# Extended Executive Summary

# People Need People

## A Co-Produced, Lived-Experience-Led Study of the Conditions Shaping Public Mental Health Across London



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**Photography;** Anne-Marie Briscombe, Service User and Co-Researcher Workshop, London 2026

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# People Need People: At a Glance

## THE STUDY AND WHAT LONDONERS TOLD US

People Need People is a co-produced, lived-experience-led study of the conditions shaping public mental health across London. Funded by Thrive LDN and undertaken by Mind in Bexley with Mind in London between March and June 2026, it asks what makes staying well difficult, what helps, and what needs to change before distress reaches crisis.

## 220 people contributed

**150** online survey respondents
- **24** lived-experience interview participants
- **29** focus group participants (**24** in four community groups and five in a DWP employment group)
- **10** strategic stakeholder interviewees
- **7** active lived-experience co-researchers.

Each individual was counted once. Eight co-researchers were initially recruited; seven remained active. A collaborative interpretation workshop brought together ten people—four lived-experience participants and six co-researchers—to challenge and refine the emerging findings and model.

## Four findings

- Relationships as the Foundation of Public Mental Health — trusted relationships, belonging and ordinary conversation help people stay well.
- Living Under Constant Pressure — financial insecurity, caring, health, work and housing pressures accumulate and interact.
- The Emotional Labour of Seeking Help — fragmented systems, repeated storytelling and waiting can deepen distress.
- Prevention Begins Before Crisis — early support belongs in homes, workplaces, schools, neighbourhoods and communities as well as services.

## Selected survey findings

**76.7%** identified friends and family as their greatest source of local support; only **12.7%** felt very connected to their local community; **54.7%** felt not very connected or not connected at all. The rising cost of living negatively affected wellbeing for **62.0%,** while waiting times were a reported barrier for **40.7%.**

These are proportions of the **150** survey respondents, not population estimates for London.

## THE RELATIONAL MODEL OF PUBLIC MENTAL HEALTH

The study's central insight is that mental wellbeing is shaped through the interaction of relationships, community environments, wider social and economic conditions, systems of support and opportunities for prevention. Relationships are not a substitute for secure housing, income, employment or accessible healthcare; relational and material conditions must be strengthened together.

## Five interacting components

- Relationships — family, friends, neighbours, peers, trusted professionals and everyday interactions.
- Relational infrastructure — libraries, parks, community cafés, faith communities, volunteering, youth provision and other welcoming spaces.
- Wider social determinants — housing, employment, education, income, caring responsibilities, discrimination and physical health.
- Systems of support — primary care, mental health services, local government, voluntary organisations and community provision.
- Prevention — timely practical help, participation, connection and conditions that protect wellbeing before crisis.

## What the model contributes

The Relational Model of Public Mental Health was developed inductively from the research evidence and refined through collaborative interpretation. It offers an organising framework for policy, commissioning, neighbourhood health and service design. It is an empirically derived interpretive framework, not a tested causal or predictive model.

# The central message

## “People need people.”

Prevention is not simply an earlier referral. It is also the presence of trusted relationships, accessible community places, practical support and systems that respond to the whole person.



# SEVEN DIRECTIONS FOR LONDON

## 1. Place relationships at the centre of public mental health policy

Recognise belonging, social connection and trusted relationships as core public mental health assets.

## 2. Shift investment upstream: make prevention the default

Invest earlier in practical, community-based and relational support, alongside effective clinical care.

## 3. Build relational neighbourhoods

Protect accessible local places, groups and organisations where connection and participation develop.

## 4. Design systems around people rather than organisations

Reduce repeated storytelling and fragmented navigation; improve continuity and coordination.

## 5. Recognise lived experience as essential expertise

Embed paid, supported lived-experience leadership in research, commissioning and governance.

## 6. Measure what matters

Measure belonging, trust, participation, continuity and hope alongside conventional indicators.

## 7. Adopt the Relational Model of Public Mental Health as a framework for system transformation

Use the model to connect prevention, neighbourhood development, integrated care and action on inequality.

## How to use these findings

This is a grounded, triangulated snapshot, not a statistically representative prevalence study. Recruitment through Mind, Healthwatch and community networks may over-represent people already connected to support. Women comprised **78.0%** of survey respondents; **50.0%** were aged **45–64**; **88.0%** reported current or previous mental health difficulties. Younger Londoners and minority ethnic communities were under-represented. Findings should guide sense-making, strategy and further inquiry—not estimates of how common experiences are across London.

Read alongside the Extended Executive Summary and the full People Need People report for methods, detailed findings, qualifications and recommendations.

# Extended Executive Summary

This report presents the findings of the Thrive LDN-funded London Public Mental Health Research Project, a co-produced and lived-experience-led study exploring the challenges, pressures, worries and conditions shaping mental health and wellbeing across London. The research was undertaken between March and the end of June 2026.

It was designed to provide Thrive LDN and wider partners with a focused, timely and practical account of how Londoners experience mental health in everyday life, what makes staying well more difficult, what helps people cope, connect and recover, and what kinds of community, service and system responses could better support public mental health across the capital.

The study was not designed as a service audit, prevalence study or narrow evaluation of provision. Instead, it was a sense-making exercise. It asked what Londoners are worried about, what challenges are affecting wellbeing, what support is working, where people are falling through gaps, and what would help create better conditions for mental health before people reach crisis.

**This report matters because:**

- Mental health is being shaped long before crisis by poverty, housing, employment, caring responsibilities, poor physical health, discrimination, loneliness and uncertainty.
- Londoners described relationships, belonging and practical support as essential to staying well.
- Many people are trying to navigate fragmented systems while already distressed.
- Prevention requires investment in the everyday places, relationships and conditions that help people remain mentally well.
- Lived experience should shape not only services, but public mental health policy, commissioning, research and system transformation

The central implication is clear: people cannot be expected to remain mentally well through individual resilience alone when the conditions around them continue to create insecurity, isolation and emotional strain.

## The Study

The project used a co-produced mixed-methods design. Across the study, 220 people residing in London contributed through five complementary strands.

**Table 1: Study participants summary.**

| Research component | Participants |
|---|---|
| Online survey respondents | 150 |
| Lived experience interview participants | 24 |
| Focus group participants, including a DWP employment focus group | 29 |
| Strategic stakeholder interviewees | 10 |
| Active coresearchers | 7 |
| Total participants engaged | 220 |


Thrive Relational Public Health Model
Five interconnected drivers of public mental health

Participants were counted once only; no individual took part in more than one strand. The **29** focus group participants comprised **24** people across four community groups and five in the additional DWP employment group.

Eight lived-experience co-researchers were originally recruited through Mind in London and local Mind networks, with seven remaining actively involved following one withdrawal. Co-researchers contributed to the development of research questions, survey design, recruitment, interviewing, interpretation and creative dissemination. Their involvement ensured that lived experience shaped not only the data collected, but also the meaning and interpretation of the findings.

Each strand of the research had a distinct purpose. The online survey provided breadth, identifying wider patterns in how participants described their mental health, social connection, barriers to support, community belonging and views on prevention. Lived-experience interviews provided depth, enabling participants to describe in their own words the pressures, relationships, turning points and systems that shaped their wellbeing over time. Focus groups added insight from specific community settings and populations, including experiences linked to culture, faith, digital inclusion, caring responsibilities, employment, education, opportunity and community support. Strategic stakeholder interviews brought in system, policy and organisational perspectives from people working across health, local government, the voluntary and community sector and wider public mental health systems.

A further DWP employment focus group explored the relationship between mental health, employment, education, opportunity and access to work. This group provided additional insight into the experiences of people facing barriers linked to disability, neurodivergence, long-term health conditions, workplace discrimination, loss of confidence, insecure employment and young people's routes into work.

Triangulation was central to the study. Survey data, interview narratives, focus group discussions, stakeholder perspectives, co-researcher reflections and collaborative interpretation were brought together to examine where findings converged, where experiences differed and how different forms of knowledge helped explain the same public mental health challenges from different positions. This strengthened the credibility, relevance and practical value of the report.

A collaborative interpretation workshop formed a final stage of analysis. Emerging findings and the developing Relational Model of Public Mental Health were returned to lived-experience participants and co-researchers for discussion, challenge and refinement. This process moved beyond traditional validation by treating participants as active interpreters of the findings. It strengthened the analysis, clarified emphasis and ensured that the recommendations remained grounded in lived experience.

## Central Message: People Need People

The central message emerging from the research is captured in the title of this report: People Need People.

Participants did not describe mental wellbeing as something shaped only by individual resilience, personal choices or access to clinical services. Instead, they consistently described mental health as something created, protected and restored through relationships, belonging, practical support, meaningful activity, community connection and systems that treat people with dignity.

Relationships were not simply described as helpful during periods of distress. They were understood as fundamental to prevention, recovery and everyday wellbeing.

Family, friends, neighbours, peer groups, faith communities, voluntary organisations, community spaces, trusted professionals and ordinary conversations were repeatedly identified as protective influences. These relationships helped people manage bereavement, financial insecurity, caring responsibilities, poor physical health, discrimination, loneliness and uncertainty.
The collaborative interpretation workshop involved ten people: four lived-experience participants and six co-researchers. It provided an opportunity to challenge the emerging themes and refine the Relational Model and recommendations.

Conversely, the absence or erosion of relationships often intensified distress. Loneliness was experienced not only as physical isolation, but as emotional disconnection, lack of trust, loss of community, absence of meaningful conversation and the feeling of having no one to turn to
.

> ***"Knowing you are surrounded by so many people yet still alone."***

> ***"Sometimes a friendly chat will save a life."***

The report therefore argues that relationships should be understood as a central public mental health asset.

# Four Messages from Londoners

## Relationships protect mental health

Across the survey, lived-experience interviews, focus groups and stakeholder interviews, participants consistently described mental wellbeing as something shaped through relationships with family, friends, neighbours, communities and trusted organisations.

People described being listened to, recognised, welcomed and remembered as central to maintaining wellbeing. Peer support, volunteering, community groups, faith spaces, friendship, neighbourhood connection and ordinary conversations were repeatedly described as experiences that helped people cope with adversity and seek support before reaching crisis.

This finding challenges approaches that treat relationships as a soft or secondary outcome. In participants' accounts, relationships were not an optional addition to formal support. They were the foundation through which people experienced belonging, trust, recognition, hope and recovery.

## Pressure accumulates before crisis

Participants rarely attributed poor mental health to a single event or one dominant cause. Instead, they described lives shaped by multiple overlapping pressures, including financial insecurity, housing problems, employment stress, caring responsibilities, poor physical health, bereavement, loneliness, discrimination and uncertainty about the future.

One respondent described:

> ***"Housing and economic pressures [are] causing high levels of anxiety, depression and feelings of being overwhelmed."***

A focus group participant captured the cumulative nature of these pressures particularly powerfully:

> ***"I mean it's been constant for 10 years. Everything has gone up and trying to get a job that sustains a family and keep a roof over our heads. Higher prices in shops, fuel prices, the cost of clothing… everything is horrendously expensive. It's impossible to keep going and the stress on my health, the constant worry, the worry about everything. It's ongoing, and debt and rising debt. It's circular, and even talking about it is making me a bit unwell to be honest."***

These pressures were not experienced separately. They interacted and reinforced one another. Financial insecurity affected family relationships and emotional security. Poor physical health reduced independence, confidence and participation. Caring responsibilities limited rest, work and social connection. Loneliness intensified anxiety and depression. Fragmented support systems added further emotional strain

## The Emotional Labour of Seeking Help

Participants consistently challenged simplistic understandings of access to mental health support. Rather than describing help-seeking as a single referral or appointment, they often experienced it as an emotionally demanding journey requiring persistence, confidence and repeated self- advocacy. One participant described the frustration of having to repeat his story:

> ***"I could have done with one man coming to see me... it seemed a silly system."***

Another explained how not feeling understood could lead people to disengage altogether:

> ***"Sometimes they don't understand me... so I just give up."***

Participants described waiting, retelling painful experiences, being passed between services, completing repeated assessments, navigating digital systems and trying to coordinate communication between organisations. Many felt that they became responsible for holding fragmented systems together while already experiencing distress.

Importantly, participants rarely blamed individual practitioners. Many spoke positively about professionals who listened, showed compassion and remained alongside them during difficult periods. The issue was more often structural. Systems were experienced as fragmented, reactive and difficult to navigate.

The findings show that access is not only about whether services exist. It is also about how support is experienced. Continuity, trust, being remembered, not having to retell traumatic stories, feeling believed and being treated as a whole person were repeatedly described as essential. Fragmentation, repeated storytelling and poor communication did not simply create inconvenience. They could deepen distress and reduce hope.

## Prevention begins before crisis

Participants understood prevention in ways that were broader than traditional service-led definitions. Prevention was not rejected as a clinical or service issue, but participants rarely defined it only as earlier diagnosis, faster referral or more therapy. Instead, they described prevention as creating the conditions in which people can remain mentally well before reaching crisis.

One participant described prevention as support that helped stop deterioration:

> ***"It prevents me from going down a downward spiral... not becoming severely ill... not becoming suicidal, not self-harm."***

A respondent captured the importance of welcoming community spaces:

> ***"Communities need places where people feel welcome without having to explain why they're there."***

Participants associated prevention with practical help, trusted relationships, meaningful activity, financial security, accessible community spaces, peer support, supportive neighbourhoods, opportunities for participation and systems that respond earlier. They repeatedly suggested that by the time someone reaches specialist mental health services, many opportunities for prevention have already been missed.

This does not mean that clinical services are unimportant. Timely, compassionate and effective mental health services remain essential. However, they are one part of a wider public mental health system. Prevention begins in everyday life: in homes, schools, workplaces, neighbourhoods, community organisations, faith communities, peer networks, primary care and local services.
The four messages describe a clear pathway: connection protects wellbeing; cumulative pressure undermines it; fragmented systems can intensify distress; and prevention requires action before crisis.

## The Relational Model of Public Mental Health

The findings are brought together through the Relational Model of Public Mental Health, conceptualised and developed by Dr David Palmer from the findings of the People Need People study and refined through collaborative interpretation with co-researchers and lived-experience contributors. The model argues that public mental health is best understood as a relational process rather than the product of isolated determinants or healthcare services alone.

**Table 2. The Relational Model of Public Mental Health**

Public mental health is shaped through the interaction between relationships, relational infrastructure, wider social determinants, systems of support and prevention.

| Component | Meaning |
|---|---|
| Relationships | The central mechanism through which people experience belonging, support, recognition and recovery. |
| Relational infrastructure | The community spaces, organisations and activities that enable relationships to develop and endure. |
| Wider social determinants | Poverty, housing, employment, education, discrimination, caring responsibilities, physical health and other conditions shaping wellbeing. |
| Systems of support | Mental health services, primary care, local government, voluntary organisations and communitybased provision. |
| Prevention | Strengthening the conditions that enable people and communities to remain well before crisis. |

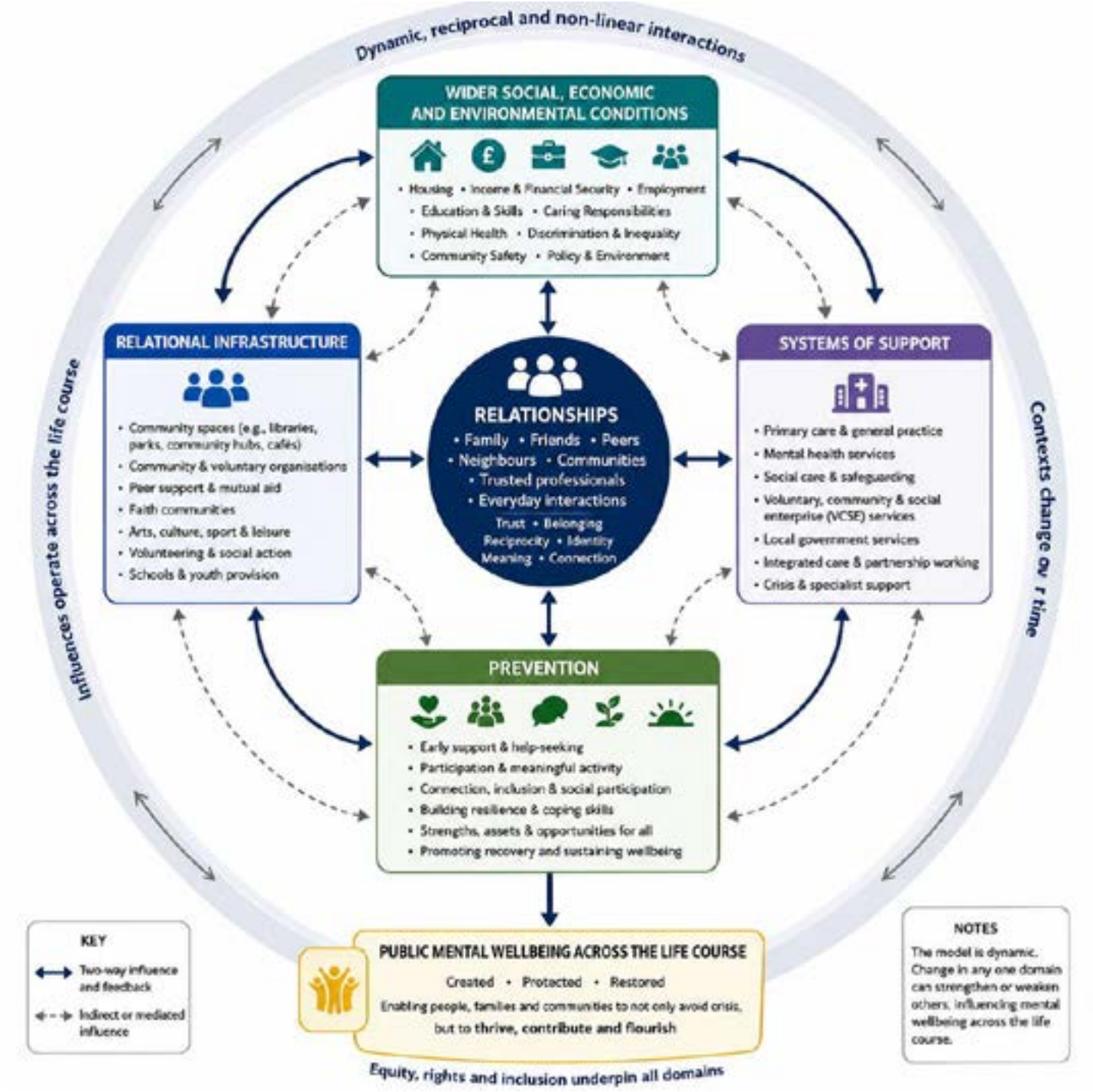


## Figure 1. The Relational Model of Public Mental Health (see Figure 10.1 in the full report)

relational infrastructure, wider social determinants, systems of support and prevention continually influence one another across the life course. Mental wellbeing is therefore understood as created, protected, undermined and restored through their interaction, rather than as the product of any single determinant or intervention.

Figure 10.1. The Relational Model of Public Mental Health

Source: Author's own conceptual model, developed inductively from the findings of the present study.



The model does not suggest that relationships replace structural determinants. Rather, it explains how those determinants are experienced in everyday life. Poverty, housing insecurity, discrimination, caring responsibilities, employment exclusion and poor physical health matter profoundly. Their impact is often felt through their effects on belonging, participation, trust, identity, dignity and relationships.

Source: Author's own conceptual model, developed inductively from the study findings and refined through collaborative interpretation.

Figure 1 is an empirically derived interpretive framework, not a tested causal or predictive model. Its application across populations and settings requires further evaluation. Relational resources cannot compensate for structural disadvantage; both relational and material conditions require strengthening.

Relational infrastructure is a key contribution of the report. Libraries, parks, community cafes, neighbourhood organisations, peer-support groups, faith communities, volunteering opportunities, youth provision, arts activities and community hubs are not simply places where wellbeing happens. They are active components of the public mental health system because they create opportunities for connection, trust, participation and belonging.

The Relational Model provides a framework for aligning prevention, neighbourhood health, community development, integrated care, action on the wider determinants of health and lived-experience leadership within a single public mental health approach.

## Why Lived Experience Matters

A defining feature of this project was its commitment to lived-experience leadership. People with lived experience were not treated simply as participants or sources of illustrative quotes. They were involved as co-researchers and contributors to knowledge production.

This mattered for several reasons. It helped ensure that the research questions were relevant, accessible and grounded in real experience. It strengthened recruitment and engagement through trusted networks. It enriched the interpretation of findings by bringing lived knowledge into the analysis. It also challenged assumptions and helped ensure that the final recommendations reflected the priorities of people closest to the issues being explored.

The project demonstrates that lived experience is not an optional addition to public mental health research. It is essential expertise. Future research, commissioning, service design and governance should embed lived-experience leadership from the beginning, with proper support, payment and influence.

## Limitations and Use of the Findings

This report provides a rich and timely snapshot of public mental health experiences, pressures and opportunities across London during the period in which the research was undertaken. It should not be read as a complete or definitive account of every public mental health issue affecting every community in the capital.

The survey was not designed to be statistically representative of London's population and should not be interpreted as a prevalence study. Participants were recruited largely through Mind in London, local Mind and partner networks, meaning that the sample is likely to include people with greater interest in, or proximity to, mental health issues than the wider population.

Some communities, boroughs and experiences may therefore be less visible within the data than others. These limitations do not weaken the value of the report, but they clarify how it should be used. It provides a grounded, triangulated and lived-experience-led account of the challenges, worries and conditions shaping mental health across London. It identifies strong recurring themes and practical implications, but it should also be seen as a starting point for further inquiry. Women comprised **78.0% (n = 117)** of survey respondents, **50.0% (n = 75)** were aged **45–64,** and **88.0% (n = 132)** reported current or previous mental health difficulties. Respondents from Black, Asian, Mixed and other minority ethnic backgrounds comprised **26.0% (n = 39),** compared with approximately 46% of London's population at the 2021 Census. Younger Londoners and minority ethnic communities were under-represented. Recruitment through Mind, Healthwatch and community networks may have favoured people already connected to organised support, including those predisposed to describe wellbeing in relational terms. The findings are therefore not population prevalence estimates.

Areas requiring deeper exploration include poverty, housing insecurity, digital exclusion, unpaid caring, men's mental health, physical health inequality, culturally specific forms of support, community infrastructure, young people's experiences, employment exclusion and variation between boroughs in access to community-based prevention and support.



# Recommendations: A Relational Agenda for Public Mental Health

The report makes seven interconnected recommendations. These should be read as a single relational agenda for public mental health rather than as separate service improvements.

## 1. Place relationships at the centre of public mental health policy:

Relationships, belonging and social connection should be recognised as core public mental health assets within strategy, commissioning and prevention.

## 2. Shift investment upstream:

make prevention the default Investment should move towards earlier support and the conditions that prevent distress from escalating. This includes practical help, community-based support, social connection, early intervention, employment support and action on the wider determinants of health.

## 3. Build relational neighbourhoods:

Neighbourhoods should be understood as part of the public mental health system. Local authorities, Integrated Care Boards, Primary Care Networks and voluntary organisations should strengthen community infrastructure, including accessible places where people can meet, participate, volunteer and feel they belong.

## 4. Design systems around people rather than organisations

Support should be easier to navigate, better coordinated and more relational. Systems should reduce repeated storytelling, improve continuity, strengthen communication and ensure that people do not have to become coordinators of their own care while distressed.

## 5. Recognise lived experience as essential expertise

Lived experience should be embedded across research, commissioning, governance and service redesign. This requires paid roles, proper support, meaningful influence and diversity of representation.

## 6. Measure what matters

Public mental health outcomes should include belonging, trust, participation, continuity, hope, community connectedness and relational wellbeing, alongside traditional performance measures.

## 7. Adopt the Relational Model of Public Mental Health as a framework for system transformation

The Relational Model should be used as an organising framework for future policy, commissioning and system transformation across London. It can help align prevention, neighbourhood health, integrated care, community development, action on inequalities and lived-experience leadership.

## Table 3. Compact Summary of Recommendations

| Recommendation | Principal finding addressed | Strategic action |
|---|---|---|
| **1. Place relationships at the centre of public mental health policy** | Relationships, belonging and social connection emerged as protective factors. | Recognise relationships within strategy, commissioning and prevention planning. |
| **2. Shift investment upstream: make prevention the default** | Distress developed through accumulated pressures before crisis. | Invest earlier in community-based, practical and preventative support. |
| **3. Build relational neighbourhoods** | Community spaces helped people feel connected and supported. | Strengthen local spaces, groups and VCSE infrastructure. |
| **4. Design systems around people rather than organisations** | Fragmented systems increased emotional burden. | Improve coordination, continuity and navigation. |
| **5. Recognise lived experience as essential expertise** | Co-production strengthened the relevance and interpretation of the research. | Embed paid lived-experience leadership in research, commissioning and governance. |
| **6. Measure what matters** | Participants valued belonging, trust, hope, participation and continuity. | Develop relational outcome measures alongside traditional performance indicators. |
| **7. Adopt the Relational Model of Public Mental Health as a framework for system transformation** | The model shows how relationships connect wider determinants, systems and prevention. | Use the model to inform future strategy, commissioning and transformation. |



# Overall Conclusion

The findings of this report point towards a clear conclusion: improving public mental health across London requires more than expanding services alone. Services matter, and timely, compassionate support can be life-changing. However, mental wellbeing is also shaped long before people reach services. It is shaped by relationships, communities, housing, income, work, caring, physical health, discrimination, loneliness, trust, participation and whether people feel they matter.

Public mental health must therefore be understood as a shared responsibility. It belongs not only to mental health services, but to local government, housing, education, employment, planning, primary care, voluntary organisations, neighbourhoods, communities and wider society.

The report calls for a shift towards a more relational, preventative and community-centred approach to public mental health. This means investing in the conditions that help people stay well, not only responding once they become unwell. It means valuing the everyday places and relationships that create belonging. It means designing systems around people rather than organisational boundaries. It means recognising lived experience as essential expertise. It means measuring what matters to people.

Above all, it means taking seriously the central message repeated throughout this research. People need services. People need safety. People need fairness. People need hope. But above all, people need people.

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