Extended Executive Summary

People Need People

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



Citation: Palmer, D., Alom, S., Bashir, A., Dodd, L., Robjohns, H., Topaz, R., Wassiczek, C., White, C. and Williams, L. (2026) *People Need People: A Co-Produced, Lived-Experience-Led Study of the Conditions Shaping Public Mental Health Across London.* London: Thrive LDN.

Public Mental Health Research Project.

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

Corresponding Author Email: dpalmer@mindinbexley.org.uk

This report presents the findings of the Thrive-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 London 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

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.

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.

Seeking help can become emotional labour

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'd just told your mate everything... I'm not going through it all again."***

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

> ***"Sometimes they don't have the patience to understand what I'm trying to get the message over... 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."***



Another respondent captured the need for earlier, community-based support:
ured that the recommendations remained grounded in lived experience.

"People need somewhere to go before they reach breaking point."

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

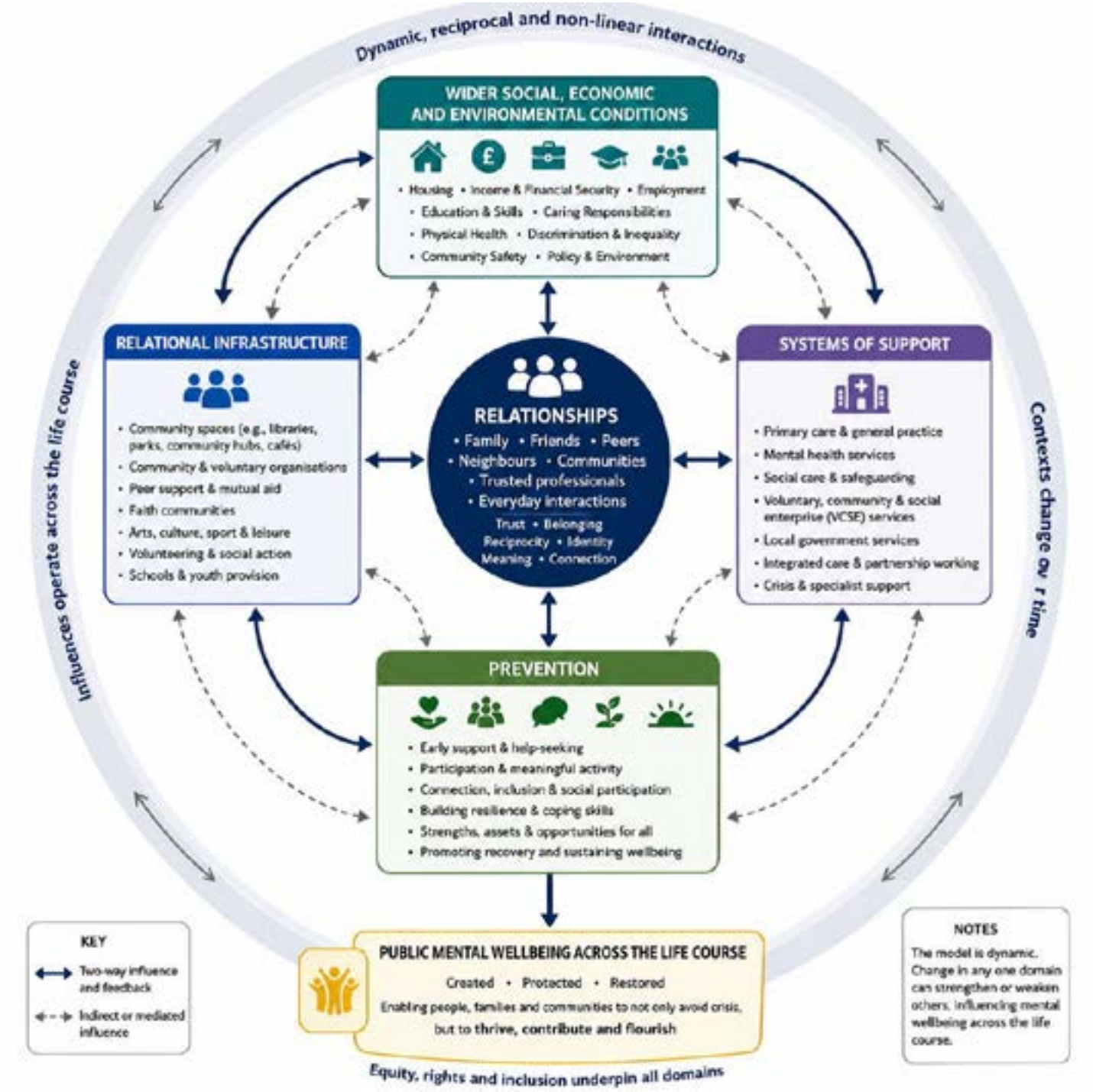
Public mental health is shaped through the interaction between relationships, relational infrastructure, wider social determinants, systems of support and prevention.

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. Components of the Relational Model of Public Mental Health

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.

Figure 1. The Relational Model of Public Mental Health. Source: 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.



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.

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. Public mental health strategies should explicitly address loneliness, belonging, participation, peer support and community connection.

2. Shift investment upstream: making 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

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 core protective factors across the study.	Recognise relationships as public mental health assets within strategy, commissioning and prevention planning.
2. Shift investment upstream: make prevention the default	Distress often developed through accumulated pressures before crisis.	Invest earlier in communitybased, practical and preventative support.
3. Build relational neighbourhoods	Community spaces and neighbourhood organisations helped people feel connected, supported and able to cope.	Strengthen local spaces, groups and VCSE infrastructure as part of the public mental health system.
4. Design systems around people rather than organisations	Fragmented systems increased emotional burden through repeated storytelling and poor continuity.	Improve coordination, continuity and navigation across services and sectors.
5. Recognise lived experience as essential expertise	Coproduction strengthened the quality, relevance and interpretation of the research.	Embed paid lived experience leadership in research, commissioning, governance and service design.
6. Measure what matters	Participants valued belonging, trust, hope, participation and continuity, not service activity alone.	Outcome measures Develop relational, alongside traditional performance indicators.
7. Adopt the Relational Model of Public Mental Health	The study developed a framework showing how relationships connect wider determinants, systems and prevention.	Use the model to guide future strategy, commissioning and system transformation across London.



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.

Correspondence
Dr David Palmer
Lead Researcher
Chief Executive, Mind in Bexley & East Kent
Honorary Senior Research Fellow, Canterbury Christ Church University
Email: dpalmer@mindinbexley.org.uk

Citation
Palmer, D., Alom, S., Bashir, A., Dodd, L., Robjohns, H., Topaz, R., Wassiczek, C., White, C. and Williams, L. (2026) *People Need People: A Co-Produced, Lived-Experience-Led Study of the Conditions Shaping Public Mental Health Across London*. London: Thrive LDN.
Photography; Anne-Marie Briscombe, Service User and Co-Researcher Workshop London 2026