked information. After a public education programme, local residents were over three times more likely to have visited the home than those in a control area. Thirteen per cent, compared with none in the control area, had invited people into their homes. The majority of people in the home (compared with none in the control area) said they had some contact with local residents. The research was funded by the Department of Health and North East Thames Regional Health Authority.

[146] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

[147] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

13.8 Care Programme Approach, Rotherham

As part of the Care Programme Approach (CPA) process for people with mental health problems, Rotherham Mental Health Services carry out an Occupational Needs Assessment and identify occupational goals. These are a core part of the CPA process and the actions are reviewed at CPA meetings.

Rotherham's Health and Social Care Community relaunched the CPA documentation in 2001. The Educational, Training and Employment (ETE) service made a fundamental change to the process of identifying and addressing occupational need within the full needs assessment. In conjunction with Rotherham Service User Monitoring Team, an occupational self-assessment was developed and enables an individual to highlight their personal strengths and skills. Identifying meaningful goals forms the initial stage of referral to the ETE Service. Feedback from people with mental health problems highlighted that meaningful activity and the support of multi-agency partnerships were valued and important.

13.9 Antenna Outreach Service, Haringey, London[148]

Since 1999, Antenna has worked with 200 Black African or African Caribbean people aged 16-25 who suffer mental distress. It is funded by the Primary Care and Mental Health Trust. At referral, 60 per cent have lost contact with friends, and 45 per cent had been involved in a violent incident. The service has links with a range of young people's services in North London, and will support mainstream providers working with young people with mental health problems. It has also developed a home tuition scheme, sports and graphic design courses, a music group and opportunities for people with mental health problems to volunteer for community work through local churches. All these build contact between people with mental health problems and the rest of the community, and aim to develop skills that facilitate a move out of the mental health sector into mainstream activities.

13.10 Imagine, Mainstream project, Liverpool[149]

Imagine is a voluntary sector organisation that runs the Mainstream project. Mainstream supports people with mental health problems to access mainstream provision rather than just mental health services. Each staff member ('Bridge Builder') is responsible for making links with a particular sector and supporting clients in these areas. Sectors include education and training; employment; visual and performing arts; sports and leisure; volunteering; and faith, spirituality and cultural communities. Clients define their own support needs and aspirations, and the client and bridge builder identify possible opportunities to meet these in mainstream settings. Bridge builders offer dedicated, tailored support to clients as they develop the confidence to use mainstream services and further develop social networks.

[148] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

[149] Taken from: Social Exclusion Unit (2004), *Mental Health and Social Exclusion*.

Section 14

Pointers for the future

The above sections give detailed information on various themes that allow us to gain a better understanding of the group. Here we capture pertinent messages that cut across many of the above sections. These are drawn out from the desk-based and primary research as well as expert opinion given at the validation workshop.

Experts have repeatedly stressed the role of the intermediary in supporting people with mental health problems. The intermediary could be a family member, staff at a day centre or member of the community mental health team. Their role consists of both practical and emotional support. Intervention should therefore consider carefully the intermediary's perception of technology as well as their skill set.

Intermediaries can facilitate the introduction of technology to the group, yet the primary research puts forward a note of caution. If an over-reliance on intermediaries is built up, then a sense of helplessness and weakening of basic life skills can occur for group members. Therefore a balance needs to be struck such that users are supported towards independent use of technology where possible.

In introducing technology to group members a clear motivation for use must be offered. This could be a hobby an individual enjoys or staying in contact with friends and family. The environment in which technology is introduced must also be given careful consideration. For some a safe environment may be limited to their own home while others will be comfortable in community settings such as libraries.

The Care Programme Approach (CPA) offers one route through which the benefits of technology could be discussed with the client and introduced. As the CPA is carried out at an individual level, it offers a real opportunity to offer a tailored solution to the client's needs. While the potential of the CPA is recognised, experts expressed concern on two fronts. Firstly, for those who qualify for the CPA, many are not being properly consulted and meetings with their care co-ordinator are scarce. Secondly, many adults with significant mental health problems do not qualify for the CPA. Thus many people could be missed if the CPA is used as a single route to introduce the benefits of technology.

This profile has focused on adults with mental health problems accessing secondary care. Given up to half of all adult mental health problems beginning in childhood[150], there is a clear argument to consider prevention and intervention at an early age. In particular, it would be useful to uncover whether certain groups of children, such as children in care, are at more risk of developing mental health problems. Also, there is a significant role that can be played by primary care agencies, in particular GPs. The role of technology in primary care to support those with mental health problems needs to be investigated further.

Lastly, professionals offered some suggestions for improved future service delivery. These are summaries in Figure 7 below.

Figure 7: Ideas for future service delivery

Provide wide public access and support in using ICT: a computer in every home would be isolating and unsupportive. Aim to make computers and Internet connections widely available and free.

Provide training designed for people who may find learning difficult: teach ICT in a staged way, one on one, with the learner taking over one more stage each time. Traditional teaching methods may be too much to remember and unhelpful.

Simplify the software used for teaching purposes. Use 'stripped down' versions to avoid making it complicated and confusing.

Provide day to day reasons for using ICT and support in using it. Make it of interest to the service user by showing how it can be used to help them. Occasional use may be a first step to other uses/skills development.

Provide funding to enable more training in ICT among helping organisations (examples of computer clubs in day centres closing down due to lack of funding)

[150] J Kim-Cohen (2003), 'Prior Juvenile Diagnoses in Adults with Mental Disorder', *Archives of General Psychiatry*, 60 (7), 709-717.

Section 15

Want to find out more?

The list of organisations below directs readers to websites from which further information can be obtained relevant to people with mental health problems. Alongside each organisation and web address, a short description of the organisation and the types of information one could expect to find is given.

Name	Contact	What they do
Mental Health Foundation	www.mentalhealth.org.uk	The Foundation aims to help people survive, recover from and prevent mental health problems. They do this by: learning what makes and keeps people mentally well; communicating their findings to a wide range of people; turning their research into practical solutions that make a difference to people's lives. Their website offers information on campaigns, publications and introductory information on mental health issues.
Rethink	www.rethink.org	Rethink is a national voluntary sector provider of mental health services with 340 services and more than 130 support groups. They help over 48,000 people every year through their services, support groups and by providing information on mental health problems. Their website offers factsheets, in-depth research, policy coverage and latest news.
United Response	www.unitedresponse.org.uk	United Response supports people with learning disabilities or mental health needs to live in the community. They do this in many different ways, from supporting people in their own homes to working with people to access training and work opportunities. They work with 1,500 people at any one time. They have a robust insight into issues related to supporting people with mental health problems in the community as well as early intervention.

Name	Contact	What they do
Sainsbury Centre for Mental Health	www.scmh.org.uk/	The Sainsbury Centre for Mental Health aim to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services. They focus on criminal justice and employment, with supporting work on broader mental health and public policy. They do this through project work, research, publications and events. Their website gives up to date information on their publications and research.
Mind	www.mind.org.uk	The mental health charity Mind works to create a better life for everyone with experience of mental distress. Their website gives up to date statistical information as well as detailed factsheets on a wide range of themes connected to mental health.
Institute of Psychiatry, King's College London	www.iop.kcl.ac.uk/virtual/?path=/contact/mental-health-and-mental-illnesses/	The Institute of Psychiatry carries out research in psychiatry, psychology, and allied disciplines, including basic and clinical neurosciences. Their website links to research on various types of mental health problems.
Nacro Mental Health Unit	www.nacro.org.uk/mhu/index.cfm	Nacro's Mental Health Unit has been in operation since 1990. We are funded by Health and Offender Partnerships. We work with government and agencies at a national and local level to develop more effective ways of dealing with defendants and offenders with mental health needs.

Name	Contact	What they do
Moving People Programme	www.movingpeople.org.uk/about/index.html	Moving People is a diverse programme of national and local activity aimed at reducing stigma and discrimination linked to mental ill health, and improving the physical and mental wellbeing of people who have experienced mental health problems,. It is led by four mental health organisations – Mental Health Media, Mind, Rethink, and the Institute of Psychiatry, King's College London. There will be 6 national and 28 local projects as well as an evaluation to share learning. There website gives up to date information on the progress of the project.
Mental Health Media	www.mhmedia.com	Mental Health Media (MHM) run a range of projects which give people with experience of mental distress the confidence, skills and resources to challenge discrimination and speak out about their experiences. They also work with journalists and broadcasters to inform their coverage of mental health issues. Their website lists their current productions and also links to a media award scheme that they run.
Richmond Fellowship	www.richmondfellowship.org.uk	The Richmond Fellowship works with hundreds of people each year who are living with the effects of serious mental health problems. They offer a wide range of housing, care and community support services, and work extensively with people who might otherwise be excluded from the workplace because of mental ill health. Through training, work experience and work placements, they provide the support needed to get people back to work.

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