People Need People

A Co-Produced and Lived Experience Led Public Mental Health Review of the Challenges, Conditions and Opportunities Shaping Wellbeing Across London. Thrive London.



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Corresponding Author Email: dpalmer@mindinbexley.org.uk

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Foreword

People Need People began with a simple but deeply held belief: that the people closest to the challenges facing London's mental health must be central to understanding them. This report brings together the voices of Londoners who spoke honestly about distress, loneliness, financial pressure, caring responsibilities, grief, poor physical health, discrimination, fragmented support and the everyday work of trying to stay well. It also captures hope, kindness, friendship, community, creativity and the many ways people support one another long before formal services become involved.

From the outset, this project was not intended to be a traditional report written about people from a distance. It was designed as a lived-experience-led and co-produced piece of public mental health research. That distinction matters. People with lived experience are not simply participants, case studies or sources of illustrative quotes. They are knowledge holders. They understand how mental health is shaped in everyday life, how systems feel when you are trying to navigate them, what helps when things are difficult, and what it means to be heard, believed and supported.
One of the greatest privileges of leading this project has been working alongside the lived-experience co-researchers. Their honesty, commitment and insight shaped the work from the beginning. They helped us ask better questions, listen more carefully, interpret the findings more thoughtfully and keep the research connected to real lives rather than institutional assumptions. Their contribution was not symbolic. It was central to the quality, integrity and distinctiveness of this work. The process also reinforced that co-production is not simply a method. It is a relationship. It requires trust, time, openness, flexibility and a willingness to be changed by what people bring. The co-researchers did not simply support the research; they shaped how we understood it. They brought warmth to interviews, humanity to analysis and imagination to the ways in which the findings might be shared. Their involvement demonstrated that public mental health research should not only describe problems. It should also create recognition, connection and the possibility of change.

This work has also been shaped by my own experiences, values and long professional involvement in community mental health. Over many years, I have learnt that trust is not created through a form, pathway or strategy document. It is built through relationships, honesty, time and a willingness to sit with complexity. That understanding helped me recognise the importance of building genuine rapport with co-researchers and participants, creating space for people to speak in their own way, and acknowledging that research of this kind carries emotional weight as well as intellectual responsibility.

I am enormously grateful to every person who took part in this study: the survey respondents, interview participants, focus group members, strategic stakeholders and co-researchers. Many people shared experiences that were painful, personal or difficult to put into words. They did so with generosity and with a clear desire to help improve things for others. I hope this report honours that trust and reflects not only what people said, but the seriousness, dignity and humanity with which they said it.

I would particularly like to thank Lucy Dodd, Strategic Lead for Mind in London, for her tremendous support throughout the project. Lucy played a vital role in recruitment, coordination and communication across the Mind in London network, helping to ensure that people were engaged sensitively and that the project remained connected to local Mind organisations and lived-experience communities across the capital. I am also deeply grateful to Thrive LDN for funding and supporting this research, and to Helen Daly, Danial Barrett and Joseph Barker from Thrive LDN, David Woodhead and Becky Higgins from the Centre for Mental Health, and members of the steering group for their guidance, encouragement and thoughtful challenge.

This report provides a snapshot of public mental health in London at a particular moment. It does not claim to tell every story or represent every community in full. London is too vast, diverse and unequal for any single project to do that. But it does offer something important: a grounded, triangulated and lived-experience-led account of the pressures people are facing, the things that help them stay well, and the conditions that could enable better mental health across the capital.

The title *People Need People* matters because it captures the central public mental health message of the project. Again and again, participants described connection as protective, loneliness as damaging, and trusted relationships as essential to prevention. They showed us that prevention does not begin only in clinics, crisis lines or referral pathways. It begins in families, neighbourhoods, peer groups, community spaces, voluntary organisations, schools, workplaces, primary care and ordinary conversations. The report should therefore be read not as an endpoint, but as a contribution to wider listening, learning and action. It should inform strategic thinking, commissioning, neighbourhood health, prevention, community development and system transformation across London. It also points towards areas requiring deeper exploration, including poverty, housing insecurity, digital exclusion, unpaid caring, men's mental health, physical health inequality, culturally specific forms of support, community infrastructure and variation between boroughs.

I hope this work helps bring lived-experience-led and user-led research closer to the centre of public mental health decision-making. Too often, lived experience is invited in after key decisions have already been made. This project shows the value of doing things differently: involving people from the beginning, recognising their expertise, paying them for their contribution, supporting them properly and allowing their insight to shape not only the evidence, but its interpretation, meaning and use. For me, this report is ultimately about dignity. It is about listening to people not as problems to be solved, but as experts in their own lives. It is about recognising that public mental health is not only a matter for services, but for communities, systems, relationships and social justice. My hope is that this work helps London listen more deeply, act earlier and hold onto the central message of this research: **people need people.** Lived experience, user-led research and community knowledge must be placed where they belong: at the centre of public mental health.

Dr David Palmer
Research Lead, People Need People

In memory of my mother, who died on 16 May 2026, while this research was under way.

Executive Summary

About this study

People Need People is a co-produced, lived-experience-led public mental health study funded by Thrive LDN and undertaken between March and June 2026 by Mind in Bexley with Mind in London. It asks what Londoners are worried about, what pressures affect their mental health, what helps, where people fall through gaps, and what would create better conditions for wellbeing before difficulties escalate into crisis.

The study sits alongside Making sense and setting direction: public mental health in London, the evidence review and service mapping undertaken by the Centre for Mental Health. That work synthesises published evidence and provision. This report brings the knowledge generated through lived experience, community testimony and co-research. The two should be read together.

Who took part

220 people contributed across five strands: 150 online survey respondents, 24 lived-experience interview participants, 29 focus group participants including a DWP employment group of five, 10 strategic stakeholders and seven active lived-experience co-researchers. Survey respondents came from nineteen London boroughs, with particularly strong participation from south-east London.

The sample is not statistically representative of London. Women made up 78.0 per cent of survey respondents, half were aged between 45 and 64, and 88.0 per cent reported current or previous mental health difficulties. Respondents from Black, Asian, Mixed and other minority ethnic backgrounds accounted for 26.0 per cent, against around 46 per cent of Londoners at the 2021 Census. Recruitment ran largely through Mind, Healthwatch and community networks, so people already connected to organised community channels are better represented than those who are isolated or distrustful of services. The findings should be read as a grounded, triangulated account of recurring experiences and mechanisms, not as estimates of prevalence.

What we found

Relationships are the foundation of public mental health. Participants understood wellbeing as created and protected through relationships rather than individual resilience or clinical services alone. Friends and family were the greatest source of local support for 76.7 per cent of survey respondents, yet only 12.7 per cent felt very connected to their local community and 54.7 per cent described themselves as not very connected or not connected at all. Loneliness was rarely about being physically alone. It was about the absence of trusted relationships and meaningful conversation.

Distress accumulates rather than arrives. Few people identified a single cause. Financial insecurity, insecure work, caring responsibilities, poor physical health, bereavement, discrimination and uncertainty combined over months and years until coping became unsustainable. The rising cost of living was the most commonly reported influence on wellbeing (62.0%, n = 93). Employment, education and access to opportunity emerged as public mental health issues in their own right.

Seeking help is itself emotional labour. Participants described repeated storytelling, multiple assessments, complex navigation and prolonged waiting, all carried while already distressed.

Waiting times were the most frequently reported barrier at 40.7 per cent, followed by cost at 27.3 per cent and lack of local services at 23.3 per cent. Criticism was rarely directed at individual practitioners. The problem was structural: systems that made continuity difficult and placed the burden of navigation on those least able to carry it.

Prevention begins before crisis. Participants located prevention in homes, schools, workplaces, neighbourhoods, community organisations and ordinary relationships, not only in earlier referral or faster treatment. 55.3 per cent believed earlier support would improve wellbeing and 48.7 per cent identified improving social connection as a key preventative measure.

The Relational Model of Public Mental Health

The study’s principal conceptual contribution is the Relational Model of Public Mental Health, developed inductively from the evidence and refined through a collaborative interpretation workshop with lived-experience participants and co-researchers.

The model treats relationships not as one determinant among many but as the mechanism through which wider social, economic and environmental conditions are experienced and negotiated. It introduces relational infrastructure, the physical, social and organisational settings through which supportive relationships develop and endure, as a public mental health construct.

Libraries, parks, community cafes, faith organisations, peer groups and neighbourhood organisations are therefore part of the public mental health system rather than an optional addition to it. The model does not suggest that relational resources can compensate for structural disadvantage. Relational and material conditions interact, and both need strengthening.

Recommendations

1. Place relationships at the centre of public mental health policy.
2. Shift investment upstream and make prevention the default.
3. Build relational neighbourhoods.
4. Design systems around people rather than organisations.
5. Recognise lived experience as essential expertise.
6. Measure what matters, adding relational outcomes to existing indicators.
7. Adopt the Relational Model of Public Mental Health as a framework for system transformation

How to read these findings

- This is a rich and timely snapshot, not a prevalence study. It does not estimate how common these experiences are across London.
- Recruitment ran through Mind, Healthwatch and community networks, so people already connected to community support are better represented than those who are isolated, digitally excluded or distrustful of services.
- Women, people in midlife and people with current or previous mental health difficulties are over-represented relative to London’s population. Younger Londoners and minority ethnic communities are under-represented.
- A sample assembled this way may be predisposed to describe wellbeing in relational terms. Chapter 10 examines this directly and sets out why the relational finding is harder to explain by recruitment alone.
- Use the findings for sense-making, strategic planning and further inquiry, not as population estmates.

Where further work is needed

Poverty and housing insecurity, digital exclusion, unpaid caring, men’s mental health, physical health inequality, culturally specific forms of support, young people’s experiences, community infrastructure, and variation between boroughs in access to preventative and community-based support. The perspectives of younger Londoners and of minority ethnic communities in particular warrant dedicated follow-up work.

Chapter 1: Introduction and Study Rationale

“Mental health difficulties are rising, and people are struggling more and more. Public mental health is protected not only by accessible services, but by whether people feel listened to, heard, seen, connected and held before they reach crisis point.”
(Community Leader)

This report presents the findings of the Thrive LDN funded Public Mental Health Research Project, a co-produced and lived-experience-led study exploring the challenges, pressures and conditions shaping mental health and wellbeing across London. Undertaken between March and the end of June 2026, the research was designed to provide 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 title, *People Need People,* reflects the central message that emerged across the research. Participants did not describe mental health as something shaped only by individual resilience, personal choices or access to clinical services. Mental wellbeing was repeatedly understood as something created, protected and restored through relationships, belonging, practical support, meaningful activity, community connection and systems that treat people with dignity. Conversely, loneliness, financial pressure, insecure housing, poor physical health, caring responsibilities, discrimination, digital exclusion and fragmented support could gradually erode wellbeing, particularly when people felt isolated, unheard or left to navigate difficulties alone.

The study was commissioned to provide Thrive LDN with stronger public mental health intelligence: evidence capable of making sense of a complex and changing London landscape rather than simply repeating what is already known. Its purpose was not to produce a prevalence study, a service audit or a narrow evaluation of existing provision. Instead, it asked what Londoners are worried about, what pressures are affecting their mental health, what helps, where people are falling through gaps, and what would create better conditions for mental wellbeing before difficulties escalate into crisis.

This lived-experience-led inquiry forms one part of a wider programme of public mental health work commissioned by Thrive LDN. Alongside it, the Centre for Mental Health undertook *Making sense and setting direction: public mental health in London*, an evidence review, service mapping exercise and assessment of evaluated public mental health approaches across the capital. That work examines what the wider evidence says about the determinants of mental health, the preventive provision currently available across London and the approaches for which there is evidence of effectiveness. *People Need People* approaches the same public mental health challenge from a different but complementary direction: it asks how these conditions are actually experienced, interpreted and negotiated in people’s lives, relationships and communities. The two reports should therefore be read alongside one another. One brings together published evidence, service infrastructure and evaluation; the other brings the knowledge generated through lived experience, community testimony, co-research and direct engagement with Londoners. Together they provide a fuller account of both the conditions shaping public mental health and what those conditions mean in everyday life.

This distinction matters because mental health is not experienced separately from the rest of life. The pressures affecting wellbeing are often embedded in rent, bills, employment, family relationships, caring, bereavement, physical illness, loneliness, discrimination, neighbourhood safety, digital access and the experience of trying to obtain help. Timely and effective mental health services remain essential, but many of the conditions that protect or undermine wellbeing sit upstream of specialist care. They are found in homes, schools, workplaces, neighbourhoods, voluntary organisations, primary care, community spaces and the everyday relationships through which people experience being recognised, supported and connected.

The research was developed within the context of London's extraordinary diversity alongside substantial inequality. Differences in income, housing, employment, health, social connection and access to opportunity are not simply abstract policy concerns. Participants described them as lived pressures: worrying about money, managing caring responsibilities, struggling with poor health, coping with bereavement, feeling unsafe or unwelcome, trying to access support, or feeling profoundly disconnected despite living in one of the world's most densely populated and socially diverse cities. The study therefore places everyday experience at the centre of public mental health understanding.

A defining feature of the project was its commitment to lived-experience leadership. Co-researchers were recruited, trained, supported and paid to contribute as active partners in knowledge production. Their role reflected the principle that lived experience is not merely testimony to be collected and interpreted by others, but a form of expertise. People who have experienced mental distress, exclusion, fragmented support, caring responsibilities, community recovery or barriers to services hold knowledge that is essential to understanding how public mental health is created and undermined in practice.

This is also what distinguishes the project from more conventional consultation. Lived experience shaped how questions were asked, how participants were engaged, how emerging findings were interpreted and how the implications of the research were understood. The project brought together survey evidence, lived-experience interviews, focus groups, strategic stakeholder perspectives and co-researcher interpretation within a single framework. Its value lies not simply in describing public mental health challenges, but in grounding their meaning in the knowledge of people directly affected by them.

The study was designed with prevention in mind, but prevention was understood more broadly than earlier diagnosis, quicker referral or additional clinical provision. Participants described prevention as what happens before specialist services are required: having somebody to talk to, being able to remain connected, having somewhere welcoming to go, receiving practical help before a problem becomes overwhelming, and encountering systems that respond early rather than waiting for crisis. Public mental health prevention therefore requires attention to the social, economic, relational and environmental conditions in which people live as well as to the accessibility and quality of services.

The project used a co-produced mixed-methods design. Across the study, 220 people contributed through complementary strands: 150 online survey respondents, 24 lived-experience interview participants, 29 focus group participants, including a DWP employment focus group of five people, 10 strategic stakeholder interviewees and seven active lived-experience co-researchers. Eight co-researchers were originally recruited through Mind in London and local Mind networks, with seven remaining actively involved following one withdrawal.

Each strand contributed a different form of knowledge. The survey provided breadth, identifying patterns in mental health experiences, social connection, barriers to support, community belonging and views on prevention.

Interviews enabled people to describe in greater depth the pressures, relationships, turning points and systems shaping their wellbeing. Focus groups added insight from particular community and employment contexts, including culture, faith, digital inclusion, unpaid caring, employment, education and opportunity. Strategic stakeholder interviews brought perspectives from health, local government, the voluntary and community sector and wider public mental health systems.

Triangulation allowed these forms of evidence to be brought into conversation with one another. Survey findings identified patterns; interviews and focus groups showed how those patterns were lived; stakeholder interviews illuminated system constraints and opportunities; and co-researchers helped test, challenge and refine emerging interpretations. A collaborative interpretation workshop then returned the developing findings and Relational Model of Public Mental Health to lived-experience participants and co-researchers before the final analysis and recommendations were completed. This was not simply a validation exercise. Participants were invited to challenge emphasis, identify omissions and consider what the findings meant for policy, commissioning and practice.

Across these different forms of evidence, relationships emerged as a central mechanism through which wider conditions were experienced. Poverty, housing, employment, discrimination, caring responsibilities, physical health and access to services matter profoundly, but their effects are often shaped through whether people have someone around them, whether they feel listened to, whether communities offer places of belonging, and whether services provide continuity and trust rather than fragmentation and repeated navigation. The argument of this report is therefore not that relationships replace action on structural inequality. It is that public mental health is produced through the interaction between material conditions, relationships, communities and systems.

Ethical governance was integral to this approach. Participants were invited to discuss experiences that could include distress, bereavement, caring responsibilities, poverty, discrimination, loneliness, poor physical health and difficult encounters with services. Ethical practice was consequently treated as an ongoing responsibility rather than a one-off approval process. The study incorporated informed consent, confidentiality, safeguarding, participant choice, researcher support and careful stewardship of people's accounts. Co-researchers were similarly supported through training, preparation and reflective check-ins, recognising both the value and the emotional demands of lived-experience-led research.

The project also asked what happens to people's testimony after the formal processes of interviewing, coding and reporting are complete. Participants' words were not understood simply as data whose purpose ended once a theme had been identified. Research poetry, audio recording, photography and other creative forms were developed as ways of carrying lived-experience knowledge beyond the written report and into wider public conversation. The research poem *People Need People* draws on recurring language, emotion and meaning within the study and was shared with co-researchers and lived-experience contributors as it developed. Other creative materials, including photography and audio, may contribute to a public exhibition and wider knowledge-sharing activity. This creates what might be understood as an afterlife of testimony: people's accounts continuing to generate recognition, dialogue and public meaning after the immediate research encounter has ended (Palmer, 2026). Importantly, this was not treated as routine dissemination of research material. Additional consent was sought where testimony, images or creative work moved into more public forms, recognising that agreeing to participate in research is not the same as agreeing to public visibility.

The creative work is therefore not an ornamental addition to the research. It extends the project's commitment to lived experience as knowledge. Poetry in particular allows fragments of testimony, repetition, emotion and contradiction to remain audible rather than being entirely absorbed into thematic summary.

In this way, creative dissemination provides another route through which the research can reach communities, practitioners, commissioners and policy-makers, while keeping the human realities behind the findings visible. The planned public-facing work is intended to place written findings alongside voice, image and testimony, allowing the evidence to be encountered in different forms and by audiences who may never read a lengthy research report.

The study does not seek to produce a single or uniform account of mental health across London. Experiences are shaped by age, gender, ethnicity, culture, faith, migration history, disability, sexuality, socio-economic position, family circumstances, neighbourhood, access to services and individual life histories. The purpose is therefore not to suggest that all Londoners experience public mental health in the same way, but to identify recurring patterns while remaining attentive to difference, inequality and context.

There are important limitations. The study provides a rich and timely snapshot rather than a statistically representative account of London's population. Recruitment took place largely through Mind in London, local Mind and partner networks, meaning participants may have greater proximity to mental health issues or community support than the population as a whole. Some communities, boroughs and experiences are therefore likely to be less visible than others. The findings should be understood as a grounded and triangulated account of recurring experiences and mechanisms, not as estimates of prevalence.

These limitations also identify where further inquiry is needed. The research points towards deeper work on poverty and housing insecurity, digital exclusion, physical and mental health inequality, unpaid caring, men's mental health, culturally specific forms of support, employment exclusion, community infrastructure and variation between boroughs. The report should therefore be understood as both an evidence base and a starting point for further listening and investigation.

Ultimately, the purpose of *People Need People* is not only to describe mental health need. It is to help Thrive LDN and wider partners understand the pressures shaping Londoners' wellbeing, the forms of support that make a difference and the conditions that enable people and communities to thrive. By bringing together lived experience, community knowledge, survey evidence, stakeholder perspectives, co-research and collaborative interpretation, the study argues for a public mental health approach that invests not only in services, but in the relationships, communities, systems and everyday conditions through which mental health is created, protected and restored.



Chapter 2: What the Literature Tells Us

“Being involved as a co-researcher has had a positive impact on my wellbeing, giving me a sense of purpose and connection through meaningful work”
(Thrive LDN lived-experience co-researcher)

Chapter Summary

This chapter sets out the theoretical and methodological foundations for the lived-experience-led approach taken in this study. It traces the development of service-user and survivor research, the recognition of experiential knowledge as a legitimate form of expertise, and the debates about power, representation and interpretive authority that shape co-produced inquiry. Drawing on Fricker’s account of epistemic injustice and on critiques of tokenistic involvement, it argues that the test of co-production is not the presence of people with lived experience but the authority their knowledge carries over what is asked, what counts as evidence and what the findings mean. The chapter closes by setting out how these principles were operationalised within the present study.

Lived Experience, Service-User Research and the Politics of Knowledge

The Mind in London-led component of the London Public Mental Health Research Project emerged from a recognition that many of the factors shaping mental wellbeing across London are most clearly understood through the experiences of people living with poverty, discrimination, housing insecurity, caring responsibilities, social isolation and mental distress. The research is grounded in a commitment to understanding public mental health through the perspectives of Londoners themselves and is informed by engagement with the Mind in London network, Healthwatch partnerships in South East London and the Mind in London *Every London Voice* listening project. This raises important questions about how lived experience contributes to knowledge production, whose voices are recognised as legitimate sources of evidence, and how different forms of expertise influence research, policy and practice.

This chapter therefore examines the development of service-user and survivor research, the recognition of experiential knowledge as a legitimate form of expertise, and co-produced approaches that seek to challenge traditional hierarchies of knowledge production. Particular attention is given to power, representation and participation because these provide the theoretical and methodological foundations for the lived-experience-led approach adopted within the Thrive LDN research.

Over the past three decades, mental health research has undergone a significant shift in how knowledge is understood, produced and legitimised. Influenced by survivor activism, disability rights movements, participatory research traditions, recovery-oriented practice and wider calls for the democratisation of knowledge production, researchers have challenged assumptions about who can generate legitimate knowledge and whose perspectives should inform research, policy and practice (Beresford, 2007; Faulkner, 2004; Rose, 2013). Rather than positioning professional expertise as the sole source of authoritative knowledge, mental health research has increasingly recognised experiential knowledge derived from lived experience of distress, recovery and service use (Beresford, 2007; Leamy et al., 2011; Repper & Carter, 2011).

Historically, people experiencing mental distress were more commonly positioned as subjects of inquiry than as contributors to knowledge production. Professional, clinical and academic perspectives largely determined how mental health difficulties were defined, interpreted and addressed, whilst people directly affected by services were frequently treated as sources of data rather than collaborators in research design, interpretation or decision-making (Faulkner, 2004; Rose, 2013). Experiential accounts could consequently be regarded as anecdotal or subjective and afforded less credibility than professional evidence. Critics argued that this marginalised the perspectives of those most directly affected by mental health systems and obscured important knowledge concerning distress, recovery, identity and support (Beresford, 2007; Kalathil, 2011).

Fricker's (2007) concept of *epistemic injustice* provides an important framework for understanding these concerns. Fricker describes how individuals and groups can be disadvantaged specifically in their capacity as knowers when their testimony is afforded less credibility because of prejudice and social inequality. Within mental health, this has clear implications for whose experiences are recognised, valued and incorporated into research, policy and practice. Lived-experience involvement is therefore more than a question of participation. It also concerns the distribution of credibility, interpretive authority and influence. This perspective further cautions against treating lived experience as homogeneous. Different communities encounter different barriers to being heard, believed and able to influence decisions, making it necessary to ask whose lived experience becomes visible within research and policy and whose remains marginalised.

Emergence of Service-User and Survivor Research

Service-user and survivor research developed from the proposition that people with direct experience of mental distress possess forms of knowledge unavailable through clinical observation alone (Beresford, 2007; Faulkner, 2004; Rose, 2013). Maddock, Lineham and Shears (2004), drawing on Faulkner and Nicholls (1999), argue that user-led research involves service users not simply participating in studies but shaping research questions, design, data collection, interpretation and dissemination. This represents a movement from participation towards ownership and leadership, informed by wider traditions within disability studies, participatory research and emancipatory inquiry that have challenged the exclusion of people most affected by policy and practice from shaping the evidence intended to inform them (Oliver, 1992; Barnes & Mercer, 2006; Beresford, 2007).

At its core, service-user research is concerned with more than methodological innovation. It raises questions about power, legitimacy and authority. Beresford (2007) argues that service-user research challenges assumptions about who has the right to define problems, generate evidence and influence decision-making. Decisions about which questions are asked, whose accounts are heard and how findings are interpreted inevitably involve values, priorities and relations of power. Faulkner (2004a; 2004b) similarly locates survivor research partly in dissatisfaction with research that marginalised the priorities of people experiencing mental distress. Accountability, reciprocity, empowerment and social change consequently became important principles within survivor-led inquiry.

These traditions challenge the assumption that professional expertise alone can adequately explain mental health, distress and recovery. They instead support a pluralistic understanding of knowledge in which experiential, professional and academic perspectives contribute different forms of insight. Service-user and survivor research is therefore more than an alternative method. It represents a broader challenge to systems of knowledge production in which people with lived experience have historically had limited authority over how their experiences are understood and represented.

Recognition of Experiential Knowledge

Parallel developments within mental health policy and practice strengthened the recognition of experiential knowledge. Recovery-oriented approaches challenged deficit-based understandings of mental illness by emphasising hope, agency, identity, connectedness and meaning rather than symptom reduction alone (Slade, 2009). Davidson et al. (2005) conceptualised recovery as a significant shift in thinking about mental illness, directing attention towards citizenship, participation and self-determination. Leamy et al. (2011) subsequently identified Connectedness, Hope, Identity, Meaning and Empowerment within the influential CHIME framework, while Repper and Carter (2011) highlighted the distinctive contribution of peer support and shared experience. Collectively, this work helped reposition lived experience from evidence of illness towards a source of knowledge about recovery, adaptation and wellbeing.

This shift also reflected dissatisfaction with narrowly biomedical accounts of mental distress. Biomedical approaches have contributed substantially to diagnosis and treatment, but critics have argued that they can understate the social context, lived realities and subjective meanings through which distress is experienced (Pilgrim, 2005; Rogers & Pilgrim, 2014). Service-user and survivor research instead gives greater attention to narratives, relationships and everyday experience as sources of understanding that cannot be reproduced through clinical observation alone (Beresford, 2007; Faulkner, 2004). Rose (2013) argues that involvement should therefore be understood not merely as a procedural requirement but as a challenge to assumptions about expertise, legitimacy and authority. Rose (2017) extends this argument by identifying distinctive epistemological contributions arising from service-user and survivor-led research.

As lived-experience involvement became more established, debate increasingly moved from whether people should participate towards how much influence that participation actually carries. Although co-production is now widely endorsed, researchers continue to question whether involvement consistently redistributes power. Barnes and Cotterell (2012) argue that participation can occur within institutional structures that continue to privilege professional expertise. Carr (2019) and Faulkner and Thompson (2023) identify emotional labour, identity negotiation and unequal power relationships within lived-experience roles, while Hawke et al. (2022) highlight the importance of disclosure, stigma, identity and organisational support. Meaningful co-production therefore depends not simply on the presence of people with lived experience but on whether their knowledge affects substantive decisions.

Questions of power are also inseparable from representation and inequality. Kalathil (2011) demonstrates how experiences of mental distress, service use and participation are shaped by ethnicity, racism, migration and exclusion, reinforcing that lived experience cannot be treated as a single category. This is particularly important in London, where exceptional social and cultural diversity exists alongside substantial inequalities in income, housing, employment, environmental conditions and mental health outcomes (Marmot, 2020; Greater London Authority, 2025). Public mental health research must therefore attend both to individual testimony and to the structural conditions shaping opportunities for wellbeing, participation and recovery.

These principles are increasingly visible in research practice. Initiatives including the Service User Research Enterprise at King's College London, the National Survivor User Network, the McPin Foundation, Mind in London's *Every London Voice* programme and *No One Knows Like We Do* (Palmer et al., 2009) illustrate different ways in which lived experience can influence research priorities, methods, analysis and dissemination. Larger co-produced programmes such as PARTNERS2 similarly show how lived-experience researchers can contribute distinctive analytical perspectives, challenge assumptions and strengthen the relevance of research for policy and practice (Pinfold et al., 2015; PARTNERS2 Writing Collective, 2020; Faulkner and Thompson, 2023).

These developments are reflected within national research infrastructure, with the National Institute for Health and Care Research (NIHR, 2024) positioning public involvement, engagement and participation as components of high-quality health research. Lived experience is consequently being recognised not only as testimony, but as expertise capable of contributing to research leadership, governance, knowledge production and translation (Hawke et al., 2022; Banfield & Palmer, 2025).

Participation as Presence and Participation as Power

Despite these developments, important tensions remain. Evidence concerning the implementation and impact of co-production is mixed (Pinfold et al., 2015; Oliver et al., 2019; NIHR, 2024). Participation does not necessarily translate into influence, particularly within organisations where professional authority and institutional priorities continue to shape decisions (Carr, 2019; Faulkner & Thompson, 2023). Co-production can become tokenistic when lived-experience involvement is visible but has little effect on substantive choices (Oliver et al., 2019). The critical question is therefore not whether people with lived experience are present, but what authority their participation carries.

These critiques strengthen rather than weaken the case for meaningful co-production. Reflecting on PARTNERS2, the PARTNERS2 Writing Collective (2020) argues that collaboration depends upon creating spaces in which different forms of knowledge can be shared, negotiated and valued. Genuine co-production therefore requires reciprocity, shared decision-making and meaningful influence over priorities, methods, interpretation and dissemination. The literature suggests that lived-experience-led research is distinguished not by participation alone, but by the extent to which expertise and interpretive authority are redistributed.

The following section considers how these principles were operationalised within the Thrive LDN Public Mental Health Research Project.

Our Model: Lived-Experience-Led Public Mental Health Research

Drawing on this literature, the Thrive LDN Public Mental Health Research Project adopted a lived-experience-led and co-produced model in which experiential knowledge informed the study throughout its development. Co-researchers were recognised and paid for their contribution and were involved in research design, recruitment, qualitative interviewing, reflection on emerging themes, interpretation and dissemination. Rather than positioning lived experience as supplementary evidence, the project treated it as one of the forms of expertise required to understand public mental health in everyday life (Beresford, 2007; Rose, 2013; Hawke et al., 2022).

Co-researchers contributed to the development of the survey, participant recruitment, interviewing and interpretation of emerging findings. Their involvement therefore extended beyond data collection. Experiential knowledge shaped both what evidence was gathered and how participants' accounts were understood and translated into implications for policy and practice.

Meaningful lived-experience leadership also required preparation, support and flexibility. Building on lessons from earlier service-user research (Palmer et al., 2009; Faulkner et al., 2019), co-researchers received structured preparation before conducting interviews and ongoing individual and group support throughout the project. These sessions created opportunities to develop interviewing skills, discuss progress, reflect on emerging experiences and address the practical and emotional demands of the research. This approach recognised lived experience as a valuable source of expertise while also acknowledging that research grounded in personal experience can carry emotional weight.

Participation was intentionally flexible. Co-researchers contributed according to their health, employment, caring responsibilities, availability and other commitments. Levels of involvement therefore varied, and one co-researcher withdrew because of personal circumstances.

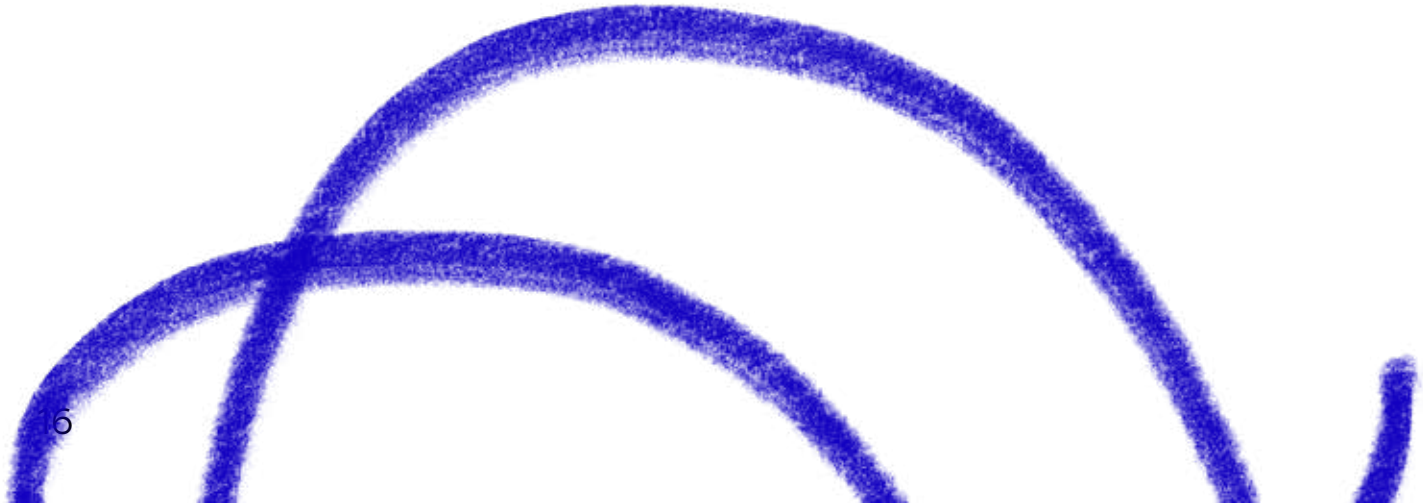
Flexibility of this kind was treated as a condition of inclusive lived-experience involvement, and variation between co-researchers was anticipated from the outset.

Shared interpretation was also built into the research process. Co-researchers were invited to comment on developing themes, and a collaborative workshop brought preliminary findings and the emerging Relational Model of Public Mental Health back to lived-experience participants and co-researchers for challenge and refinement. Experiential perspectives therefore contributed not only to generating data but to deciding what that evidence meant. This iterative process reflects a central principle of co-production: knowledge is produced through dialogue and reciprocal interpretation rather than solely through researcher analysis.

The approach also reflects wider developments within UK health research, where public involvement, engagement and participation are increasingly understood as dimensions of research quality rather than optional additions to study design (NIHR, 2024). The contribution of the Thrive project lies in applying these principles within a public mental health inquiry in which lived-experience expertise informs research design, interpretation, ethical practice and the translation of findings.

Importantly, this report sits alongside the wider public mental health evidence review and service mapping undertaken by the Centre for Mental Health as part of Thrive LDN's broader programme. That work synthesises evidence concerning the determinants of mental health, prevention, evaluated approaches and the distribution of preventive provision across London. The present chapter has a different but complementary purpose. It establishes the theoretical and methodological foundations for the lived-experience-led empirical inquiry undertaken through the Mind in London component of the programme. Read together, the two strands connect what the wider evidence and service landscape tell us about public mental health with how those conditions are experienced, interpreted and negotiated by Londoners themselves.

Collectively, the literature reviewed here demonstrates that recognising lived experience as legitimate expertise requires more than inviting people into research. It requires attention to credibility, power, representation, reciprocity and interpretive authority. These principles informed the design and analysis of the Thrive LDN Public Mental Health Research Project. The chapters that follow draw on survey responses, lived-experience interviews, focus groups, strategic stakeholder perspectives and collaborative interpretation to examine how social, economic, relational and environmental conditions interact to shape public mental health across London.




Collaborative Interpretation Workshop
June 2026

Chapter 3: Methodology and Ethical Governance

“Meaningful approaches need to be shaped by the voices of those directly affected...and this is what we are doing here with this project.” (Co-researcher)

Chapter Summary

This chapter sets out the methodology and ethical governance underpinning the Thrive LDN Public Mental Health Research Project. The study used a lived-experience-led, co-produced mixed-methods design in which experiential knowledge informed research design, recruitment, interviewing, interpretation and knowledge translation. Across five complementary strands, 220 people contributed through an online survey, lived-experience interviews, focus groups, strategic stakeholder interviews and co-research.

Data analysis combined descriptive survey analysis with reflexive thematic analysis and collaborative interpretation with lived-experience participants and co-researchers. Ethical governance through the Mind in Bexley Research and Ethics Advisory Board treated consent, safeguarding, participant autonomy and the public use of testimony as continuing responsibilities rather than matters resolved at a single approval point. The chapter also describes co-researcher preparation and support, reflexivity, triangulation, trustworthiness and the project’s creative approach to knowledge translation.

Introduction

This chapter sets out the methodology and ethical governance underpinning the Public Mental Health Research Project. The study was designed as a lived-experience-led, co-produced mixed-methods inquiry examining how Londoners understand public mental health, prevention, community connection, inequalities and access to support.

The project combined an online public mental health survey, lived-experience interviews, community focus groups, a DWP employment focus group, strategic stakeholder interviews, co-researcher involvement and a collaborative interpretation workshop. Across these components, 220 people contributed to the research: 150 online survey respondents, 24 lived-experience interview participants, 29 focus group participants, including a DWP employment focus group of five people, 10 strategic stakeholders and seven active co-researchers.

The methodological approach was grounded in the principle that people with lived experience are more than sources of data, but contributors to knowledge production. Lived-experience researchers helped shape the research questions, survey design, recruitment, interviewing, interpretation and creative dissemination. This reflects established traditions in survivor research, participatory inquiry and co-produced public mental health research, where experiential knowledge is understood as a legitimate form of expertise rather than as anecdotal evidence alone (Beresford, 2007; Rose, 2013; Faulkner *et al.,* 2019; Palmer *et al.*, 2009).

Ethical governance was central from the outset. The study involved potentially sensitive issues, including mental distress, loneliness, bereavement, caring responsibilities, financial insecurity, discrimination, fragmented services and experiences of exclusion. Ethics was therefore treated not as a one-off approval event but as an ongoing relational practice involving consent, safeguarding, participant choice, researcher reflexivity and careful stewardship of participants’ accounts.

This approach was overseen through the Mind in Bexley Research and Ethics Advisory Board, a community-based ethics body rooted in lived experience, safeguarding expertise, qualitative research and oral history practice.

Research Design

The study used a co-produced mixed-methods design. It combined descriptive survey analysis with qualitative thematic analysis of open-text survey responses, lived-experience interviews, community focus groups, a DWP employment focus group, strategic stakeholder interviews, co-researcher reflections and collaborative interpretation workshop data.

The design was intended to generate both breadth and depth. The online survey provided a broad view of public mental health experiences across London, including demographic characteristics, mental wellbeing, community connection, barriers to support and views on prevention. Interviews and focus groups enabled more detailed exploration of lived experience, while strategic stakeholder interviews provided system, policy and organisational perspectives. Co-research and collaborative interpretation ensured that lived experience informed not only data generation but also interpretation, refinement and knowledge translation.

The study was not designed to produce a statistically representative sample of London's population. Instead, it aimed to generate a rich, diverse and credible evidence base capable of identifying recurring patterns, lived-experience insights and practical implications for public mental health policy and practice. The rigour of the study therefore rests on credibility, transparency, reflexivity, triangulation and transferability rather than statistical generalisability (Lincoln and Guba, 1985; Braun and Clarke, 2021).

Partnership Working, Project Oversight and Iterative Feedback

The study was undertaken within a wider partnership involving Mind in Bexley, Mind in London and Thrive LDN. In addition to formal ethical governance through the Mind in Bexley Research and Ethics Advisory Board, the research process was supported by regular dialogue between the Lead Researcher, the Strategic Lead for Mind in London, Thrive LDN colleagues and wider project partners. These discussions provided opportunities to reflect on recruitment, participant engagement, emerging findings, public mental health priorities and the practical implications of the research as it developed.

The Strategic Lead for Mind in London, Lucy Dodd, played a key role in coordinating access to Mind in London networks, supporting recruitment, liaising with participants and helping to ensure that involvement opportunities were communicated clearly and sensitively. This support was particularly important because the project sought to engage people with lived experience of mental health difficulties, community-based support and social inequalities across London. The partnership with Mind in London therefore strengthened the reach, accessibility and practical organisation of the study.

Early drafts of research materials, emerging findings and conceptual ideas were also shared with Thrive LDN colleagues for comment and reflection. This iterative feedback helped ensure that the study remained relevant to public mental health priorities while retaining its grounding in lived experience. Colleagues from the Centre for Mental Health, who were involved in related aspects of the wider programme, contributed to broader discussion of emerging ideas and concepts. These conversations supported reflexive thinking and helped situate the study within wider public mental health debates, but they did not replace formal analysis, ethical governance or collaborative interpretation with participants and co-researchers.

The Lead Researcher also sought informal academic feedback on draft material from colleagues at SOAS and the University of Kent. This provided an additional layer of critical reflection, helping to test interpretations, refine concepts and consider alternative explanations before finalisation. This wider structure of partnership working, peer reflection and lived-experience interpretation strengthened the study's credibility while maintaining a clear distinction between advisory feedback and the empirical and collaborative processes through which the findings were generated.

Co-Production and Lived-Experience Leadership

A defining feature of the project was the involvement of lived-experience co-researchers. Eight co-researchers were initially recruited through Mind networks in London, with seven remaining actively involved following one withdrawal because of personal circumstances. Co-researchers brought direct lived experience of mental health challenges, services, communities or inequalities, alongside an interest in research and public mental health.

Co-researchers contributed to the development of research questions, survey design, recruitment activities, qualitative interviewing, discussions about emerging findings and creative dissemination. Their involvement helped ensure that lived experience remained present throughout the research process rather than being confined to participant testimony.

The co-research model deliberately moved beyond consultation. Co-researchers were not asked merely to comment on a predesigned study. They contributed to decisions about how the research was framed, how questions were asked, how participants were approached and how findings were interpreted. This was particularly important in a study concerned with public mental health from the perspectives of people and communities directly affected by mental distress, inequality and barriers to support.

Co-researcher reflections reinforced the value of this approach. Several described the project as meaningful because it enabled lived experience to shape knowledge production directly. One co-researcher described the work as "insightful and rewarding", adding that "meaningful approaches need to be shaped by the voices of those directly affected" and that being part of a project that "amplifies those voices has been powerful." Another described the interviews as more than a research exercise, explaining that they created "a space where participants could share their experiences openly and feel genuinely heard."

These reflections suggest that co-researchers understood their role not simply as gathering information but as helping to create conditions for voice, recognition and participation. Their involvement therefore strengthened both the epistemic and ethical quality of the study.

Training, Preparation and Ongoing Support for Co-Researchers

Co-researchers received training and preparation before undertaking research activities. Training addressed the purpose of the study, principles of co-produced research, ethical practice, informed consent, confidentiality, safeguarding, relational interviewing, active listening, boundaries, managing distress and the practical use of survey and interview materials.

Ongoing supervision and support were provided through individual and group check-ins. These sessions enabled co-researchers to discuss progress, reflect on experiences, address anxieties, share learning and seek guidance where required. This was particularly important because the study involved sensitive topics and because co-researchers brought different levels of previous research experience alongside varied health needs, caring responsibilities, employment commitments and personal circumstances.

Co-researcher feedback indicated that this support was central to ethical and methodological rigour. One co-researcher reflected that the preparation helped them feel ***"grounded in good practice"*** and ***"more assured in my ability to engage with participants thoughtfully and professionally."*** Another advised future co-researchers to "make full use of the check-in and support sessions, as they are valuable for building confidence."

The support model reflected the principle that lived-experience involvement must be properly resourced and ethically supported. Co-production can place emotional, practical and interpretive demands on co-researchers, particularly when research topics resonate with personal experience. Ongoing supervision, flexibility and payment for time and travel were therefore treated as core elements of the methodology rather than optional additions.

Support included both online and face-to-face contact. Group meetings enabled shared reflection and collective learning, while individual check-ins provided space to discuss confidence, emotional impact, boundaries and practical questions arising from interviews or participant contact. The Strategic Lead for Mind in London also provided practical coordination and relational support, helping to arrange interviews, maintain communication with participants and support involvement in accessible and respectful ways.

Development of Research Questions and Questionnaire

The research questions and online questionnaire, co-produced by the Lead Researcher and lived-experience co-researchers, combined structured questions with open-text responses. Structured questions generated descriptive data on demographic characteristics, mental health experiences, social connection, loneliness, barriers to support and views on prevention. Open-text questions enabled participants to describe, in their own words, what affected their mental health, what helped them cope, what made accessing support difficult and what they believed would improve public mental health across London.

Co-production shaped both the content and tone of the questionnaire. Questions were designed to be accessible, respectful and non-clinical, avoiding unnecessary jargon and allowing participants to respond from personal, community and system-level perspectives. This mattered because the study focused on public mental health rather than service use alone. Participants were therefore invited to reflect not only on formal mental health provision but also on relationships, loneliness, financial pressures, discrimination, neighbourhood environments, caring responsibilities and everyday sources of support.

Recruitment and Sampling

Recruitment used voluntary, non-probability sampling through community and voluntary-sector networks. The online survey was distributed through Mind in London networks, Healthwatch networks, local Minds, community organisations and wider public mental health contacts across London.

Survey respondents came from nineteen London boroughs, including Bexley, Greenwich, Bromley, Lewisham, Croydon, Southwark, Wandsworth, Hackney, Newham, Islington, Harrow and Westminster. The sample therefore provided a broad geographical cross-section of inner and outer London communities, while being particularly strong in south-east London.

Participation was voluntary. Individuals self-selected into the online survey, interviews or focus groups after receiving information about the project. This enabled the research to engage people who wished to share their experiences and views, but it also introduced limitations.

Those who participated may have been more connected to voluntary-sector networks or more willing to discuss mental health than people who were isolated, digitally excluded, distrustful of services or less connected to community organisations.

Participants

In total, 220 individuals contributed to the project.contributed to the project. Participants were counted once only; no individual took part in more than one strand.

Research component	Participants
Online survey	150
Lived experience interview participants	24
Focus groups	29
Strategic stakeholder interviewees	10
Active co-researchers	7
Total participants engaged	220

The main demographic profile, drawn from the online survey, showed respondents from a wide range of ages, genders, ethnic backgrounds, boroughs, employment circumstances and health experiences. Almost nine in ten survey respondents reported either current or previous mental health difficulties, meaning that the survey predominantly captured perspectives from people with direct lived experience rather than general public opinion.

The qualitative components broadened the study further. Lived-experience interview participants ranged in age from 18 to 78 years and represented diverse ethnic backgrounds and London boroughs. Focus groups brought together people from different community and employment contexts, including perspectives on culture, faith, digital inclusion, unpaid caring, employment, education, opportunity and access to support. Strategic stakeholder interviews contributed wider insight from professionals, community organisations and system leaders.

Data Collection
Online Survey

The online survey captured public mental health experiences across London. It included questions on demographic characteristics, mental health experiences, social connection, loneliness, barriers to accessing support, sources of help, community assets and views on prevention. Open-text questions enabled participants to provide detailed narrative responses and examples.

The survey was completed anonymously unless participants chose to provide contact details for further involvement. Participants could skip questions they did not wish to answer.

Lived-Experience Interviews

Lived-experience interviews provided more detailed accounts of how mental wellbeing was shaped by relationships, community connection, economic pressures, caring responsibilities, bereavement, physical health, discrimination and experiences of support.

Interviews were conducted by the Lead Researcher and trained co-researchers. They were semi-structured and relational in style, enabling participants to describe what mattered most to them while ensuring that the core research questions were explored.

Interview practice was informed by trauma-informed and person-centred principles. Participants were reminded that they could pause, decline to answer questions or stop the interview at any time. Co-researcher reflections emphasised warmth, empathy, active listening, silence, flexibility and non-judgement. One co-researcher explained that trust was built through “rapport building techniques and a warm approach”, while another highlighted the importance of “active listening and empathy” in helping participants feel at ease.

Co-researchers also reflected on the skill involved in sensitive interviewing. They described the need to balance openness with appropriate boundaries, allow participants time to gather their thoughts and adapt to different communication styles, confidence levels and comfort. These reflections reinforced the importance of understanding interviewing as a relational and ethical practice rather than simply a technical procedure.

Focus Groups

Focus groups were conducted with different participant groups and community contexts, including people accessing digital inclusion support, unpaid carers and participants in a DWP employment focus group. The groups enabled participants to discuss common barriers, community assets, service gaps and priorities for prevention, as well as experiences linked to employment, education, opportunity and access to work.

Strategic Stakeholder Interviews

Strategic stakeholder interviews were conducted with ten individuals working in professional, voluntary-sector, public health, community or system leadership roles. These interviews explored wider structural issues, including commissioning, service fragmentation, prevention, community infrastructure, inequalities and opportunities for improving public mental health across London. Stakeholder data were analysed alongside lived-experience material while maintaining a distinction between professional and lived-experience perspectives.

Ethical Governance

Ethical governance was provided through the Mind in Bexley Research and Ethics Advisory Board. The Board is a community-based ethics body comprising lived-experience representatives, unpaid carers, clinicians, safeguarding leads and qualitative and oral history researchers. Its purpose is to provide ethical scrutiny that is procedurally robust while remaining grounded in the lived realities, local support systems and safeguarding pathways relevant to community-based mental health research.

This model has been described in detail elsewhere (Palmer, 2025). It combines formal ethical scrutiny with continuing oversight embedded in community support and safeguarding structures. This was particularly important in the present study because ethical questions could arise throughout the research process, including during sensitive interviews, co-researcher involvement, collaborative interpretation and the movement of participant testimony into creative and public-facing forms.

This approach reflects the distinction between procedural ethics and ethics in practice (Guillemin and Gillam, 2004). Procedural ethics ensured that documentation, consent and governance were established before data collection. Ethics in practice required continuing judgement as circumstances changed, particularly when participants discussed distressing experiences, when co-researchers required support or when participants were invited to contribute to public-facing outputs.

The project was reviewed with attention to participant information, consent, recruitment, safeguarding, data handling, confidentiality, researcher support, emotional risk, co-researcher involvement and potential public dissemination. Ethical oversight therefore continued throughout the project rather than ending once initial approval had been provided.

Consent and Participant Autonomy

Informed consent was treated as an ongoing process rather than a single event. Participants received information about the study purpose, voluntary participation, confidentiality, data use and their right to withdraw.

For the online survey, consent was obtained before participation through introductory information and consent confirmation. For interviews, focus groups and workshops, consent was revisited verbally and/or in writing as appropriate.

Participants were informed that they could decline to answer any question, pause or stop participation, and withdraw where this remained practically possible. Participants were not expected to disclose anything they did not wish to share.

Consent was revisited when people were invited to participate in additional activities. These included the collaborative interpretation workshop, photography for exhibition purposes and the development of creative outputs such as the research poem People Need People. Where participants agreed to be photographed for potential public exhibition, additional consent was obtained specifically for image use. Consent to research participation was therefore not treated as automatic consent to public visibility.

Safeguarding and Participant Wellbeing

The study was designed with careful attention to safeguarding and emotional wellbeing. Participants could experience distress when discussing mental health, bereavement, caring responsibilities, loneliness, discrimination or difficulties accessing support. Interviewers and co-researchers were therefore supported to use careful, person-centred and trauma-informed approaches.

Safeguarding procedures were supported by the Mind in Bexley Research and Ethics Advisory Board and by organisational safeguarding pathways. The Board's community-based model connects ethical review with practical support and safeguarding infrastructure, ensuring that governance is not remote from participants' lived realities.

Where distress arose, participants could pause, skip questions or stop. Information about support options was available where required. Co-researchers were also supported through supervision and check-ins, recognising that sensitive research can affect researchers with lived experience as well as participants.

Data Management and Confidentiality

Data were managed in accordance with principles of confidentiality, data minimisation and secure storage. Survey data were collected through an online platform and exported for analysis. Interview and focus group data were anonymised or pseudonymised where appropriate. Identifying information was removed from analytic extracts unless explicit additional consent had been provided for attribution or public use.

Care was taken to distinguish between confidential research data and material that participants later chose to make public through photography, exhibition, performance or other creative outputs. Participants could make different choices about anonymity, attribution and public visibility at different stages. This was particularly important in lived-experience research, where some contributors may wish their stories or images to be recognised while others prefer anonymity or limited circulation.

Attribution and the Presentation of Quotations

Quotations are attributed according to the strand of the study from which they are drawn and the level of detail each participant consented to. Survey extracts carry a respondent number with gender and age band, because these were collected as structured survey items. Interview extracts are attributed either by pseudonym, where participants agreed that their contributions could be followed across the report as a single voice, or by strand alone, where a participant preferred that their extracts were not linked to one another or where linking them risked identification. Focus group and stakeholder extracts are attributed by group or role. Variation in attribution therefore reflects consent and confidentiality decisions and should not be read as a difference in the evidential weight of the accounts.

Data Analysis

Data analysis combined descriptive quantitative analysis of survey responses with qualitative analysis of open-text survey responses, interviews, focus groups, stakeholder interviews, co-researcher reflections and collaborative interpretation materials.

Survey data were analysed descriptively using frequencies and percentages. These statistics provided an overview of participant characteristics, reported mental health experiences, sources of support, barriers to access, community connection and views on prevention. They were not treated as representative of London's population but as contextual evidence supporting interpretation of the qualitative findings.

Qualitative data were analysed using reflexive thematic analysis, informed by Braun and Clarke's approach to identifying, developing and refining patterns of meaning across a dataset (Braun and Clarke, 2006; Braun and Clarke, 2019; Braun and Clarke, 2021). Analysis involved familiarisation with the data, initial coding, development of candidate themes, comparison across data sources, refinement and synthesis into the final thematic structure.

Coding was both inductive and interpretive. Initial analysis remained close to participants' own words, identifying recurring concerns including loneliness, relationships, financial insecurity, barriers to support, fragmented systems, community connection, caring responsibilities, employment exclusion and prevention. Later stages considered how these issues connected conceptually, particularly through the emerging *Relational Model of Public Mental Health.*

Analysis also drew on narrative and participatory qualitative principles. Attention was paid not only to what participants said, but also to emphasis, repetition, emotional tone, silence, contradiction and metaphor. This was important because participants frequently described mental health through relational and everyday language rather than formal clinical categories. Previous Mind in Bexley research similarly combined inductive thematic coding with attention to narrative structure, silence and emotional cadence, involving trained co-researchers in interpretive dialogue.

Collaborative Interpretation and Refinement

Following initial thematic analysis, emerging findings were returned to lived-experience participants and co-researchers through a collaborative interpretation workshop. This workshop formed a final stage of analysis rather than a simple validation exercise. Ten people participated: four lived-experience participants recruited through Mind in London and six co-researchers who had contributed to the wider research programme.

The workshop was co-facilitated by the Lead Researcher and members of the co-research team. Participants were presented with the emerging findings and the draft Relational Model of Public Mental Health. They were invited to consider whether the findings reflected their experiences, identify omissions, discuss examples of good practice, explore barriers within current support systems and contribute to refining the final recommendations. Participants also completed collaborative mind-mapping exercises exploring the relationships, community assets and wider conditions they believed enabled good mental health.

The process moved beyond routine approval. Participants were not simply asked whether the findings were correct. They were treated as active interpreters capable of questioning emphasis, adding nuance, identifying practical implications and challenging researchers' assumptions. Participants broadly recognised the emerging themes while contributing additional depth and clarification. Although no additional overarching theme emerged, the workshop strengthened the analysis by refining emphasis, strengthening the conceptual model and ensuring that recommendations remained grounded in lived experience.

Consent was revisited at this stage. Participants were reminded of the purpose of the workshop, how their contributions would inform the final report and how quotations or creative material might be used. This reinforced the project's commitment to ongoing consent and participant authority.

Creative and Public Engagement Outputs

The study included creative and public engagement elements designed to support knowledge translation and public dialogue. A research poem, People Need People, was developed from the findings and participant narratives, drawing on recurring phrases, emotional expressions and themes identified during analysis, including loneliness, financial insecurity, pressure, uncertainty, belonging and the importance of human connection. The poem was not treated as a substitute for formal analysis. It functioned as an arts-based method for carrying lived-experience knowledge into public conversation. Draft material was shared with co-researchers and lived-experience contributors and comments were invited, reflecting the wider methodological commitment to collaborative interpretation and accountability.

One co-researcher later recorded the poem with the Lead Researcher. She described the recording as ***"a really meaningful experience",*** explaining that the poem ***"powerfully captured the stories, emotions and realities we had heard throughout the research."*** She added that it did not fee***l "like just a poem",*** but rather ***"the collective voice of the people who had trusted us with their experiences."***

Her reflection shows the poem working as more than dissemination. She noted that ***"behind every finding and every theme in the report is a real person navigating the pressures of everyday life"*** and described wanting to help ***"bring those voices to life." She also reflected that, while not everyone will read a lengthy research report, poetry can communicate findings in a way that is "accessible, memorable and deeply human."***

Creative forms of knowledge translation also extended the afterlife of testimony beyond the immediate research encounter, allowing participants' words and experiences to enter wider public conversation while requiring renewed attention to consent, attribution and visibility. Poetry, photography, audio and potential exhibition materials were therefore treated not simply as outputs but as further stages in the ethical stewardship of lived-experience knowledge.

Some participants consented to being photographed for a potential public exhibition. This required separate consent because public visual representation carries different ethical implications from anonymous research participation. Participants were able to decide whether they wished to be photographed and how images could be used. This reflected the wider ethical principle that consent must be specific, revisitable and proportionate to the form of participation.

Reflexivity and Researcher Positioning

Reflexivity was embedded throughout the project. The research team included people with professional, academic, community and lived-experience backgrounds. This created methodological strengths but also required continuing attention to power, interpretation and positionality.

The Lead Researcher occupied multiple roles within the study, including project lead, qualitative researcher, analyst, writer and facilitator of collaborative interpretation. He also brought his own lived experience and professional experience within community mental health, which was discussed openly with the co-research group where relevant. This positionality supported relational engagement, sensitivity to participants' accounts and understanding of community-based mental health practice, but it also required active reflexive attention to assumptions, emotional resonance and interpretive authority.

Support from Mind in Bexley colleagues, including colleagues with safeguarding, clinical, community and lived-experience expertise, provided an important reflective structure. The Lead Researcher was therefore working within an organisational environment in which emerging ethical, emotional and methodological questions could be discussed rather than resolved in isolation.

The involvement of lived-experience co-researchers also helped challenge assumptions that might otherwise have shaped the research from a predominantly professional or academic perspective. Co-researchers identified issues, experiences and nuances that may have been overlooked within more traditional approaches and repeatedly emphasised the importance of rapport, warmth, empathy, active listening, silence and flexibility in creating trust.

At the same time, lived-experience involvement does not automatically remove power imbalances. Researchers, organisations and funders continue to influence priorities, timelines, interpretation and dissemination. Reflexive discussion, supervision, collaborative interpretation, partner feedback and ethical oversight were therefore used to examine how decisions were being made and whose knowledge was being prioritised. The project's reflexive stance was based not on claims of neutrality but on transparency, shared interpretation and continuing attention to power, representation and responsibility.

Rigour and Trustworthiness

The credibility and trustworthiness of the study were strengthened through multiple and complementary data sources, lived-experience involvement in research design and interpretation, collaborative refinement of emerging findings, reflexive attention to researcher positionality and power, and transparent reporting of recruitment, sampling and limitations.

Triangulation across survey responses, interviews, focus groups, stakeholder perspectives, co-researcher reflections and collaborative interpretation enabled emerging patterns to be considered across different forms and sources of evidence.

Returning emerging interpretations to participants can strengthen the credibility and practical relevance of qualitative research (Lincoln and Guba, 1985; Birt et al., 2016). In this study, collaborative interpretation went beyond validation. Participants were able to question emphasis, identify omissions, contribute alternative explanations and refine the developing conceptual model before the analysis and recommendations were finalised.

Wider project and academic feedback provided an additional reflexive check on the developing analysis, as described above. This feedback was advisory and did not substitute for formal analysis, ethical governance or collaborative interpretation with lived-experience participants and co-researchers.

Limitations

The study has several limitations. Recruitment relied on voluntary participation through Mind, Healthwatch and community networks. This enabled the project to engage people with relevant lived experience but may have under-represented individuals who were more isolated, digitally excluded, distrustful of services or less connected to voluntary-sector organisations.

This recruitment route also has implications for the central finding of the study. People reached through Mind, Healthwatch and community networks have, by definition, some existing connection to community-based support, and their accounts may foreground relational and community explanations of wellbeing more strongly than the wider London population would. The Healthwatch route is worth distinguishing here. Local Healthwatch organisations are independent of Mind and of mental health provision, acting as the statutory independent champion for health and social care, and they reach people through contact with health and care services generally rather than through mental health support alone. Recruitment was therefore not confined to the service users of a single organisation, although respondents reached this way were still people already connected to organised civic or community channels. Survivor and service-user research has long recognised that experiential samples are shaped by the networks through which they are recruited, and that whose lived experience becomes visible is itself a question of access and power (Beresford, 2007; Kalathil, 2011; Rose, 2013). The implications of this for the relational reading of the findings are examined directly in Chapter 10.

The online survey was not statistically representative of London's population. Women, people in midlife and people with current or previous mental health difficulties were strongly represented. These characteristics are important to interpretation and are discussed transparently in the following chapter.

Setting the sample against London's population makes the gap explicit. Women made up 78 per cent of survey respondents, whereas women account for approximately half of London's population. Respondents aged 18 to 24 comprised 5.3 per cent of the sample, in a city whose median age at the 2021 Census was 35 years, five years below the figure for England, and whose largest single age group was people aged 30 to 34; participation here was concentrated instead in midlife, with half of respondents aged between 45 and 64. Respondents from Black, Asian, Mixed and other minority ethnic backgrounds accounted for 26.0 per cent, compared with around 46 per cent of Londoners at the 2021 Census. The findings should therefore be read as an in-depth account of the experiences of those who took part rather than as an estimate of how common those experiences are across London, and the perspectives of younger Londoners and of minority ethnic communities in particular warrant further work.

The study also depended on participants' willingness to discuss sensitive experiences. Some perspectives may remain absent because people did not wish to speak, did not feel safe enough to participate or did not regard the research as relevant to them. This limitation is ethically important. Silence should not automatically be understood as missing data, but as a reminder that some experiences may resist public articulation.

Co-production strengthened the study but also required careful support, supervision and ethical attention. Lived-experience research can be demanding for co-researchers, particularly when discussing distressing or personally resonant material. Training, reflective support, supervision and ongoing check-ins were therefore essential components of the methodology rather than optional additions.

Conclusion

The London Public Mental Health Research Project used a co-produced mixed-methods design to explore how Londoners understand public mental health, prevention, community connection and access to support. The study combined broad survey evidence with lived-experience interviews, focus groups, stakeholder perspectives, co-researcher involvement and collaborative interpretation.

The methodology was grounded in lived-experience leadership, relational ethics and participatory knowledge production. Ethical governance through the Mind in Bexley Research and Ethics Advisory Board ensured that consent, safeguarding, participant autonomy and the public use of findings were treated as continuing responsibilities. Data analysis combined descriptive survey analysis with reflexive thematic analysis and collaborative interpretation, ensuring that findings were grounded both in empirical evidence and in the expertise of people with lived experience. This approach strengthened the credibility, relevance and practical value of the findings. It also reflects the central principle underpinning the project: public mental health research should not only study lived experience, but work with lived experience as a source of knowledge, interpretation and change.



Collaborative Interpretation Workshop June 2026

Chapter 4: The People Who Engaged with the Research

Chapter Summary

This chapter introduces the people who engaged with the Thrive LDN Public Mental Health Research Project and provides an overview of participation across the study. In total, 220 people contributed through five complementary components: 150 online survey respondents, 24 lived-experience interview participants, 29 focus group participants, 10 strategic stakeholder interviewees and seven active co-researchers. Together, they brought perspectives from people with lived experience of mental health difficulties, unpaid carers, community members, professionals, strategic leaders and people engaging with community-based support, employment, education and other aspects of everyday life across London.

Survey respondents came from a wide range of inner and outer London boroughs and reflected varied social, economic and community circumstances. The survey was not designed to be statistically representative of London's population, and the demographic profile presented here should therefore be understood as a description of the people who took part rather than of Londoners as a whole.

Half of survey respondents were aged between 45 and 64 years, although participants were represented across the adult life course. Women comprised 78.0% of survey respondents. The sample also included people from a range of ethnic backgrounds and a population with substantial direct experience of mental health difficulties. Almost nine in ten survey respondents reported current or previous mental health difficulties, alongside considerable experience of long-term physical health conditions, disability, caring responsibilities, employment pressures and barriers to accessing support.

The qualitative components broadened the range of perspectives represented. Interview participants ranged from 18 to 78 years of age and came from different ethnic backgrounds and areas of London. Focus groups brought together people from community and employment contexts, including women, men accessing digital inclusion support, unpaid carers, younger people and participants in a DWP employment focus group.

This profile provides important context for interpreting the findings that follow by making visible both the breadth of experiences represented and the limits of the sample from which the evidence was generated.

Introduction

This chapter describes the people who contributed to the Thrive LDN Public Mental Health Research Project. It provides an overview of participation across the online survey, lived-experience interviews, focus groups, strategic stakeholder interviews and co-research process. Recruitment, sampling and ethical procedures are described in detail in the Methodology and Ethical Governance chapter. The purpose here is to establish whose experiences, expertise and perspectives underpin the findings presented throughout the report.

Research component	Participants
Online survey	150
Lived experience interview participants	24
Focus groups	29
Strategic stakeholder interviewees	10
Active co-researchers	7
Total participants engaged	220

The characteristics of the study population are important to interpretation. Demographic information does more than describe who participated; it helps locate the findings within the social, economic and environmental circumstances in which mental health is experienced. This chapter therefore makes visible both whose voices contributed to the research and where the limits of representation lie.

Most of the detailed demographic analysis relates to the 150 respondents who completed the online public mental health survey. Brief profiles of interview and focus group participants are provided later in the chapter to contextualise the qualitative findings.

Survey responses were received from across inner and outer London, with particularly strong participation from south-east London. Respondents included people living in Bexley, Greenwich, Bromley, Lewisham, Southwark, Croydon, Wandsworth, Newham, Hackney, Waltham Forest, Islington, Harrow, Barking and Dagenham, Camden, Ealing, Hammersmith and Fulham, Hounslow, Richmond upon Thames and Westminster. The survey was not designed to provide a statistically representative sample of London's population, but it engaged people living within varied social, economic and community contexts.

Respondents also reflected considerable diversity in age, ethnicity, employment, health and life circumstances. Many were balancing paid work, caring responsibilities, financial pressures, long-term health conditions, disability or neurodivergence alongside their own mental wellbeing.

Age and Life Course

Respondents were represented across the adult life course, although participation was concentrated in midlife. The largest age group was 55–64 years (26.0%, n = 39), followed by 45–54 years (24.0%, n = 36). Adults aged 25–34 accounted for 18.0% (n = 27) and those aged 35–44 for 16.0% (n = 24). Younger adults aged 18–24 comprised 5.3% (n = 8), while respondents aged 65 years and above accounted for 8.0% (n = 12). Four respondents preferred not to disclose their age.

Exactly half of respondents (50.0%, n = 75) were aged between 45 and 64 years.

The age profile should not be interpreted as representative of London's wider population. It nevertheless provides perspectives from adults at different stages of employment, family life, caring and later life, all of which are relevant to understanding public mental health. limited circulation.



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Age	N	%
Under 18	0	0.0%
18–24	8	5.3%
25–34	27	18.0%
35–44	24	16.0%
45–54	36	24.0%
55–64	39	26.0%
65+	12	8.0%
Prefer not to say	4	2.7%

Gender

Women comprised 78.0% (n = 117) of survey respondents, while men accounted for 18.0% (n = 27). Three respondents identified as non-binary (2.0%), one preferred to self-describe (0.7%) and two preferred not to disclose their gender (1.3%).

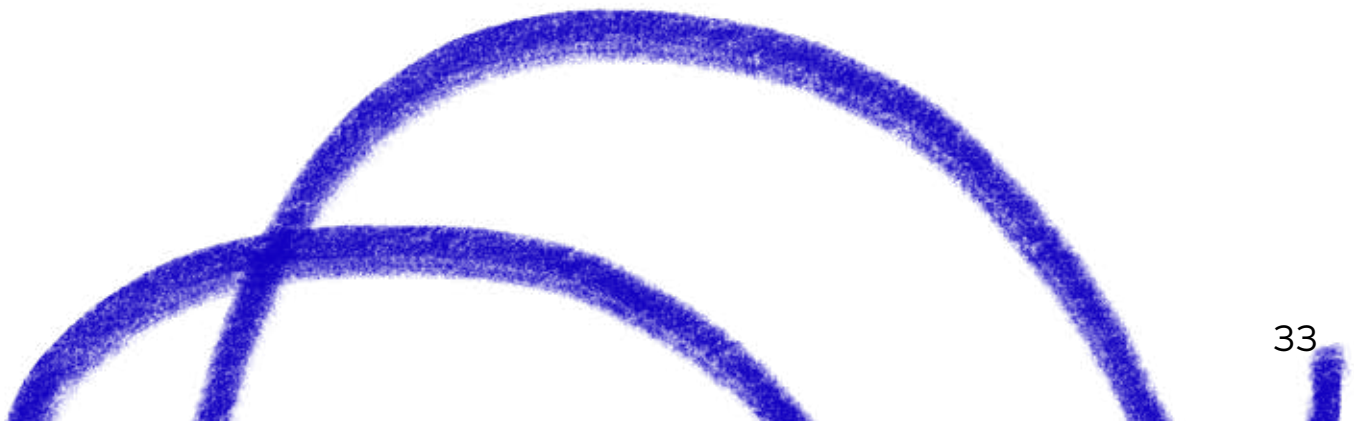
Women's higher participation is consistent with evidence that women are often more likely than men to participate in health and wellbeing research (Mackenzie et al., 2006). The gender distribution should nevertheless be taken into account when interpreting the findings, particularly because the sample does not reflect London's population profile.

Ethnicity

The survey included respondents from a range of ethnic backgrounds. The largest group identified as White English, Welsh, Scottish, Northern Irish or British (59.3%, n = 89). A further 9.3% (n = 14) identified with another White background, 1.3% (n = 2) as White Irish and 0.7% (n = 1) as White Gypsy or Irish Traveller. Respondents from White backgrounds therefore accounted for 70.7% of the survey sample.

Just over one-quarter of respondents, 26.0%, identified with Black, Asian, Mixed or other ethnic backgrounds. Asian or Asian British participants accounted for 10.7% (n = 16), Black or Black British participants for 10.0% (n = 15), participants from Mixed ethnic backgrounds for 3.3% (n = 5), and other ethnic backgrounds for 2.0% (n = 3). A further 3.3% (n = 5) preferred not to disclose their ethnicity.

Numbers within individual ethnic groups are too small to support meaningful subgroup analysis. The value of the profile lies instead in demonstrating that the findings were informed by people from multiple ethnic and cultural backgrounds while recognising that this diversity does not make the sample representative of London as a whole.



Ethnicity	N	%
White (English, Welsh, Scottish, Northern Irish, British)	89	59.3%
White (Irish)	2	1.3%
White (Gypsy or Irish Traveller)	1	0.7%
White (Any other)	14	9.3%
Mixed (White and Black Caribbean)	3	2.0%
Mixed (Any other)	2	1.3%
Asian or Asian British (Indian)	8	5.3%
Asian or Asian British (Pakistani)	0	0.0%
Asian or Asian British (Bangladeshi)	2	1.3%
Asian or Asian British (Chinese)	1	0.7%
Black or Black British (Caribbean)	4	2.7%
Black or Black British (African)	10	6.7%
Black or Black British (Any other)	1	0.7%
Other Ethnic Group (Any other)	3	2.0%
Asian or Asian British (Any other)	5	3.3%
Prefer not to state	5	3.3%

Mental Health Profile

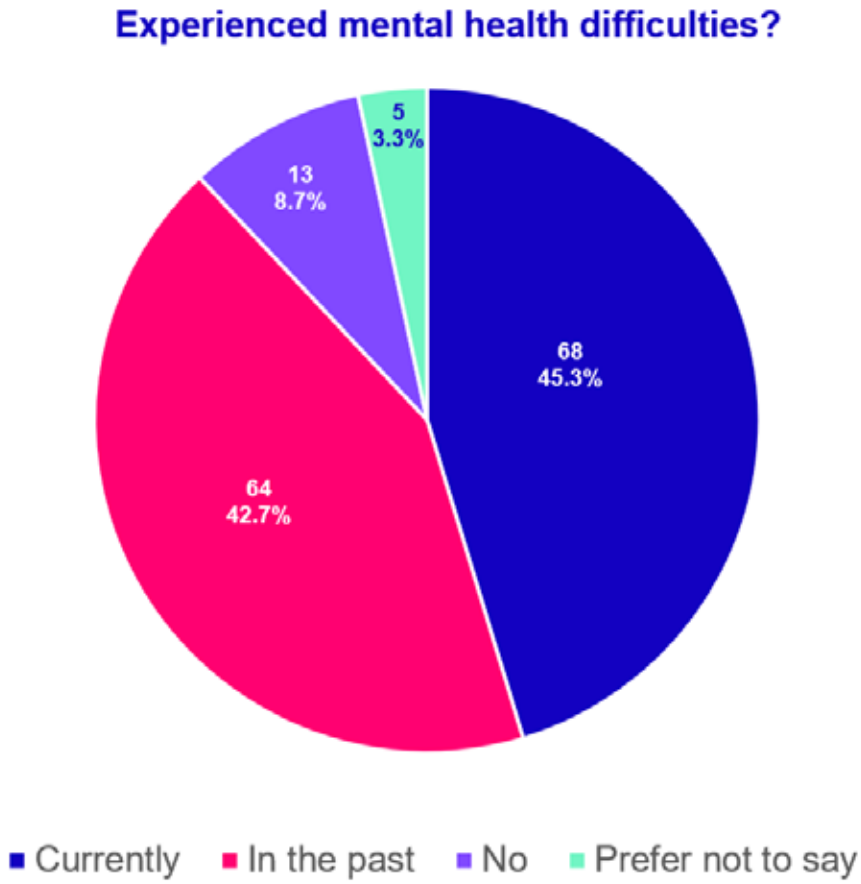
The survey engaged a population with substantial direct experience of mental health difficulties. Almost half of respondents (45.3%, n = 68) reported currently experiencing mental health difficulties, while a further 42.7% (n = 64) reported previous experience. Thirteen respondents (8.7%) reported no previous mental health difficulties and five (3.3%) preferred not to disclose this information. Overall, 88.0% of respondents reported current or previous experience of mental health difficulties.

Current wellbeing also varied considerably. Just over one-third of respondents described their mental wellbeing as mixed (36.7%, n = 55), while 32.0% (n = 48) rated it as good and 8.7% (n = 13) as very good. Almost one-quarter, 22.7% (n = 34), described their current mental wellbeing as poor or very poor.

Respondents could identify more than one mental health difficulty or experience, so percentages for this item are not mutually exclusive. Anxiety was the most frequently reported difficulty (74.7%, n = 112), followed by depression (66.0%, n = 99), burnout or chronic stress (60.0%, n = 90) and trauma (51.3%, n = 77). Loneliness was identified by 34.7% (n = 52), while 14.7% (n = 22) reported severe mental illness. Neurodivergence is considered separately below because it should not be conflated with mental illness.

These findings indicate that participants frequently experienced overlapping forms of psychological and emotional distress rather than isolated difficulties. Mental health also affected everyday functioning: 61.3% (n = 92) reported at least a moderate impact on daily life, including 30.7% (n = 46) reporting a significant impact and 8.0% (n = 12) a severe impact.

This profile is important to interpretation. Much of the survey evidence comes from people drawing on direct experience of psychological distress, support systems and the interaction between mental health and wider social circumstances.



Accessing Support: High Demand, Persistent Barriers

Almost two-thirds of survey respondents (64.0%, n = 96) reported attempting to access mental health support during the previous two years.

Percentages in this section are calculated using the full online survey sample (N = 150) rather than the sub-sample of 96 respondents who reported seeking support, so they describe the proportion of all respondents using each source. Readers comparing these figures with service-level data should keep that denominator in mind. Participants could select more than one response, so the percentages are not mutually exclusive.

Respondents reported using statutory, voluntary and independent sources of support. General practice was the most frequently reported source (35.3%, n = 53), followed by NHS talking therapies (32.0%, n = 48), private counselling or psychotherapy (24.7%, n = 37), online mental health support (16.0%, n = 24), crisis services (15.3%, n = 23), community organisations, charities and social enterprises (15.3%, n = 23), peer support (12.7%, n = 19) and workplace support (12.0%, n = 18).

Where did you seek support?	N	%
GP	53	35.3%
NHS therapy	48	32.0%
Crisis services	23	15.3%
Community organisation/Charity/Social Enterprise	23	15.3%
Peer support	19	12.7%
Faith/community group	3	2.0%
Online support	24	16.0%
Private therapy	37	24.7%
Workplace support	18	12.0%

Waiting times were the most frequently reported barrier (40.7%, n = 61), followed by cost (27.3%, n = 41), lack of locally available services (23.3%, n = 35), previous negative experiences (21.3%, n = 32), uncertainty about where to seek help (20.7%, n = 31) and eligibility thresholds (15.3%, n = 23). Stigma, digital barriers and cultural barriers were reported less frequently.

Two response options in the questionnaire captured local availability: an item asking whether support was local to the respondent (6.0 per cent, n = 9) and a separate item on lack of local services (23.3 per cent, n = 35). These should be read together rather than as independent barriers, and the wording of the first item is retained in the table below as it appeared in the survey.

Main barriers (tick all)	N	%
Waiting times	61	40.7%
Not knowing where to go	31	20.7%
Was it local to you	9	6.0%
Stigma	17	11.3%
Cost	41	27.3%
Cultural barriers	7	4.7%
Digital barriers	8	5.3%
Eligibility thresholds	23	15.3%
Lack of local services	35	23.3%
Negative past experience	32	21.3%

The pattern suggests that difficulties accessing support related not simply to willingness to seek help but to waiting, affordability, service availability, eligibility and the complexity of navigating support systems.

Neurodivergence, Disability and Physical Health

In a separate survey question, one-third of respondents (33.3%, n = 50) identified as neurodivergent, while a further 20.0% (n = 30) were unsure. This finding should be understood separately from mental health diagnoses and experiences and highlights the importance of accessibility and flexibility in public mental health support.

Long-term physical health conditions and disability were also common. Almost half of respondents (45.3%, n = 68) reported living with a disability or long-term health condition, while 6.7% (n = 10) were unsure. In a separate question concerning physical health conditions, 60.7% (n = 91) reported at least one long-term condition.

Reported physical health experiences included chronic pain (22.0%, n = 33), respiratory conditions (14.7%, n = 22), diabetes (8.7%, n = 13) and cardiovascular disease (4.7%, n = 7). Learning disability, dyslexia and dyspraxia were considered separately rather than classified as physical health conditions.
Self-rated physical health also varied, with 34.7% (n = 52) describing their health as fair, 18.7% (n = 28) as poor and 6.0% (n = 9) as very poor.

Taken together, these findings demonstrate substantial overlap between mental health, physical health, disability and neurodivergence within the survey population and support the need to understand wellbeing in whole-person rather than narrowly diagnostic terms.

Employment and Economic Circumstances

Respondents represented varied employment circumstances. Almost half were employed full-time (47.3%, n = 71), while 20.7% (n = 31) worked part-time. A further 13.3% (n = 20) were unable to work because of their health, 6.7% (n = 10) were retired, 6.0% (n = 9) were unemployed, 3.3% (n = 5) identified caring responsibilities as their current situation, 1.3% (n = 2) were students and 1.3% (n = 2) selected another category.

What best describes your current situation?	N	%
Working full-time	71	47.3%
Working part-time	31	20.7%
Unemployed	9	6.0%
Student	2	1.3%
Retired	10	6.7%
Unable to work due to health	20	13.3%
Caring responsibilities	5	3.3%
Other	2	1.3%

The profile demonstrates that mental health difficulties were experienced both within and outside paid employment. A substantial number of respondents were working while managing mental health difficulties, while others reported being unable to work because of their health.

In a separate survey question, 20.7% of respondents (n = 31) identified unpaid caring responsibilities as affecting their wellbeing. This is distinct from the smaller number who identified caring as their primary current situation. Caring therefore forms an important part of the social context in which the findings should be interpreted.

Digital Access, Health Behaviours and Physical Healthcare

Most respondents reported reliable digital access. Some 83.3% (n = 125) reported always having reliable internet access and 15.3% (n = 23) reported reliable access some of the time. Two respondents (1.3%) reported never having reliable access.

Do you have reliable internet access?	N	%
Always	125	83.3%
Sometimes	23	15.3%
Rarely	0	0.0%
Never	2	1.3%

Confidence in using digital services was also generally high: 58.7% (n = 88) described themselves as very confident and 33.3% (n = 50) as somewhat confident. Nevertheless, 8.0% (n = 12) reported limited confidence and 4.7% (n = 7) reported that digital exclusion had affected their mental health or ability to access support.

Digital exclusion was therefore uncommon within this particular sample but remains important when considering equitable access, particularly because an online survey is itself less likely to reach people experiencing the greatest digital exclusion.

More than half of respondents reported ongoing sleep difficulties (54.0%, n = 81), 40.0% (n = 60) reported low levels of physical activity and 28.7% (n = 43) described their diet as poor.

Smaller proportions reported smoking (8.0%, n = 12) or alcohol use above recommended levels (7.3%, n = 11). The survey also identified variation in engagement with preventive physical healthcare. Some 64.0% (n = 96) reported attending a GP health check during the previous two years, 29.3% (n = 44) an NHS Health Check, 24.7% (n = 37) routine physical health monitoring and 19.3% (n = 29) cancer screening. Twenty-two per cent (n = 33) reported none of these forms of preventive healthcare.

Taken together, the survey describes a population experiencing intersecting mental, physical, social and economic circumstances rather than a narrowly defined clinical group. This provides important context for the thematic findings that follow while remaining subject to the sampling limitations described throughout the report.

Understanding the Interview Participants

Twenty-four people participated in lived-experience interviews. Demographic information was available for 20 participants, while four chose not to disclose age, ethnicity or location. Participants with available demographic information ranged from 18 to 78 years. The sample was concentrated in mid and later adulthood, with nine participants aged 40–59 and nine aged 60 years or above.

The interview group included participants identifying with White British, White European, Indian, South Asian, Chinese, Sri Lankan and Black African backgrounds. White British participants formed the largest individual group (n = 11). Participants also came from different parts of London, including Bexley, Islington, Croydon, Harrow, Lambeth, Wandsworth and Greenwich.
The interview sample was not intended to be representative of London's population. Its value lies in bringing together people with differing ages, cultural backgrounds, geographical contexts and lived experiences for the qualitative analysis that follows.

Understanding the Community Focus Group Participants

The focus group strand involved 29 participants: 24 people across four community focus groups and five participants in an additional DWP employment focus group.

Individual demographic information was not collected for focus group participants. The groups themselves were selected to bring together people from different life stages and community contexts relevant to public mental health.

The community groups comprised a women's wellbeing group, the Sakinah Project (n = 8), a men's Digital Hub group (n = 7), an unpaid carers group (n = 5) and an Active Horizons young people's group (n = 4). The DWP employment focus group (n = 5) explored mental health in relation to employment, education, opportunity and access to work.

Each group contributed a different perspective. The Sakinah Project group brought experiences connected with family, employment and caring. The men's Digital Hub group brought perspectives from a community-based digital inclusion setting. The unpaid carers group contributed experiences of supporting relatives or friends, while Active Horizons brought younger people's perspectives on education, employment, identity and transition to adulthood. The DWP group added experiences associated with employment, health, disability, neurodivergence and barriers to work.

Together, these groups broadened the range of social and community contexts represented within the qualitative evidence. Alongside survey respondents, interview participants, strategic stakeholders and co-researchers, they contribute to a broader understanding of how public mental health is experienced across different parts of London.

Findings

Chapter 5: People Need People – Relationships as the Foundation of Public Mental Health

“Sometimes a friendly chat will save a life.”
(Survey Respondent 114, female, aged 25–34 years.)

Chapter Summary

This chapter presents the first and most prominent theme emerging from the Thrive LDN Public Mental Health Research Project: the central importance of relationships in shaping mental health and wellbeing. Drawing together evidence from the online survey, lived-experience interviews, community focus groups, the wider focus group strand and strategic stakeholder interviews, it demonstrates that participants understood mental wellbeing as more than an individual psychological state, and as something created, sustained and protected through relationships with family, friends, neighbours, communities and trusted organisations.

Across the research, participants returned to one simple but powerful proposition: people need people. Relationships were described not merely as sources of support during periods of distress, but as the primary mechanism through which people coped with bereavement, financial insecurity, caring responsibilities, discrimination, physical illness and loneliness. Participants consistently framed prevention not as early clinical intervention alone, but as maintaining meaningful connections, opportunities for everyday conversation and access to welcoming community spaces before difficulties escalated into crisis.

The chapter demonstrates strong convergence across the survey, interviews, focus groups and strategic stakeholder interviews. Participants emphasised that listening, belonging and trusted human connection were fundamental to good mental health. These findings suggest that while wider social determinants shape people’s lives, their impact is often experienced and negotiated through relationships.

This theme provides the conceptual foundation for the chapters that follow. Rather than representing one determinant among many, relationships emerged as the thread connecting participants’ experiences across the life course and across different communities, laying the foundations for the *Relational Model of Public Mental Health* developed later in this report.

Relationships Matter

The demographic profile set out in Chapter 4 provides the context for the theme examined here.

Across every stage of the research, participants returned to one remarkably consistent proposition: people need people. Whether discussing bereavement, caring responsibilities, financial pressures, poor physical health, discrimination or difficulties accessing support, participants rarely understood these experiences in isolation.



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Instead, they explained that the impact of life's challenges was shaped by the presence, or absence, of trusted relationships, supportive communities and opportunities to connect with others. Mental wellbeing was therefore understood as more than an individual experience, and as something created, sustained and protected through relationships with family, friends, neighbours, colleagues and wider communities.

This finding emerged clearly within the survey data. Friends and family were identified as the greatest source of local support by over three-quarters of respondents (76.7%, n = 115). However, this contrasted sharply with how connected respondents felt within their own communities. Only 12.7% (n = 19) reported feeling very connected to their local community, while over half (54.7%, n = 82) described themselves as either not very connected (41.3%, n = 62) or not connected at all (13.3%, n = 20). More than one-third of respondents (34.7%, n = 52) identified loneliness as affecting their mental health, and almost half (48.7%, n = 73) believed that improving social connection would help prevent mental health problems from worsening.

These quantitative findings were reinforced throughout the interviews and focus groups. Participants consistently described relationships as far more than sources of comfort during periods of emotional distress. Rather, they were viewed as protective resources that enabled people to cope with adversity, maintain hope and prevent mental health difficulties from escalating into crisis. Belonging, friendship, volunteering, peer support, community groups and opportunities for ordinary conversation were described as creating the conditions in which mental wellbeing could be sustained.

Importantly, participants rarely described loneliness simply as being physically alone. Instead, they spoke of emotional disconnection, the absence of trusted relationships and the loss of opportunities for meaningful conversation. As one woman aged 45–54 years reflected:

"Knowing you are surrounded by so many people yet still alone." (Survey Respondent 120, female, aged 45–54 years.)

Similarly, a male respondent aged 35–44 years observed:

"London can be a very lonely place. It's hard to make real friends." (Survey Respondent 92, male, aged 35–44 years.)

These reflections suggest that living within one of the world's largest and most densely populated cities did not necessarily protect people from profound isolation. Rather, participants described loneliness as arising from the absence of meaningful relationships rather than simply the absence of other people.

CREATIVE OUTPUT | Research Poetry as Knowledge Translation

The following poem is presented as a creative knowledge-translation output, developed through thematic synthesis of the study material and creative revoicing (Palmer, 2026). It draws together recurring themes and participant testimony from across the survey, interviews and focus groups, with language shaped into a composite poetic narrative rather than representing the verbatim account of any one participant. The purpose is not to introduce new findings, but to communicate the lived and emotional meaning of those already identified: loneliness, fragmented neighbourhoods, the loss of everyday community spaces, and the importance of being noticed, expected and known. By using testimony and creative revoicing in this way, the poem seeks to make these experiences more visible and memorable, supporting wider understanding and awareness of the relational conditions that can protect mental health before formal support or crisis intervention is needed.

Who Would Notice?
D. A. Palmer

From Camden to Brent,
Bexley to Richmond,
there are millions of us here.
That is what makes the loneliness harder to explain.
We sleep a few feet from strangers.
Hear their televisions through the wall.
Recognise their footsteps on the stairs.
And still do not know their names.
“We are definitely fragmented in our neighbourhoods,
our communities and London as a whole.”
Perhaps it happened quietly.
The meeting room stopped opening.
The social club lost its funding.
The corner cafe became somewhere to pass through, not stay.
The familiar faces scattered.
And we lost more than buildings.
We lost the accidental conversation.
The chair pulled out for somebody else.
The person who noticed you had gone quiet.
The place where somebody knew your name
before they needed to know what was wrong.
Without those things,
the distance between people grows.
Suspicion finds room.
Confidence retreats.
Going out becomes something to think about
rather than something you simply do.
One missed conversation becomes a week.
A week becomes a habit.
The world beyond the front door gets harder to enter.
And this is how someone can begin to disappear.
Not always with a crisis.
Not always where anybody can see it.
Sometimes it is a life becoming smaller.
A person speaking less.
Trust disappearing.
Anxiety starts deciding where they go,
who they meet,
how much of themselves they allow the world to see.
“It’s easier when you know people actually want you there.”
That sentence matters.
Perhaps community is not simply
people living in the same place.
Perhaps it is knowing
there is somewhere you are expected,
somebody who knows your name,
somebody who would recognise your absence.
So look at the doors along your street.
Who lives behind them?
And if someone behind one of those doors
started quietly disappearing,
who would notice?
Who would knock?

Relationships as Prevention

One of the strongest findings emerging across the study was that participants understood relationships as more than sources of support during periods of poor mental health, treating them as fundamental mechanisms for preventing distress from escalating into crisis. Across the survey, lived-experience interviews, focus groups and stakeholder interviews, prevention was rarely framed as early clinical intervention alone. Instead, participants consistently described it as something rooted in everyday human connection: having someone to telephone, somewhere to go, people who noticed when they had not attended, neighbours who checked in and community groups that created routine, purpose and belonging.

Survey respondents linked good mental wellbeing with feeling connected to other people. While respondents valued improved access to mental health services, they were equally likely to identify stronger social relationships, welcoming community spaces and earlier relational support as important ways of preventing mental health problems from worsening. More than half of respondents (55.3%, n = 83) believed that earlier support would improve mental wellbeing, while almost half (48.7%, n = 73) identified improving social connection as a key preventative measure. Together, these findings suggest that participants understood prevention as extending well beyond healthcare systems alone.

This understanding was reinforced throughout the lived-experience interviews. Participants rarely described a single event that transformed their mental health. Instead, they spoke about how ordinary relationships helped them navigate bereavement, caring responsibilities, financial insecurity, loneliness and declining physical health before these pressures became overwhelming. Prevention was therefore experienced less as a specific intervention than as an ongoing process of remaining connected to people, places and communities that provided encouragement, routine and a sense of belonging.

The focus groups echoed this perspective. Participants repeatedly described the importance of having trusted places where they could speak openly, share everyday experiences and feel accepted without judgement. These environments were valued not because they offered specialist interventions, but because they fostered relationships that reduced isolation, strengthened resilience and enabled people to seek support before reaching crisis point.

These findings suggest that participants understood prevention as inherently relational. While access to timely clinical care remained important, relationships were consistently described as the first line of support, protecting mental wellbeing long before formal services became necessary. Participants located prevention within the ordinary relationships, conversations and community connections that enabled people to feel seen, valued and supported throughout everyday life. Few described it as something healthcare systems deliver on their own.

The Power of Ordinary Conversation

Perhaps the most striking finding across the study was the importance participants attached to ordinary conversation. Across the main evidence strands of the research, respondents distinguished between professional intervention and everyday human interaction. While counselling, therapy and specialist mental health services were widely recognised as valuable, participants explained that simple conversations with trusted people often had an equally profound influence on their wellbeing.

Survey respondents frequently described wanting to be listened to rather than judged. They spoke of the importance of people who took the time to understand rather than immediately offer advice or solutions, and of having opportunities to speak openly without fear of criticism or stigma. This emphasis on being heard rather than immediately "fixed" recurred across the survey.

One participant reflected on the importance of finding:

"People who take the time out to listen and understand, not assume or make judgements."
(Survey Respondent 135, female, aged 35–44 years.)

For younger participants, the issue was often one of recognition as much as support. One young woman explained:

"To be heard and listened to as more often single people are less heard if they have no support whatsoever."
(Survey Respondent 147, female, aged 18–24 years.)

These survey findings were reinforced throughout the lived-experience interviews. Bill described how his mental health deteriorated following the death of his mother, for whom he had been the primary carer. Living alone for the first time, he explained that the greatest challenge was not simply bereavement but the silence that followed.

"Being alone... that's the hardest because it leaves you with your thoughts."

He described how prolonged periods without conversation allowed negative thoughts to become increasingly difficult to interrupt. For Bill, loneliness was more than the absence of company. He described becoming trapped within his own thoughts, particularly on days when he struggled to leave home. Isolation gradually eroded both his confidence and motivation, making it increasingly difficult to reconnect with other people.

Despite these challenges, Bill deliberately attended community activities because they offered something that could not be recreated while sitting alone.

"Sometimes I have to force myself because of my mental health to come out... once I'm here, I feel better."

Asked what had helped him most, his answer was remarkably simple:

"Talking... it's quite simple really."

Bill's reflections encapsulate one of the central findings of this study. Participants repeatedly suggested that the value of conversation did not lie in solving problems or providing professional advice. Rather, talking itself created connection, interrupted isolation and reminded people that they were neither invisible nor facing their difficulties alone.

This distinction emerged across the interviews. Sarah described the importance of ***"connection to other people, connection to talk, connection to not feel isolated or lonely",*** before adding that despite often being surrounded by others, ***"they're not listening to me."***

Her account highlights an important distinction running throughout the research. Participants were rarely describing an absence of people; instead, they described an absence of meaningful relationships in which they felt genuinely heard, understood and accepted.

Maria similarly described attending a community group where she experienced a sense of belonging that had been absent elsewhere.

"I feel belong to that group and it makes me feel happy because they know me and I know them."

Unlike many formal services, participants described these community settings as places where relationships developed naturally over time. Staff, volunteers and fellow members remembered their names, noticed when they had been absent and created environments where they felt safe to speak honestly. Across the interviews, these seemingly ordinary acts of kindness were described as having an extraordinary influence on participants' confidence, resilience and overall wellbeing. These findings suggest that conversation itself functioned as a form of relational support.

Participants consistently portrayed listening, empathy and genuine human presence not as peripheral aspects of mental health, but as fundamental resources that sustained wellbeing, fostered belonging and helped prevent distress from escalating into crisis.

Community Voices: Relationships in Practice

The importance of relationships extended beyond the individual interviews and was reinforced across the community focus groups. Although the groups represented different communities and life experiences, including unpaid carers, participants attending the Digital Hub, women participating in the Sakinah Project and young people involved in Active Horizons, they returned to remarkably similar conclusions. Across these groups, participants emphasised the importance of belonging, trust and meaningful human connection, despite discussing very different personal circumstances.

Participants consistently distinguished between being surrounded by people and feeling genuinely connected to others. Loneliness was rarely described as simply being alone. Instead, it reflected the emotional consequences of carrying responsibilities without adequate support, feeling unable to speak openly about personal difficulties or lacking trusted spaces where they could be themselves without fear of judgement.

This was particularly evident within the unpaid carers focus group. Participants described caring as emotionally demanding and socially isolating, explaining that the constant responsibility of supporting another person often left little opportunity to maintain friendships, pursue personal interests or prioritise their own wellbeing. One participant reflected:

"It's lonely, really lonely and at times it's too much. I'm dealing with it all mostly on my own and at times it's too much. Digital apps and telephone support are fine but really you just want to speak to another person, preferably someone who understands what you are going through…not find a solution, just listen, be there and be a shoulder to lean on."
(Female, Unpaid Carers Focus Group.)

This account reflects one of the clearest findings emerging across the wider study. Participants were not necessarily seeking solutions or immediate intervention. Instead, they described the value of empathy, shared understanding and simply knowing that another person was willing to remain present and listen. Caring was frequently experienced as an invisible form of emotional labour, leaving participants feeling overlooked despite providing substantial support to others. Recognition, understanding and opportunities to connect with people who genuinely understood their experiences were therefore viewed as important sources of emotional protection as well as practical support.
Similar experiences emerged within the Digital Hub focus group. Although participants had initially joined the programme to improve digital confidence and access to technology, discussions quickly shifted towards loneliness, belonging and the importance of face-to-face relationships. As one participant explained:

"Loneliness, mate, that's the big problem. I don't have many around me that I can talk to or feel comfortable sharing things with, you know? It's hard and the isolation thing definitely impacts on me and is a significant reason as to why I am like this in the first place. There just isn't that human interaction and I guess a tablet can't fix loneliness."
(Male, Digital Hub Focus Group.)

Participants acknowledged that technology could improve access to information, services and opportunities for communication. However, they consistently distinguished communication from connection. Digital tools were valued as helpful resources, but they were not viewed as substitutes for trusted relationships or meaningful face-to-face interaction. Across the focus groups, participants argued that while technology could facilitate contact, it could not replicate the reassurance, empathy and sense of belonging created through genuine human relationships.

Women participating in the Sakinah focus group echoed many of these experiences while also highlighting the importance of culturally trusted community spaces. Participants described these organisations not simply as places where support was available, but as environments where they felt welcomed, respected and accepted without judgement. One woman described the role of the group through a simple but powerful metaphor:

"It's like a pillow. Pillows for support."
(Female, Sakinah Focus Group.)

This metaphor captures the emotional safety participants associated with trusted community organisations. Women described these settings as places where friendships developed, confidence grew and they experienced a genuine sense of belonging, and seldom as services at all. Although the Sakinah Project reflected the experiences of predominantly Muslim and ethnically diverse women, participants described priorities that closely mirrored those emerging elsewhere in the study. Relationships, belonging and trusted community support remained central, while also illustrating how these experiences were shaped by culture, faith, family and community identity.

Young people participating in the Active Horizons focus group similarly emphasised the importance of connection, belonging and acceptance. Discussions centred on confidence, identity and feeling recognised by peers and trusted adults. Community activities were described not simply as recreational opportunities but as psychologically safe environments where friendships developed naturally and young people felt genuinely wanted and valued for who they were, rather than defined by their circumstances.

Across the discussion, young people repeatedly described the importance of having somewhere to go, people to talk to and opportunities to share everyday experiences with others who understood.

These community settings reduced isolation, strengthened confidence and enabled participants to seek reassurance before problems escalated. These activities functioned as relational spaces where wellbeing was actively nurtured through belonging, mutual support and shared experience, and their value extended well beyond leisure. The community focus groups demonstrated remarkable consistency despite representing very different populations. Whether discussing caring responsibilities, digital exclusion, cultural identity or adolescence, participants returned to the same central proposition: mental wellbeing was sustained through trusted relationships, meaningful conversation and communities in which people felt recognised, valued and connected.

Convergence Across the Research

Perhaps the clearest indication of convergence across the study was the remarkable consistency of findings across the main evidence strands. Survey respondents, lived-experience interview participants, focus group members and strategic stakeholders described relationships as fundamental to maintaining good mental health, despite representing diverse communities, professional perspectives and life experiences.

Across the survey, participants repeatedly identified loneliness, social disconnection and the absence of meaningful relationships as important influences on their mental wellbeing. The lived-experience interviews added depth to these findings, illustrating how bereavement, caring responsibilities, financial insecurity, declining physical health and discrimination became more manageable when individuals remained connected to trusted people and supportive communities. Similarly, the focus groups demonstrated that although experiences differed across unpaid carers, Digital Hub participants, women attending the Sakinah Project and young people involved in Active Horizons, participants consistently returned to the importance of belonging, being listened to and feeling understood.

Strategic stakeholders reinforced these lived experiences. Participants working across health, local government and voluntary sector organisations argued that improving public mental health required investment not only in clinical services but also in the community infrastructure that enables relationships to flourish. One senior stakeholder described community organisations as:

“The glue that often holds people together before they reach crisis.”

Others argued that voluntary and community organisations created opportunities for trust, belonging and everyday human connection that statutory services alone could not provide. These strategic perspectives closely reflected the experiences described throughout the survey, interviews and focus groups, reinforcing the importance of understanding public mental health as extending beyond healthcare systems alone.

“We can commission a service in six months. We can’t commission trust, familiarity or that feeling of walking through the door and somebody already knowing who you are” (Strategic stakeholder)

Researchers made similar observations throughout data collection. Interviews frequently continued long after the recording had ended, with participants commenting that they rarely had opportunities to speak openly about their experiences. Several thanked researchers simply for listening. Within the focus groups, participants often nodded in agreement, completed one another’s sentences and reassured one another that they were “not the only one.” These observations suggest that the research process itself became relational, illustrating the importance participants attached to being heard, recognised and understood without judgement.

"When I stopped the recording she carried on talking about things. She said nobody had really asked her any of this before." (Co-researcher reflection.)

Across the main evidence strands, listening emerged as an important intervention in its own right. Whether discussing bereavement, caring responsibilities, financial hardship, discrimination, physical illness or loneliness, participants rarely expected others to solve their problems. Instead, they consistently valued empathy, compassion and opportunities to share experiences with people who genuinely understood. The consistency of these findings across multiple sources of data strengthens confidence that relationships, belonging and meaningful human connection were not isolated experiences but fundamental features of how participants understood and maintained mental wellbeing.

Rather than identifying relationships as one determinant among many, the convergence of evidence suggests that they function as the mechanism through which many wider social, economic and environmental influences are experienced. In other words, while public mental health is shaped by structural determinants, participants described relationships as the means through which those determinants either protected or undermined wellbeing. This proposition forms the foundation for the conceptual model developed later in this report.



Collaborative Interpretation Workshop June 2026

Chapter 6: Living Under Constant Pressure – The Accumulation of Everyday Pressures

“I’m working but constantly trying to get more hours so that I can keep afloat, but I’m drowning.”
(Interview participant)

Chapter Summary

This chapter presents the second major theme emerging from the Thrive LDN Public Mental Health Research Project: the accumulation of everyday pressures and the emotional weight of modern life. It demonstrates that participants rarely attributed declining mental wellbeing to one event, diagnosis or life circumstance. Instead, they described lives in which financial insecurity, insecure employment, caring responsibilities, poor physical health, bereavement, loneliness and uncertainty gradually combined over time.

Across the research, participants consistently resisted simple or individualised explanations for poor mental health. They did not describe distress as a sudden collapse, but as the cumulative consequence of trying to keep going while responsibilities intensified and opportunities for recovery diminished. Work, welfare, education, housing, health and relationships were experienced as closely connected rather than separate parts of life.

The additional DWP employment focus group strengthened this theme by showing how employment, unemployment, education and access to opportunity are public mental health issues. Participants described work as closely linked to identity, dignity, confidence, financial security and belonging. However, inaccessible workplaces, discrimination, poor reasonable adjustments, insecure employment and limited routes into work, particularly for people living with neurodivergence, disability or long-term health conditions, could also become significant sources of distress.

Read alongside Chapter 5, these findings show how cumulative social and economic pressures erode the relational foundations of good mental health. If relationships, belonging and meaningful human connection help people remain well, then poverty, insecure work, caring responsibilities, ill health and uncertainty progressively reduce the time, energy and confidence needed to sustain those connections. Prevention therefore requires attention not only to mental health services, but to the wider conditions through which people live, work, care and belong.

Living Under Constant Pressure

Chapter 5 established relationships as the foundation of good public mental health. Participants were equally clear that those relationships existed within lives of continual pressure, and that emotional wellbeing was eroded gradually through the accumulation of financial insecurity, employment demands, caring responsibilities, poor physical health, loneliness, bereavement and uncertainty about the future.

A defining feature of this theme was that participants resisted simple explanations for poor mental health. Few people identified one dominant cause. Instead, they narrated lives characterised by continual adaptation, where ordinary pressures accumulated over time until they became increasingly difficult to sustain.

Financial insecurity affected housing and employment; physical illness reduced independence and opportunities to work; caring responsibilities limited time for rest and self-care; loneliness intensified existing anxiety; and uncertainty about the future permeated everyday decision-making. Collectively, these accounts suggest that mental distress was experienced not as a series of isolated adversities, but as the cumulative consequence of multiple intersecting pressures operating across the life course.

The demographic profile of survey respondents provides important context for these findings. Half of respondents were aged between 45 and 64 years (50.0%, n = 75), women comprised the majority of respondents (78.0%, n = 117), one-third identified as neurodivergent (33.3%, n = 50), and almost half reported living with a disability or long-term health condition (45.3%, n = 68). These characteristics are significant because many respondents occupied several roles simultaneously. Participants described balancing employment alongside caring responsibilities, managing chronic illness whilst maintaining family life, or coping with financial insecurity during periods of bereavement or changing health. Consequently, declining mental wellbeing was rarely attributed to one dominant stressor; instead, it reflected the interaction of multiple social, economic and personal circumstances unfolding concurrently.

Survey responses reinforced this interpretation. 62.0% of respondents (n = 93) reported that the rising cost of living had negatively affected their mental health, making it the most commonly reported influence on wellbeing. Respondents also identified loneliness, housing insecurity, physical health problems, insecure employment and uncertainty about the future as important determinants of emotional wellbeing. Importantly, these issues were rarely discussed in isolation. Participants linked economic concerns with relationships, community connection, health and everyday functioning, demonstrating an understanding of mental health that extended well beyond access to clinical services.
One woman aged 55–64 years described how financial insecurity had become inseparable from her emotional wellbeing:

"Housing and economic pressures (are) causing high levels of stress, anxiety, depression and feelings of being overwhelmed again and again and again."
(Survey respondent, female, aged 55–64 years.)

Rather than describing housing simply as an economic issue, her account illustrates how financial insecurity undermined feelings of safety, stability and control within everyday life. Similarly, a young male respondent connected economic pressure, employment and social disconnection:

"Employment support, financial pressures and worries and loneliness exacerbated by COVID and fragmented communities."
(Survey respondent, male, aged 18–24 years.)

Although separated by generation and life stage, both respondents described remarkably similar experiences in which financial insecurity, uncertainty and social disconnection became mutually reinforcing. Other survey responses echoed these concerns, linking the cost of living with low morale, disconnected communities, hopelessness, housing pressure and isolation. These accounts demonstrate that participants rarely experienced financial hardship as an isolated economic issue. Instead, rising living costs were consistently associated with diminishing optimism, reduced community cohesion and increasing emotional distress.

Perhaps the clearest illustration of cumulative pressure emerged from one Digital Hub focus group participant who reflected upon more than a decade of persistent financial insecurity:

"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, high fuel prices, the rising cost of clothing and basics... everything is madly expensive. It's impossible to keep going and the stress on my health, the constant worry, the worry about everything and the impact. It's ongoing, it's day to day… debt, more debt… rising debt. It's circular, and even talking about it is making me a bit unwell to be honest."
(Digital Hub Focus Group participant.)

This account extends far beyond concerns about income. It reveals how prolonged financial insecurity gradually permeated almost every aspect of everyday life. Employment, housing, debt, family responsibilities and physical health became inseparable from emotional wellbeing. Particularly striking is the participant's observation that even talking about these pressures made them feel unwell. This suggests that financial insecurity had become embodied through persistent anxiety and chronic stress, illustrating how long-term economic pressures can influence mental wellbeing long before an individual reaches crisis point.

Employment featured prominently within these narratives, yet participants rarely described work itself as the sole source of poor mental health. Instead, employment became another point at which multiple pressures converged. Younger respondents commonly discussed insecure contracts, limited opportunities and uncertainty regarding future housing. Participants in midlife more frequently described balancing employment alongside caring responsibilities, rising living costs and emerging physical health problems. Older respondents reflected upon working beyond anticipated retirement because of continuing financial obligations. Although these experiences differed according to life stage, the underlying narrative remained remarkably consistent: paid employment no longer guaranteed financial security or psychological stability.

The DWP employment focus group added further depth to these findings by showing how work, unemployment, education and access to opportunity were closely connected to mental health. Participants did not describe employment simply as an economic issue. Work was linked to identity, confidence, independence, stability, dignity and belonging. When employment was supportive, properly adjusted and built around individual strengths, it could protect wellbeing. However, when work was insecure, inaccessible, discriminatory or poorly adapted to people's needs, it could become a significant source of distress.

Participants described barriers including stigma, misunderstanding, discrimination, lack of reasonable adjustments, insecure employment, ageism, financial pressure, poor employer awareness and limited access to specialist employment support. These barriers were particularly acute for people living with neurodivergence, long-term physical health conditions, invisible disabilities or previous negative experiences of work. One participant described the cumulative effect of repeated workplace exclusion:

"Stigma, feeling misunderstood, discrimination, financial, career progression, relationships and my age has been against me for some time now in relation to work."
(DWP Employment Focus Group participant.)

The focus group also highlighted the emotional impact of losing work. Employment loss was not experienced only as loss of income, but as a loss of confidence, identity, independence and security. One participant explained:

"My mental health took a severe battering when I lost my employment a few years ago."
(DWP Employment Focus Group participant.)

These accounts strengthen the wider finding that mental health difficulties often develop through the accumulation of everyday pressures. Employment problems were rarely separate from other forms of adversity. They interacted with financial insecurity, housing pressure, physical health, caring responsibilities, confidence, self-worth and access to support. For some participants, poor workplace experiences reinforced longstanding feelings of being misunderstood or judged. For others, the absence of early, specialist employment support meant that difficulties escalated before effective help was available.

For younger participants, concerns extended beyond simply finding employment to questioning whether education itself continued to offer a realistic pathway towards opportunity and financial stability. Several described entering adulthood burdened by significant debt whilst facing an increasingly insecure labour market, so that higher education felt less like an investment in their future than a liability. As one young participant reflected:

"There just isn't any work and that's becoming a major issue for my generation. You come out with £50,000 worth of debt from doing a degree and you'll be lucky to get something at Tesco. There's nothing, absolutely nothing out there. It's really hard to get a job, even in a cafe or shop. It's dire. It really is and the impact is huge on confidence, self-esteem, low mood, mental health generally."
(Survey respondent, male, aged 18–24 years.)

This account reflects more than anxiety about graduate employment. It reveals a profound sense of disillusionment with the promise that education will lead to secure employment and upward social mobility. Instead of anticipating opportunity, this participant described entering adult life with substantial debt but limited prospects, illustrating how concerns about future security had become embedded within everyday experiences of mental wellbeing.

The DWP employment focus group provided further insight into young people's access to work, education and training. Participants challenged the idea that young people's employment difficulties are simply about motivation. Instead, they described a labour market in which young people are expected to have experience before they can access opportunities, while also facing fewer entry-level roles, low confidence, stigma, stereotypes and increasingly automated recruitment processes.

"Lack of opportunities, young people do not have the experience so it becomes a catch 22."
(DWP Employment Focus Group participant.)

"Mental health challenges, fewer entry level job vacancies, automated recruitment processes, lack of required work experience (the catch 22), lack of confidence, age discrimination and stereotypes."
(DWP Employment Focus Group participant.)

These accounts suggest that young people's employment difficulties should be understood as a public mental health issue, not simply a labour market issue. Lack of opportunity, repeated rejection, low confidence, stigma and limited access to early support can undermine wellbeing before young people have had the chance to establish financial independence, identity or a stable route into adulthood. At the same time, participants were clear that good employment support could be protective. Support that was relational, specialist and attentive to mental health, neurodivergence and disability helped people feel understood, regain confidence and remain connected to opportunity.

One participant explained that what mattered was:

"Being treated as an individual who matters and treated with dignity and respect, feeling heard, listened to and understood."
(DWP Employment Focus Group participant.)

Employment, education and opportunity are therefore not separate from public mental health. They are part of the everyday conditions through which people experience dignity, security, confidence, participation and hope. Supporting people to enter, remain in or return to good work should therefore be understood as a form of public mental health prevention.

A young woman aged 18–24 years highlighted another dimension of this uncertainty, explaining that there was a need for everyday spaces where young people could meet others and discuss worries before they intensified:

"A lack of real opportunities to just go out and meet others and discuss issues and worries in everyday spaces."
(Survey respondent, female, aged 18–24 years.)

Her observation provides an important bridge between Themes One and Two. Whilst participants identified relationships and belonging as protective factors for mental wellbeing, they simultaneously described social and economic conditions that increasingly undermined opportunities to experience those very connections. These findings challenge explanations of mental health that focus upon single causes or individual vulnerability. Instead, respondents portrayed emotional wellbeing as something continually shaped by the interaction of financial insecurity, employment, housing, physical health, community relationships and uncertainty about the future. Mental health rarely deteriorated because of one event. Rather, it deteriorated because participants had been carrying multiple intersecting pressures for prolonged periods with few opportunities for recovery.

When Pressures Collide: Lives Shaped by Accumulation Rather Than Crisis

Whilst the survey demonstrated the breadth of pressures affecting participants' mental wellbeing, the lived-experience interviews revealed how these pressures accumulated and interacted across the life course. Participants rarely structured their stories around a single issue. Instead, conversations evolved organically, often beginning with one experience before gradually revealing a much broader narrative in which bereavement, declining physical health, employment, caring responsibilities, loneliness and financial insecurity had become deeply intertwined.

This cumulative pattern was evident from the outset of many interviews. One woman who had recently lost a job she loved explained:

"I am currently focussing on getting through just one day at a time."
(Lived-experience interview participant.)

Rather than describing one defining crisis, her reflection illustrates the gradual narrowing of emotional capacity described throughout this theme. Faced with the combined effects of job loss, uncertainty and the loss of a valued role, her attention had become directed towards managing each day as it came. This emphasis on endurance rather than recovery reinforces the wider finding that participants experienced declining mental wellbeing as the cumulative consequence of multiple everyday pressures rather than a single adverse event.

One of the most striking features of the interviews was the absence of clear boundaries between different determinants of mental health. Participants rarely distinguished between physical and emotional wellbeing, employment and financial security, or relationships and loneliness. Instead, these experiences were described as mutually reinforcing, illustrating how the cumulative burden of everyday life gradually diminished emotional resilience over time.

Across the interviews, participants demonstrated that cumulative pressure was not confined to major life events such as bereavement, redundancy or serious illness. Equally important were the gradual disruptions to the ordinary routines that helped people remain emotionally well. Several participants described how relatively small changes, poor sleep, cancelled appointments, declining physical health, increasing caring responsibilities or financial worries, combined over time until coping became significantly more difficult.

One interview participant illustrated this process through the importance of routine. Rather than describing one catastrophic event, he returned to the role that structure played in maintaining emotional wellbeing:

"When I've got a handle on structure, the rest tends to fall into place generally."
(Lived-experience interview participant.)

For this participant, structure extended beyond organisation or time management. It encompassed maintaining regular sleep, exercise, meals, medication, appointments and avoiding becoming overwhelmed by competing demands. As he explained:

"Structure in the sense of exercise, breakfast, sleep, daily activities, appointments... getting that structure and that balance right is really important for me."
(Lived-experience interview participant.)

Reflecting on a recent deterioration in his wellbeing, he described how relatively minor disruptions gradually accumulated following a break:

"I came back from some time out, I hadn't been going to the gym, a couple of appointments were cancelled and it's taken me almost two weeks to get myself back on track."
(Lived-experience interview participant.)

Rather than describing a sudden crisis, this account illustrates how seemingly ordinary disruptions progressively reduced his capacity to cope. Importantly, these experiences resonate with the wider dataset, where participants repeatedly described emotional wellbeing as being sustained through everyday protective routines that could be gradually undermined by the accumulation of seemingly minor pressures.

Sleep emerged as another recurring example of the interaction between physical and emotional wellbeing. Participants understood poor sleep as something that shaped every other aspect of their lives, and not only as a symptom of declining mental health. One interview participant explained:

"If I got my sleep right, I tend to be able to cope better... when I haven't got my sleep right, I think a lot of problems stem from that."
(Lived-experience interview participant.)

A focus group participant described the same experience in more immediate terms, illustrating how disturbed sleep created a self-perpetuating cycle of exhaustion, worry and declining emotional wellbeing:

"I don't sleep, and if I don't sleep it impacts me during the day. I can't function and I get down and low. At night things circle round me and I worry, and worry, and worry. I have to get up at three and have a cup of tea, and by the morning I'm just whacked... and it starts again."
(Focus group participant.)

Rather than viewing sleep as a secondary consequence of poor mental health, participants frequently described it as one of the mechanisms through which everyday pressures accumulated. Disturbed nights reduced emotional resilience during the day, making it increasingly difficult to manage work, caring responsibilities and other everyday demands before returning once again to another night of persistent worry. The participant's observation that it starts again powerfully captures the cyclical nature of the cumulative pressures described throughout this theme.
A similarly cumulative pattern emerged in another interview with a woman in her early sixties who had experienced progressive hearing loss, deteriorating eyesight, chronic musculoskeletal pain and redundancy within a relatively short period. Although each challenge could have been understood independently, she described experiencing them collectively:

"It's not an easy journey."
(Lived-experience interview participant.)

As the interview developed, she explained that coping involved considerably more than managing physical symptoms:

"Taking care of my body as well as my mental health."
(Lived-experience interview participant.)

Rather than separating physical illness from emotional wellbeing, she understood them as inseparable. Declining health affected confidence, independence, employment, relationships and opportunities to participate within community life. Emotional wellbeing therefore became increasingly difficult to disentangle from wider social and physical circumstances.
Her reflections also suggest that cumulative pressure was shaped not only by external circumstances but by longstanding social expectations around coping, self-sacrifice and perseverance. Rather than prioritising her own wellbeing, she described a lifetime of enduring difficulties without acknowledging their emotional impact:

"I think I've always pushed my mental health to one side because I was of that generation that we just pushed through. But this time I couldn't push through."
(Lived-experience interview participant.)

"You just suppress everything and you kind of forget about yourself."
(Lived-experience interview participant.)

These reflections resonated strongly with many survey respondents, particularly female participants aged between 45 and 64 years, who described balancing employment, caring responsibilities and family commitments whilst consistently placing their own emotional wellbeing last. These narratives suggest that resilience itself had gradually been depleted through decades of continual responsibility.

A similar understanding emerged in another interview when a participant attempted to explain why their wellbeing had deteriorated after years of managing multiple demands:

"Sometimes it comes in one big go because you realise you've got to deal with it."
(Lived-experience interview participant.)

This quotation reaffirms one of the defining findings of the study. Participants were not describing a single catastrophic event. Instead, they described reaching a point where numerous ordinary pressures, financial insecurity, changing health, bereavement, employment demands and caring responsibilities, had accumulated to such an extent that continuing to cope became increasingly difficult.

The interviews also showed how bereavement, loneliness and changing identity could interact with employment and financial insecurity. One participant who had spent several years caring for a parent before their death initially understood bereavement as the main explanation for declining mental health. As the interview unfolded, however, a much more complex story emerged. Living alone for the first time, attempting to establish new routines, diminished confidence, financial uncertainty and increasing social isolation gradually combined to undermine wellbeing.

Several interviewees described similar experiences of quietly carrying increasing responsibility over many years. One participant reflected that they had spent years:

"holding everything together all the time"

while another commented that there was:

"no space to fall apart yourself."

These statements were delivered without drama, yet they encapsulate the emotional labour evident throughout the interviews. Participants prioritised partners, children, ageing parents, colleagues and friends whilst postponing attention to their own emotional wellbeing until they reached a point of exhaustion.

Employment formed part of almost every participant's story but was rarely discussed in isolation. Instead, work was woven into wider narratives concerning financial insecurity, caring responsibilities, physical illness and uncertainty about the future. Several participants explained that they continued working despite deteriorating health because they could not afford to reduce their hours. Others described the anxiety associated with insecure employment or contracts that no longer provided sufficient income to support their families. Employment therefore emerged as more than a determinant of mental health, and as one component within a wider web of interacting pressures.

These accounts illustrate an important distinction between resilience and endurance. Participants demonstrated remarkable determination in continuing to work, care for others and manage long-term health conditions despite considerable adversity. However, they simultaneously questioned how long such endurance could reasonably be sustained. Rather than suggesting that individuals lacked resilience, their narratives instead point towards the gradual erosion of emotional resources through prolonged exposure to multiple, intersecting pressures.

Caring, Physical Health and the Invisible Weight of Everyday Responsibility

Although financial insecurity featured prominently throughout the research, participants rarely experienced these pressures independently. Conversations repeatedly returned to caring responsibilities, chronic illness and the emotional labour associated with supporting others, illustrating how these experiences intensified existing financial, social and emotional pressures. Caring, physical health and economic insecurity did not operate as separate determinants of poor mental health. They became woven together, creating lives characterised by continual responsibility and limited opportunity for recovery.

The demographic profile of the survey reflects the significance of these experiences. Almost half reported living with a disability or long-term health condition (45.3%, n = 68), while one-third identified as neurodivergent (33.3%, n = 50). Furthermore, the largest proportion of respondents were aged between 45 and 64 years, a stage of life frequently associated with balancing employment, caring responsibilities and emerging physical health problems. Consequently, many participants described managing several intersecting demands simultaneously, often whilst attempting to maintain employment and support family members.

Across the interviews, participants consistently rejected any clear distinction between physical and mental wellbeing. Chronic illness was rarely described solely through symptoms or diagnosis. Instead, participants explained how deteriorating physical health influenced confidence, independence, relationships, employment, financial security and opportunities for social participation. Chronic pain affected sleep; reduced mobility limited opportunities for social connection; sensory impairment undermined confidence; and deteriorating health generated financial uncertainty through reduced employment or redundancy. Collectively, these experiences disrupted identity as much as physical functioning.

One participant described the experience of managing multiple long-term conditions as:

“It’s like a full-time job with an illness.”
(Lived-experience interview participant.)

This observation captures the invisible labour associated with chronic illness. Participants described appointments, medication, paperwork, treatment and navigating fragmented health and welfare systems as continual responsibilities requiring significant emotional and practical effort. By the time these tasks had been completed, many explained that little energy remained for maintaining friendships, participating within their communities or engaging in activities that might otherwise protect their mental wellbeing.

The emotional consequences of invisible illness emerged throughout the interviews. Several participants described the frustration of feeling misunderstood because their conditions were not immediately apparent. One participant explained:

“Sometimes they don’t understand me... so I just give up.”
(Lived-experience interview participant.)

Rather than simply describing communication difficulties, this quotation reflects a gradual process through which repeated misunderstanding contributed to declining confidence, increasing social withdrawal and reduced participation within community life.

Participants frequently explained that withdrawing from others was not a conscious choice but the cumulative consequence of feeling repeatedly unheard, misunderstood or emotionally exhausted by continually having to explain themselves.

The emotional labour associated with caring for others formed another dominant narrative across the dataset. Whilst survey respondents frequently referred to caring responsibilities, the unpaid carers focus group provided a much richer understanding of their cumulative impact. Participants rarely described caring simply as providing practical support. Instead, they portrayed it as an ongoing emotional state characterised by vigilance, responsibility and the continual anticipation of future problems.

One woman caring for a family member reflected:

"It's massive this caring stuff. Massive… and you have guilt and responsibility every day. And you can't go out and walk away… ever. I'm always on call even when shattered."
(Female, Unpaid Carers Focus Group.)

Another explained how caring responsibilities extended into the future as well as the present:

"I'm getting on and I do worry a lot who will look after B when I'm gone. Who will look after her? It's such a worry for me."
(Unpaid Carers Focus Group participant.)

These accounts demonstrate that caring responsibilities extended far beyond practical assistance. Participants described constantly anticipating problems, organising appointments, monitoring risks and attempting to protect loved ones whilst suppressing their own emotional needs. Several reflected that they no longer recognised the extent to which caring had affected their own wellbeing because responsibility had become an ordinary part of everyday life rather than an exceptional burden. Importantly, participants rarely portrayed themselves as resentful carers. On the contrary, they spoke warmly and compassionately about those they supported. Their distress arose not from caring itself but from the absence of opportunities to rest, share responsibility or prioritise their own wellbeing without experiencing guilt. Emotional exhaustion therefore emerged not because participants lacked commitment, but because caring had become continuous, often extending over many years without meaningful respite.

The survey findings echoed these experiences. Respondents linked caring responsibilities with financial insecurity, declining physical health and increasing social isolation. Several middle-aged respondents described supporting both children and ageing parents whilst remaining in full-time employment, illustrating the multiple competing demands characterising this stage of the life course. Younger participants more commonly described caring for relatives whilst attempting to establish careers or secure housing, whereas older respondents reflected upon continuing caring responsibilities despite declining health of their own. Although circumstances differed, respondents described the cumulative impact of sustained responsibility.

One striking feature across the interviews and focus groups was that participants seldom viewed caring, illness or financial insecurity as independent experiences. Instead, conversations moved fluidly between these topics, revealing how closely interconnected they had become. A participant discussing chronic pain would begin describing employment before reflecting upon caring responsibilities or financial pressures. Another talking about bereavement would quickly move towards loneliness, changing identity and declining confidence. These shifting narratives suggest that participants themselves did not compartmentalise their experiences. Rather, they understood their mental wellbeing as being shaped by the interaction of multiple aspects of everyday life.

Across the interviews, participants repeatedly returned to the idea that emotional wellbeing was gradually worn away through the continual accumulation of responsibility rather than any single overwhelming event. Participants described reaching a point where years of balancing work, caring, finances, physical health and family responsibilities could no longer be sustained through endurance alone. Few identified one defining crisis. Emotional distress therefore emerged not as the consequence of one catastrophic experience, but as the cumulative weight of ordinary life.

Convergence Across the Research: Understanding Public Mental Health Through Accumulation Rather Than Crisis

One of the most striking findings emerging from the Thrive LDN Public Mental Health Research Project was the remarkable consistency of evidence across all components of the study. Survey respondents, lived-experience interview participants, community focus groups, the DWP employment focus group and strategic stakeholders all described the challenges to mental wellbeing in fundamentally similar ways. Although their perspectives differed according to personal experience and professional role, they described lives shaped by the gradual accumulation of social, economic, physical and relational pressures that, over time, became increasingly difficult to sustain.

Participants rarely spoke about reaching a single breaking point. Instead, they described a gradual erosion of emotional wellbeing that often occurred almost unnoticed until everyday life became significantly more difficult to manage. Many reflected that they had continued working, caring, supporting others and maintaining family responsibilities for years before recognising the impact these cumulative pressures had upon their own mental health. Distress therefore emerged not as an abrupt departure from wellbeing but as the cumulative consequence of carrying multiple responsibilities without adequate opportunities for recovery.

This interpretation was independently reinforced by strategic stakeholders. One reflected that:

"The breadth of determinants that are impacting people's mental health at the moment is huge, and it's all related."
(Strategic stakeholder.)

Another situated these experiences within a broader post-pandemic context:

"Since Covid it's been hard, really hard and individuals and families are struggling big time. The mental health issues have definitely exacerbated since then."
(Strategic stakeholder.)

These observations closely mirror participants' own accounts throughout the study. Survey respondents rarely discussed the cost of living without also referring to housing, employment or relationships. Interview participants moved naturally between bereavement, physical health, loneliness, caring responsibilities and financial insecurity. Focus group participants similarly described multiple pressures intersecting within everyday life. Rather than producing competing explanations, each strand of the research reinforced the others, creating a coherent understanding of public mental health as a socially determined and relational phenomenon.

The convergence of findings across all datasets represents one of the principal strengths of this research. Survey findings quantified the breadth of challenges affecting Londoners. Interviews provided rich insight into how these pressures accumulated over time. Community focus groups demonstrated that these experiences were shared collectively rather than individually.

The DWP employment focus group added a more specific account of how work, unemployment, reasonable adjustments, education and opportunity shape mental wellbeing. Stakeholder interviews then situated these narratives within wider structural and policy contexts.

Together, these complementary sources of evidence strengthen confidence that the findings presented here reflect enduring patterns rather than isolated experiences. Participants were not asking researchers to identify one cause of poor mental health because that was not how they experienced their lives. They described a more complex reality in which employment, income, caring, housing, disability, physical health, relationships and community connection continually interacted. Public mental health therefore needs to be understood through accumulation rather than crisis alone.
These findings also have important implications for prevention. If distress often develops through the slow accumulation of pressures, then support cannot be limited to crisis response. Prevention requires earlier attention to the conditions that help people remain well: secure income, good work, fair access to opportunity, reasonable adjustments, respite for carers, accessible community spaces, trusted relationships and support that recognises the whole person rather than one presenting problem.

This understanding provides an important foundation for the following theme, which explores participants' experiences of navigating mental health systems and why many felt support was often accessed only after cumulative pressures had already reached crisis point.



Collaborative Interpretation Workshop
June 2026

CREATIVE OUTPUT | Research Poetry as Knowledge Translation

The following poem is presented as a creative knowledge-translation output, developed through thematic synthesis of the study material and creative revoicing (Palmer, 2026). It draws on recurring themes and participant testimony concerning unpaid caring, physical ill health, memory loss, appointments, financial pressure and the quiet administrative work involved in sustaining another person's life. These experiences are brought together as a composite poetic narrative rather than as the verbatim story of any one participant. The poem therefore does not add a separate finding; instead, it uses testimony and creative revoicing to communicate the cumulative weight of ordinary responsibilities at an emotional as well as analytical level, helping to build awareness of how waiting, organising, remembering, shopping and caring can gradually become a substantial public mental health burden.

Wait / Weight

D. A. Palmer

A woman
stands
in the supermarket.
Tea bags.
Soft bread.
Incontinence pads.
A birthday card.
She reaches
for chocolates.
Then remembers
her father won't remember his birthday.
She buys the card.
Leaves the chocolates.
The appointment
lasted
twelve minutes
He sits
in the hospital car park
for another twenty..
The engine
is off.
For twenty minutes nobody needs him.
He cannot remember the last time that
happened.
She knows
which hospital entrance
has the shortest walk.
Which lift
sticks
on Level Three.
Which receptionist
always smiles.
She cannot remember the last place she went
simply because she wanted to.
Monday.
Memory clinic.
Tuesday.
Blood tests.
Wednesday.
District nurse.
Thursday.
Hospital.
Friday.
Prescription collection.
Saturday.
Shopping.
Bills.
Sunday.
She turns
the page.
Tomorrow
is Monday.
There is no
single moment
life
becomes heavy.
It is the wait
that gathers
the weight.
Just
ordinary things.
Added together.
Eventually,
someone asks,
"How are you?"
She looks
at the shopping bags
in her hands.
Then
the handbag
over her shoulder.
Then
the overnight bag
waiting
by the door.
She shifts them
slightly,
making room
for one more.

Chapter 7: The Emotional Labour of Seeking Help

“It’s constant and it is a battle to be heard.” (Lived-experience interview participant.)

Chapter Summary

Across the survey, lived-experience interviews, focus groups including the DWP employment focus group, and strategic stakeholder discussions, participants consistently challenged simplistic understandings of access to mental health support. They portrayed help-seeking as an emotionally demanding journey requiring persistence, confidence and repeated self-advocacy while already experiencing considerable distress. Their accounts ranged well beyond isolated barriers such as waiting lists, referral pathways or service availability. Participants became navigators of fragmented systems, explaining their circumstances, coordinating communication between organisations and waiting for support while financial insecurity, loneliness, caring responsibilities, poor physical health, employment instability and other everyday pressures continued to accumulate.

Importantly, respondents rarely attributed these difficulties to individual practitioners. On the contrary, many spoke warmly about professionals who listened carefully, showed compassion and remained alongside them during difficult periods. Their experiences instead highlighted structural systems that frequently responded to episodes of crisis despite participants themselves experiencing deteriorating mental wellbeing as gradual, cumulative and deeply relational. This mismatch between lived experience and service design represents one of the central findings of the study.

Perhaps the most significant finding to emerge from this theme is that relationships remained central throughout every stage of the help-seeking journey. Participants demonstrated that continuity, trust and feeling genuinely heard were not simply desirable characteristics of good services but active mechanisms through which hope, confidence and engagement were sustained. Fragmentation, repeated storytelling and discontinuity therefore represented considerably more than organisational inefficiencies; they disrupted precisely those relational processes participants identified as fundamental to recovery.

These findings suggest that improving public mental health requires considerably more than increasing the availability of services or reducing waiting times alone. Participants consistently argued for systems that are easier to navigate, respond earlier to gradual deterioration and prioritise continuity of relationships alongside clinical intervention. Their accounts challenge crisis-oriented models of care by demonstrating that mental wellbeing is shaped not only by the availability of support but also by how that support is experienced. Public mental health systems therefore need to respond not simply to moments of crisis but to the cumulative realities of people’s everyday lives.
This theme also provides the conceptual bridge to Chapter 8. If the earlier findings demonstrated that mental wellbeing is created or undermined through relationships and the accumulation of everyday pressures, this theme shows that the same relational principles remain central once people seek formal support. Chapter 8 therefore moves beyond participants’ experiences of existing systems to explore their vision for prevention, examining how communities, services and policymakers might work together to create the conditions in which good public mental health can flourish long before crisis develops.

Introduction

While uncertainty about where to seek help represented an important barrier, participants described the emotional effort required to remain engaged with support once they had entered the system. Across the interviews, focus groups and survey responses, help-seeking was rarely portrayed as a single referral or appointment. Instead, respondents described a prolonged process requiring persistence, repeated self-advocacy and considerable emotional resilience. Before receiving meaningful support, many explained that they had to recount deeply personal experiences to multiple professionals, repeatedly justify the seriousness of their circumstances and continue navigating fragmented services while already experiencing anxiety, depression, bereavement or emotional exhaustion. Consequently, participants frequently described the process of seeking help itself as another burden that had to be carried.

Perhaps the clearest finding to emerge across the interviews concerned the repeated expectation that individuals should continually retell their stories. Participants recognised that professionals fulfilled different roles and worked within different organisations; however, many questioned why fragmented systems appeared unable to communicate effectively with one another. Respondents described becoming responsible for carrying information between services themselves, with little sense of being held within a coordinated system of care. This often meant explaining painful experiences repeatedly, completing multiple assessments and effectively beginning again each time they encountered a new professional.

Philip, a retired man in his seventies living with long-term physical health problems alongside recurrent depression, described attending a crisis mental health service during a period of acute emotional distress. Having waited to be seen, he carefully explained the circumstances that had led him to seek urgent support. Shortly afterwards, another practitioner entered the room and asked him to repeat his account from the beginning. Reflecting on the experience later in the interview, Philip questioned why information had not simply been shared between professionals:

“I could have done with one man coming to see me... it seemed a silly system.”

Although Philip spoke without anger, his account illustrates one of the clearest findings emerging throughout the research. Participants were rarely criticising individual practitioners. Instead, they described organisational structures that unintentionally transferred responsibility for continuity onto people already experiencing significant emotional distress. Respondents often found themselves becoming the communication system between professionals, carrying information between organisations while simultaneously trying to manage their own deteriorating wellbeing.

Several participants reflected that recounting traumatic experiences became emotionally exhausting in itself. Rather than facilitating recovery, each new assessment required individuals to revisit bereavement, suicidal thoughts, relationship breakdown, childhood trauma or experiences of abuse before trust had been established. Participants frequently explained that by the time they reached another professional they felt less able, rather than more willing, to continue explaining themselves.

This experience was described particularly powerfully by Annie, a woman in her fifties living with long COVID, chronic fatigue and previous experiences of depression. Throughout her interview she reflected upon the cumulative impact of deteriorating physical health, unemployment, financial insecurity and relationship breakdown. However, when discussing support services, she described another form of exhaustion altogether: the gradual loss of confidence that came from feeling misunderstood and having to explain herself repeatedly.

This narrative captures an important process evident across numerous interviews. Participants rarely described dramatic refusals of support. More commonly, they described gradually disengaging because repeated misunderstandings diminished their confidence that continuing to explain their circumstances would make any meaningful difference. Giving up therefore represented not a lack of motivation, but the cumulative consequence of feeling unheard over prolonged periods.

Survey responses echoed these experiences. Several respondents described feeling ***"passed from service to service", "starting again every time"*** or becoming uncertain about who was ultimately responsible for coordinating their care. Others explained that referral processes generated additional assessments rather than practical support, leaving them feeling trapped within systems that appeared to assess need repeatedly while offering limited intervention. Participants frequently perceived disconnected organisations operating alongside one another with little continuity between them, and few experienced services as coordinated pathways.

The emotional burden associated with navigating support systems was discussed extensively within the Sakinah women's focus group. Participants reflected that contacting public services had become increasingly stressful because telephone systems, automated menus and online forms frequently required individuals to navigate complex administrative processes before speaking with another human being. One participant explained:

"It's the most stressful thing... you press one, then another... then you get through to somebody and you're not in the right department. Then you have to start all over again."

Another participant immediately broadened this observation beyond her own experience:

"Can you imagine people that can't speak English, or they have mental health problems?... It's just ridiculous."

These reflections illustrate that participants were not simply criticising digital technology itself. Rather, they questioned systems that assumed individuals possessed the emotional energy, cognitive capacity and digital confidence necessary to navigate increasingly complex administrative processes while already struggling with poor mental health or other everyday pressures. Administrative complexity therefore became another determinant of emotional wellbeing, particularly for individuals experiencing multiple disadvantages simultaneously.

Interestingly, participants also described what effective support looked like. Across interviews, respondents rarely emphasised specialist interventions or clinical expertise as the defining characteristics of good care. Instead, they consistently valued continuity, familiarity and relationships. Feeling recognised by name, speaking with someone who remembered previous conversations or not having to justify their need for support were described as profoundly important experiences. Participants repeatedly explained that being believed, listened to and understood often mattered as much as the intervention itself.

This finding creates an important conceptual bridge with the earlier theme on relationships. Earlier findings demonstrated that trusted relationships, belonging and meaningful human connection formed the foundations of good public mental health within communities. Here, participants described remarkably similar principles operating within formal systems of care. Effective support depended not simply upon availability but on relationships characterised by continuity, trust and genuine understanding. Fragmentation therefore represented more than organisational inefficiency; it disrupted precisely the relational foundations that participants identified as essential for recovery.

These findings suggest that seeking help involved considerably more than accessing services. It required participants to become advocates, navigators and coordinators of their own care while already emotionally exhausted. The emotional labour associated with explaining experiences, negotiating fragmented pathways and sustaining hope throughout prolonged periods of uncertainty frequently became another source of distress. Rather than reducing the cumulative pressures described in Chapter 6, fragmented systems sometimes inadvertently added to them, reinforcing participants' perception that asking for help represented the beginning of another difficult journey rather than the end of one.

The DWP employment focus group also reinforced the finding that systems can create additional emotional labour when they are difficult to navigate or insufficiently responsive to people's lived realities. Participants described having to explain hidden disabilities, neurodivergence, workplace discrimination and support needs repeatedly, often while already dealing with financial insecurity, loss of confidence or employment instability. For some, employment and welfare systems felt impersonal or difficult to trust. This suggests that employment support, welfare advice and mental health support need to be better connected, relational and responsive to the realities of people's lives.

The Heavy Weight of Waiting: When Support Arrives Only at Crisis Point

Although participants acknowledged that waiting times represented a significant practical barrier to accessing mental health support, their accounts suggest that the impact of waiting extended far beyond delayed appointments. Across interviews, focus groups and survey responses, waiting was consistently described as an emotionally active experience characterised by uncertainty, deteriorating wellbeing and the continual fear that circumstances would worsen before meaningful intervention became available. Waiting was more than a measure of list length. Participants described what it felt like to continue carrying financial pressures, loneliness, bereavement, caring responsibilities or declining physical health while remaining uncertain whether support would arrive in time. Consequently, waiting itself emerged as more than an organisational challenge, and as another determinant of poor mental health.

Survey findings reflected the prevalence of this experience. Waiting times represented the single most frequently reported barrier to accessing support, identified by 40.7% of respondents (n = 61). However, participants rarely discussed waiting in isolation. Instead, delays were experienced alongside worsening financial insecurity, deteriorating physical health, insecure housing, relationship breakdown and increasing social isolation. Waiting therefore became another pressure within already complex lives rather than a discrete inconvenience.

One survey respondent captured this frustration succinctly:

"Mental health can't wait."

Others echoed this sentiment, calling for support when needed rather than months later, and describing long waits as incompatible with genuine prevention. Collectively, these survey responses suggest that participants understood prevention not as a policy aspiration but as timely support capable of interrupting deterioration before crisis developed.

"I waited ten months. By the time they rang me I was really a different person to the one who asked for help." (Survey Respondent, female, aged 35–44 years.)

Louisa's interview illustrates the consequences of prolonged waiting particularly powerfully. Living with long-term mental health difficulties, she explained that seeking help required considerable determination. However, once she had acknowledged that she could no longer cope alone, she encountered repeated delays that gradually undermined her confidence that meaningful support would arrive. Reflecting on this experience, she described the waiting as constant and the process of securing support as an ongoing struggle to be heard.

Louisa portrayed waiting as continual emotional work. She described repeatedly contacting services, attempting to remain visible within systems and trying to manage worsening mental health while simultaneously waiting for intervention. Her account illustrates that delayed access required sustained emotional effort rather than simple patience.

As her interview progressed, Louisa described how her mental health continued to deteriorate before meaningful support became available.

"The only way I managed to get help eventually was I ended up in A&E."

This narrative is particularly significant because it was delivered matter-of-factly rather than dramatically. For Louisa, attending Accident and Emergency was not perceived as an exceptional event but as the point at which support finally became accessible. Her experience reflects a broader pattern emerging throughout the research, whereby participants described systems responding most effectively once distress had reached crisis rather than during earlier periods when preventative intervention may have been possible.

Bharati described a strikingly similar experience when reflecting on her attempts to access talking therapy. She explained that long waits did more than inconvenience her: delays fundamentally undermined the purpose of prevention itself.

"I was waiting and waiting for a long time for a talking therapy. And when you need it, you can't get it. You can't prevent. It can get very worse."

Reflecting further, she added:

"The waiting list is big and longer time. I think it should not be that."

Unlike many policy discussions that frame waiting times primarily as an issue of service capacity, Bharati's account highlights the emotional consequences of delay. In her experience, prevention depended upon receiving support while difficulties remained manageable. Once waiting continued until mental health had significantly deteriorated, the opportunity for early intervention had already been lost.

Ian described a similarly reactive experience when seeking help during periods of suicidal crisis. Recalling repeated contact with the crisis team, he explained:

"I've had three or four times where I spoke to the crisis team... told them I was feeling suicidal... and they said... 'try and listen to some music or something.'"

Reflecting on that experience, he added:

"Imagine telling somebody they're telling you this suicidal and they're telling you to go and listen to some music."

Ian's account reinforces the wider finding that participants were not simply seeking immediate specialist intervention. Rather, they expected responses proportionate to the seriousness of their distress. His experience illustrates the perceived disconnect between participants' lived experience of crisis and organisational responses constrained by limited options and high thresholds for intervention.

Similar concerns emerged throughout the survey. Respondents questioned why eligibility criteria often appeared to require people to demonstrate severe levels of distress before receiving meaningful support. Several reflected that they had attempted to seek help earlier but felt their circumstances were not considered sufficiently serious. Others described being signposted elsewhere, placed on waiting lists or encouraged to continue self-managing until their mental health deteriorated further. Collectively, these narratives suggest that participants experienced support systems as predominantly reactive rather than preventative.

Strategic stakeholders independently reinforced these observations. Several reflected that increasing demand, workforce pressures and constrained resources had gradually shifted services towards responding to crisis rather than providing earlier intervention. One stakeholder explained that organisations across the system were increasingly operating at:

"the emergency end" of mental health support, leaving fewer opportunities to intervene while problems remained manageable.

Another described fragmented pathways and lengthy waiting times as consequences of wider structural pressures rather than failings of individual practitioners. These perspectives closely mirrored participants' lived experiences, strengthening confidence that these findings reflected systemic rather than isolated organisational issues. Importantly, participants did not expect immediate access to specialist services for every difficulty they encountered. Many recognised the pressures facing health and care systems and acknowledged the commitment of individual professionals. Their frustration instead centred upon a perceived mismatch between how mental health difficulties developed and how services were organised to respond. As Chapter 6 demonstrated, emotional distress was rarely experienced as a sudden event. Rather, participants described wellbeing gradually deteriorating through the interaction of financial insecurity, caring responsibilities, loneliness, physical illness and the accumulation of everyday pressures. Yet support systems appeared configured to respond only once these pressures had intensified into crisis.

This mismatch represents one of the central findings of the study. Participants did not simply experience long waiting lists; they experienced systems whose underlying logic differed fundamentally from their own lived experience of mental health. While emotional distress accumulated progressively over months or years, support frequently became available only after difficulties had intensified sufficiently to satisfy increasingly high thresholds for intervention. In effect, people were often required to fit service assumptions and eligibility criteria, rather than services being organised around the realities of people's lives. Prevention therefore meant more than expanding service capacity: it meant redesigning systems capable of recognising and responding to gradual deterioration before crisis became inevitable.

These findings suggest that waiting was not merely an administrative consequence of rising demand. It represented another stage within participants' mental health journeys during which uncertainty, worsening wellbeing and repeated attempts to obtain support frequently compounded existing distress. For many respondents, the greatest challenge was not accepting that services were busy, but living with the uncertainty of whether help would arrive before their circumstances deteriorated further. In this respect, waiting itself became an active component of poor mental health rather than simply the period between referral and treatment.

Relationships Matter Within Services Too

Although participants described considerable frustration when navigating fragmented systems, they were equally clear that positive support was not defined by speed or availability alone. What mattered was whether services were experienced relationally. Participants described feeling most supported when professionals listened carefully, remembered previous conversations, recognised the wider context of their lives and remained alongside them over time. In many respects, the characteristics participants valued within formal services closely mirrored those identified earlier as essential for good public mental health within communities. Continuity, trust, compassion and feeling genuinely heard were not simply desirable features of good care, but fundamental to therapeutic processes.

Across the interviews, participants rarely praised services because they offered particularly sophisticated clinical interventions. Instead, they spoke warmly about individual practitioners who made them feel recognised as people rather than cases. Small acts of kindness, consistent communication and simply being remembered often carried profound significance. Several participants reflected that professionals who took time to understand the wider circumstances of their lives, including financial insecurity, caring responsibilities, bereavement, physical illness and loneliness, helped them feel that their distress finally made sense rather than existing as a collection of disconnected problems.

Participants' accounts therefore connect directly with the earlier findings on relationships. Participants had already described ordinary conversation, familiarity and belonging as protective resources within communities. In this theme, the same principle became visible within formal systems of care. People were more likely to remain engaged when they felt listened to, remembered and understood. Conversely, repeated assessments, changing professionals and fragmented communication undermined trust and made support feel transactional rather than relational.

This point was reinforced by strategic stakeholders, one of whom observed that:

"people really flourish when they are taken seriously and believed."

Rather than viewing listening as a passive communication skill, stakeholders described feeling heard, believed and understood as an active mechanism through which recovery and resilience could begin. One stakeholder captured this idea succinctly, describing recovery as:

"healing by relational support."

These reflections reinforce participants' own accounts that relationships were not simply the context within which care was delivered but were themselves therapeutic processes. Participants within the Digital Hub focus group expressed remarkably similar views. While recognising the benefits of digital technology, they argued that online services could not replace opportunities for genuine human interaction. Several reflected that although digital platforms improved access to information and practical support, emotional wellbeing depended upon feeling known, recognised and connected to other people. One participant memorably summarised this simply:

"It's the person we want to speak to... not machines, not tele this or that, not digital, or apps or websites... it's human to human, man to man, woman to man, woman to woman."

Although concise, this observation encapsulates one of the most consistent findings across the entire study. It echoes the central argument developed throughout the earlier findings on relationships and demonstrates the remarkable consistency of participants' accounts across interviews, focus groups and survey responses. While digital technology was widely recognised as improving access and convenience, it was never viewed as a substitute for trusted human relationships.

The Sakinah women's focus group similarly highlighted the importance of culturally safe and trusted relationships. Participants explained that feeling understood within the context of their faith, culture and family circumstances determined whether they continued engaging with support. Several women reflected that services became most effective when practitioners demonstrated curiosity, respect and a genuine willingness to understand experiences extending beyond clinical symptoms alone. Trust therefore emerged not simply through professional expertise but through relationships characterised by empathy, cultural understanding and genuine listening.

Strategic stakeholders independently reinforced these observations. Several reflected that community organisations often succeeded because they were able to build trusting relationships over extended periods rather than responding solely to episodes of crisis. One stakeholder described community-based support as creating:

"relational continuity"

allowing people to return repeatedly without feeling that they were beginning again with each new interaction. Another argued:

"mental recovery isn't linear and people need access over long time periods. Short-term fixes don't work."

These reflections closely mirrored participants' own experiences, suggesting that continuity was not simply an organisational aspiration but an essential feature of effective public mental health support. Stakeholders also reflected that voluntary and community organisations frequently occupied a unique position because they were able to combine practical advice, emotional support and social connection within the same environment, further strengthening the argument that relationships are central to effective public mental health practice.

These findings suggest that participants did not simply seek faster access to services. They sought systems organised around relationships rather than transactions. Being listened to without judgement, speaking to professionals who remembered previous conversations, avoiding repeated assessments and feeling that somebody genuinely understood the complexity of their lives were consistently described as experiences that promoted hope, trust and sustained engagement. Conversely, fragmented pathways, repeated storytelling and discontinuity undermined precisely those relational processes participants regarded as most therapeutic.

Importantly, these findings create a direct conceptual bridge between the earlier theme on relationships and the present theme on help-seeking. Earlier findings demonstrated that relationships, belonging and meaningful human connection formed the foundations of good public mental health within communities. The present findings suggest that these same principles remain equally important within formal systems of care. Across participants and stakeholders alike, continuity, trust and relational support were identified as fundamental to recovery. Effective public mental health therefore depended not simply upon increasing service capacity but on creating opportunities for trusting relationships to develop over time. Continuity emerged not as an organisational convenience but as a therapeutic intervention in itself.

CREATIVE OUTPUT | Research Poetry as Knowledge Translation

The following poem is presented as a composite creative knowledge-translation output developed from the themes and testimony generated through the Digital Hub focus group and the wider findings in this chapter. It brings together participants' words, phrases and shared experiences with creative revoicing (Palmer, 2026), through which the lead researcher synthesises and re-voices patterns across multiple accounts rather than reproducing the experience of any single participant. The poem therefore combines direct testimony, thematic synthesis and crafted connective language. It does not introduce new findings and should not be read as a verbatim transcript; instead, it uses testimony and creative revoicing to communicate the emotional labour of fragmented systems, repeated storytelling and waiting in a form intended to strengthen awareness, support public dialogue and preserve the human meaning of the evidence presented above.

At the Table
D. A. Palmer

I tell my
story.
Again.
Then again.
"I'd just
told your mate everything..."
The room
changes.
The face changes.
The questions
stay the same.
I become
the referral,
the assessment,
the waiting list,
the waiting list number,
the messenger
carrying words
between people
who never speak
to each other.
A battle
to be heard.
So I
wait.
And wait.
Waiting
to be waiting.
Because
mental health
cannot wait.
But
apparently
it does.
When I
need help,
it is not there.
Prevention
cannot wait
for the waiting list.
Days
become months.
Hope becomes paperwork.
Strength becomes
another form to complete.
"Sometimes
they don't have
the patience...
so I just give up."
Not
because
I stopped needing help.
Because I ran out
of words.
Until
the only door
still open
is A&E.
And
still,
what I wanted
was simple.
A person.
Not machines.
Not tele this or that.
Not digital.
Not apps.
Not websites.
Human to human.
Man to man.
Woman to man.
Woman to woman.
Not
another number.
Not another department.
Not another beginning.
Just
someone
who remembers
that I have already
told my story.
Somewhere,
inside the system,
my story has
gone
missing.



Collaborative Interpretation Workshop
June 2026

Chapter 8: Prevention Begins Before Crisis – Reimagining Prevention Through Lived Experience

“Prevention is better than cure... being proactive in trying to help myself rather than being reactive. Getting the right level of support at the right time.” (Lived-experience interview participant.)

Chapter Summary

This chapter presents the fourth and final theme emerging from the Thrive LDN Public Mental Health Research Project: the need to reimagine prevention through lived experience. Across the research, participants described prevention in ways that extended beyond traditional service-led understandings of mental health.

While participants recognised the importance of timely access to clinical support, they rarely defined prevention as simply providing more mental health services. Instead, prevention was understood as creating the conditions in which people could remain mentally well before reaching crisis. Participants described prevention as something embedded in everyday life through supportive relationships, welcoming communities, financial security, meaningful activity, practical assistance, good work, accessible education and opportunities to connect with others long before specialist intervention became necessary.

This insight was consistent across the evidence strands. Survey respondents called for earlier support, stronger communities and practical assistance that addressed the circumstances contributing to emotional distress. Interview participants reflected that prevention often occurred through ordinary interactions, trusted relationships and opportunities to develop coping strategies before difficulties became overwhelming. Focus group participants repeatedly described prevention as reducing loneliness, creating spaces where people felt they belonged and strengthening communities rather than simply increasing clinical provision. Strategic stakeholders independently reinforced these perspectives, arguing that investment in prevention required attention to housing, education, employment, community development and the wider social determinants of mental health alongside healthcare.

The DWP employment focus group strengthened this theme by showing that prevention also includes access to good work, education, training, reasonable adjustments and employment support. Participants described employment as not simply an economic issue, but as a route to confidence, identity, dignity and belonging. This reinforces the wider finding that prevention depends on the conditions that enable people to participate in everyday life, not only on access to mental health services.

Importantly, participants did not reject clinical services. Rather, they challenged the assumption that prevention begins only when someone enters a mental health pathway. Across the research, respondents suggested that by the time individuals reached specialist services, many opportunities for prevention had already been missed. Instead, they argued that prevention begins much earlier, within homes, schools, workplaces, neighbourhoods and communities where supportive relationships, practical help and opportunities for participation enable people to maintain wellbeing before emotional distress intensifies.

Reimagining Prevention Through Lived Experience

The earlier themes show that participants understood good mental health as rooted in relationships and belonging, while also demonstrating how wellbeing can be undermined by the accumulation of everyday pressures and compounded by fragmented systems once support is sought. Having described these experiences, participants consistently turned their attention towards a different question: what actually prevents mental health difficulties from developing or becoming overwhelming?
Participants described prevention in ways that differed markedly from traditional service-led understandings, and the accounts that follow show what that meant in the circumstances of particular lives.

Mo, a man living with long-term severe mental illness, described prevention not as avoiding all mental health difficulties but as preventing deterioration before reaching crisis. Reflecting upon what prevention meant in his own life, he explained:

"It prevents me from going down a downward spiral... not becoming severely ill... not becoming suicidal, not self-harm."
(Lived-experience interview participant.)

Rather than describing prevention as an abstract public health concept, Mo's account located prevention within everyday support that enabled him to remain well despite living with ongoing mental illness. He reflected that learning practical coping strategies from his psychologist, including maintaining routines, organising medication, breathing exercises and distraction techniques, had fundamentally changed his ability to manage independently following his father's death. As he explained:

"The psychologist taught me how to maintain a schedule... strategies to use when things get bad."
(Lived-experience interview participant.)

His account highlights an important finding emerging throughout the interviews. Participants rarely viewed prevention as eliminating distress altogether. Instead, prevention was understood as equipping people with the relationships, confidence, knowledge and practical resources necessary to prevent understandable difficulties from escalating into crisis.

James, a 46-year-old lived-experience consultant who had experienced severe anxiety and depression, articulated a remarkably similar understanding. Reflecting upon his motivation for participating in the study, he explained that although mental health journeys are rarely straightforward, relatively small interventions delivered early could prevent considerably greater difficulties later:

"There are so many things that are small things... that actually we could do a lot of prevention before we're actually into crisis."
(Lived-experience interview participant.)

Unlike many policy discussions that frame prevention around major programmes or new services, James' account emphasised the cumulative impact of relatively modest interventions delivered consistently and early. His perspective resonates strongly with the wider dataset, where participants repeatedly described everyday conversations, timely practical support, opportunities for connection and trusted relationships as experiences that protected wellbeing long before specialist services became necessary.

Strategic stakeholders independently reinforced these observations. Drawing on fifteen years' experience leading a large voluntary and community sector mental health organisation, Deborah reflected that current investment often remains concentrated at the point where people have already reached the most acute end of the mental health pathway. As she explained:

"Prevention needs to start really early... if it's suicide prevention, we're already at one end of the scale, really extreme."
(Strategic stakeholder.)

Deborah argued that despite widespread policy commitment to prevention, resources frequently remain focused on responding to crisis rather than creating the conditions that enable people to remain mentally well. Her reflections closely mirrored participants' lived experiences described throughout the earlier themes, strengthening confidence that these findings represent systemic challenges recognised by both people with lived experience and senior leaders.

These accounts suggest that participants redefined prevention as a process occurring long before individuals enter specialist mental health services. Rather than locating prevention solely within healthcare, respondents described it as something produced collectively through supportive relationships, practical assistance, community participation and early intervention across everyday settings. Prevention was therefore something other than an earlier stage of treatment: it was a different way of understanding and promoting public mental health.

Prevention Happens in Everyday Life, Not Just Mental Health Services

Perhaps the strongest finding emerging across the research was that participants rarely viewed prevention as something delivered exclusively through mental health services. Instead, they consistently located prevention within the ordinary environments of everyday life. Relationships with family, friends and neighbours, opportunities to volunteer, meaningful employment, welcoming community spaces, peer support groups, faith communities, access to nature and simple everyday conversations were described as the experiences that protected mental wellbeing long before specialist intervention became necessary. Collectively, these findings suggest that participants understood prevention not as a clinical intervention but as a social process embedded within everyday community life.

This understanding contrasted sharply with traditional models of mental healthcare, where prevention is often conceptualised as earlier identification of illness or faster access to treatment. Participants did not dismiss the importance of healthcare services. Rather, they argued that by the time individuals required specialist intervention, many opportunities to prevent deterioration had already been lost. Prevention therefore became associated less with healthcare itself and more with creating the social conditions that reduced loneliness, strengthened resilience and enabled people to remain connected, valued and supported throughout everyday life.

Survey respondents repeatedly reinforced this broader understanding. Many described the need for welcoming community spaces where people could meet without stigma, build relationships naturally and seek support before crisis. Calls for additional clinical services alone were uncommon. One respondent explained:

"Communities need places where people feel welcome without having to explain why they're there."
(Survey respondent, female, aged 18–24 years.)

These responses extend the findings of Chapter 5. Participants were describing more than a sense of belonging that improved wellbeing; they viewed belonging as preventing deterioration by creating opportunities for connection before emotional distress became overwhelming.

Muhit's interview illustrates this particularly well. Living with severe and enduring mental illness, he returned not only to the importance of medication and psychological therapy but also to the value of community-based peer support. Reflecting upon his weekly support group, he explained:

"Talking about mental health and hearing other people's stories and telling my story, that really helps a lot."
(Lived-experience interview participant.)

When discussing periods of isolation, Muhit described a markedly different experience:

"I get severely depressed when I'm isolated... it really is a bad sort of place to be when you're isolated."
(Lived-experience interview participant.)

Rather than portraying peer support and social connection as optional additions to treatment, Muhit described them as essential mechanisms through which deterioration could be prevented. His account reinforces one of the central findings running throughout this report: meaningful relationships and opportunities for participation are not peripheral to mental health but constitute an essential part of prevention itself. Stephen similarly reflected that remaining mentally well often depended upon continuing to participate in everyday life, even when anxiety made this exceptionally difficult. Describing the preparation required before attending unfamiliar places, he explained:

"A lot of people think, 'Oh, you can just get up and go,' and you can't... it takes time to actually get yourself ready... sometimes that starts a couple of days beforehand."
(Lived-experience interview participant.)

Stephen's account adds an important dimension to participants' understanding of prevention. Rather than assuming that participation is effortless, he demonstrates the considerable emotional work required simply to remain connected with everyday life while living with anxiety. Prevention therefore involved creating environments that were sufficiently welcoming, flexible and psychologically safe for people to continue participating, even when doing so required significant effort.

These experiences were independently reinforced by strategic stakeholders. Reflecting on the role of voluntary and community organisations, Anja argued that community-based organisations often occupied a distinctive position because they developed trusted relationships over many years. Unlike services responding primarily at points of crisis, community organisations enabled people to seek help earlier because relationships already existed. As she explained:

"We probably have more trusted relationships... less staff turnover... we have more trusted relationships with many service users."
(Strategic stakeholder.)

Rather than viewing trust as simply improving service quality, Anja's observation reinforces participants' accounts that trusted relationships themselves functioned as preventative infrastructure, enabling earlier conversations, earlier disclosure and earlier support.

Participants also consistently described meaningful activity as preventative. Volunteering, employment, creative activities, caring for others and contributing to local communities were rarely discussed as formal mental health interventions. Instead, they were portrayed as experiences that strengthened identity, created routine, fostered confidence and reduced isolation. Prevention emerged through creating opportunities for people to contribute, participate and experience purpose within their everyday lives.

The DWP employment focus group reinforced this understanding by showing that access to employment, education and training can itself function as prevention when support is timely, relational and properly adapted. Participants described good work as providing more than income; it can support confidence, independence, routine, identity and social connection. However, they also described how discrimination, inaccessible recruitment, poor reasonable adjustments and limited entry-level opportunities could undermine wellbeing. Prevention therefore requires not only mental health services but work and education systems that enable people to participate with dignity.

These findings suggest that participants understood prevention as something woven into the fabric of ordinary life rather than delivered solely through mental health services. Public mental health was therefore conceptualised not simply as access to treatment but as the presence of communities, relationships and opportunities that enable people to remain connected long before specialist intervention becomes necessary. Prevention emerged not as a discrete intervention but as a characteristic of healthy, inclusive communities in which people are supported to belong, participate and flourish.

Making Prevention Possible: Investing Before Crisis

While participants articulated a compelling vision for prevention, they also recognised that achieving this vision would require fundamental changes in how mental health is understood, organised and resourced. Across stakeholder interviews, prevention was repeatedly described as being widely endorsed in principle yet comparatively underdeveloped in practice. Respondents suggested that although policies increasingly emphasise early intervention and prevention, investment continues to be concentrated at the point where mental health difficulties have already become severe. Consequently, participants questioned whether current systems genuinely prioritise prevention or remain predominantly configured to respond once people have reached crisis.

This tension emerged particularly strongly within the stakeholder interviews. Reflecting on the realities of delivering mental healthcare, Joe, a consultant psychiatrist, argued that the NHS increasingly recognises the importance of public mental health but continues to face uncertainty regarding its role in addressing the wider determinants that shape emotional wellbeing. As he explained:

“All of those are really, really important drivers of mental illness. The NHS as a provider... struggles still to understand what its role is in tackling those issues and how it should work with partners.”
(Strategic stakeholder.)

Joe’s observation is particularly significant because it mirrors the experiences described in Chapters 5 to 7. Respondents consistently described housing insecurity, financial hardship, loneliness, caring responsibilities, unemployment and social isolation as the pressures most affecting their mental wellbeing. Yet these were also the issues that participants frequently experienced as falling between organisational responsibilities.

Joe therefore identifies an important systemic challenge: recognising the wider determinants of mental health does not automatically create systems capable of responding to them effectively.

Stakeholders argued that meaningful prevention requires coordinated action across organisations, and none suggested that healthcare services should assume sole responsibility for it. Reflecting on his organisation's work addressing health inequalities, Joe explained:

"Primary prevention... cost of living... loneliness... we can have some impact if we work with partners, but actually our impact is going to be limited given the resources we've got."
(Strategic stakeholder.)

Rather than portraying this as organisational failure, his account highlights the limits of prevention when responsibility remains fragmented. Participants throughout this study demonstrated that emotional wellbeing develops through the interaction of social, economic and relational factors. Consequently, preventing poor mental health requires similarly integrated responses involving healthcare, local government, education, employers and voluntary and community organisations rather than expecting any single sector to respond alone.

Importantly, participants also challenged assumptions that prevention necessarily requires entirely new services. Instead, they frequently described relatively modest interventions that addressed practical problems alongside emotional wellbeing. Helping people manage debt, return to employment, improve physical health, access stable housing or reconnect with their communities were consistently described as important mental health interventions because they reduced the pressures that participants repeatedly identified as contributing to emotional distress.

Alice, a clinical lead, reflected directly on this broader understanding of mental healthcare:

"We don't just treat... give the antidepressants, give the CBT and our work is done. We've got to work alongside other partners... enabling residents to get some of these other needs met."
(Strategic stakeholder.)

This perspective closely mirrors the experiences described in Chapter 6. Emotional wellbeing was rarely experienced as separate from financial security, employment, physical health or relationships. Consequently, prevention emerged not simply through psychological intervention but through practical support that addressed the circumstances underpinning emotional distress.

Stakeholders also identified examples demonstrating how prevention could be embedded within existing systems. One participant highlighted Individual Placement and Support services as illustrating how investment in meaningful employment generated benefits extending far beyond income alone. Reflecting on the programme, he explained:

"Meaningful work is such a core pillar of good mental health."
(Strategic stakeholder.)

He similarly described Recovery Colleges as creating opportunities for people to gain confidence, knowledge and practical skills that strengthened self-management, while integrated debt advice and smoking cessation programmes demonstrated how practical interventions could improve both physical and psychological wellbeing simultaneously. These examples illustrate a preventative philosophy in which practical support, social participation and healthcare become mutually reinforcing.

Several stakeholders further argued that prevention requires a broader understanding of value than is typically captured through traditional service evaluation. Community organisations, peer support, employment initiatives and practical advice services were described as generating benefits extending beyond individual clinical outcomes, including stronger communities, improved employment, reduced welfare dependency and better physical health. One interviewee reflected that much of the evidence supporting prevention already exists, observing:

"We're 80 or 90 per cent there... we just need somebody to do it."
(Strategic stakeholder.)

Rather than calling for entirely new ideas, he suggested that the challenge lies in bringing existing evidence together in ways that influence commissioning and investment decisions, enabling prevention to be understood as long-term social investment rather than short-term service activity. These findings suggest that making prevention possible requires more than expanding mental health services alone. Participants and stakeholders argued for sustained investment in the wider social, economic and community conditions that enable good mental health to flourish. Prevention therefore meant more than intervening earlier within existing systems: it meant reorientating them towards addressing the everyday circumstances that shape mental wellbeing long before specialist care becomes necessary.

Prevention Is a Collective Responsibility

Perhaps the most significant finding to emerge across the dataset was that participants consistently rejected the idea that mental health prevention could be achieved by healthcare services alone. While respondents recognised the importance of accessible clinical care, they repeatedly argued that good mental health is created collectively through the environments in which people live, learn, work and connect with others. Prevention was therefore understood as a shared social responsibility requiring coordinated action across public services, employers, schools, voluntary organisations, communities and wider society rather than the responsibility of mental health services in isolation.

This understanding reflected the experiences of mental health described in Chapters 5 to 7. Emotional wellbeing was portrayed as being shaped through the interaction of financial insecurity, insecure housing, loneliness, physical health, caring responsibilities, discrimination and fragmented systems rather than any single event or circumstance. Participants therefore argued that meaningful prevention must address these wider influences rather than focusing solely upon treatment after difficulties have become established.

Survey respondents reinforced this broader understanding of prevention. Many highlighted affordable housing, secure employment, accessible public transport, opportunities for education and lifelong learning, safe neighbourhoods, green spaces and stronger community infrastructure as essential foundations for good mental health. Others argued that reducing poverty, improving workplace wellbeing and strengthening local communities would ultimately have a greater impact on population mental health than simply increasing clinical services. Although very few respondents used the language of public mental health, their accounts consistently reflected an ecological understanding in which wellbeing emerged through the interaction of multiple social, economic and environmental influences.

Importantly, participants also recognised that prevention is inseparable from reducing inequality. Throughout the interviews and focus groups, respondents repeatedly described how poverty, housing insecurity, discrimination, disability, caring responsibilities and social exclusion created unequal opportunities for good mental health. Prevention therefore became closely associated with fairness as well as healthcare.

Participants argued that improving population mental wellbeing requires creating environments in which everyone has genuine opportunities to participate, contribute and access support regardless of income, ethnicity, disability, age or social circumstance.

Strategic stakeholders independently reinforced these observations. They argued that sustained improvement depends upon partnership between healthcare, local government, education, employers, housing, transport and the voluntary and community sector, since prevention exceeds the reach of any single organisation. Earlier stakeholder accounts highlighted that although public policy increasingly recognises prevention, investment and organisational responsibility often remain concentrated at the point of crisis. Participants' lived experiences demonstrate the consequences of this mismatch, while stakeholder perspectives illustrate why coordinated partnership remains essential if prevention is to move beyond aspiration.

Respondents also challenged the assumption that prevention is an abstract policy ambition. Instead, they described practical actions that could be implemented within local communities. Schools promoting emotional wellbeing alongside educational attainment, employers supporting healthy working lives, neighbourhoods where people know one another, affordable community spaces, accessible transport, green spaces, volunteering opportunities and peer support groups were all identified as investments capable of strengthening mental wellbeing before clinical intervention becomes necessary. Prevention therefore emerged as something tangible, achievable and embedded within everyday life rather than a distant strategic objective.

The findings suggest that participants conceptualised prevention as fundamentally different from treatment. Treatment was associated with responding to established mental health difficulties, whereas prevention involved creating the social, economic and relational conditions that make good mental health more likely across the population. Healthcare remained an essential component of this system, but participants consistently argued that it represented only one part of a much broader network of influences shaping mental wellbeing across the life course.

Perhaps most significantly, this theme demonstrates that participants naturally articulated an ecological understanding of public mental health without drawing upon academic or policy terminology. Respondents understood wellbeing as something collectively produced through relationships, communities, opportunity and the wider conditions of everyday life, and seldom as the product of individual resilience or healthcare alone. Prevention therefore meant more than intervening earlier: it meant creating societies in which fewer people reach crisis in the first place.

Together, the four themes arising from our research present a coherent and interconnected understanding of public mental health. Chapter 5 demonstrated that relationships and belonging form the foundations of good mental wellbeing. Chapter 6 illustrated how emotional distress develops gradually through the accumulation of interconnected everyday pressures. Chapter 7 showed that participants encountered systems organised around crisis despite experiencing mental health as cumulative and relational. Finally, Chapter 8 demonstrated that preventing poor mental health requires sustained investment in the wider social conditions that enable people to remain connected, valued and supported before difficulties escalate.

Collectively, these findings suggest that public mental health cannot be understood solely through the provision of clinical services or the treatment of mental illness. Instead, participants consistently conceptualised mental wellbeing as something created, protected and restored through relationships, communities and the wider conditions of everyday life. In doing so, they articulated a relational and ecological understanding of public mental health that challenges crisis-oriented models of care and provides the conceptual foundation for the discussion chapter that follows. The discussion chapter that follows brings these themes and the insights and learning from the research together in the proposed 'Relational Model of Public Mental Health'.

CREATIVE OUTPUT | Research Poetry as Knowledge Translation

This final creative output uses thematic synthesis, participant and stakeholder testimony, and creative revoicing (Palmer, 2026) to bring together the prevention findings developed across this chapter. Direct or closely retained phrases from the research sit alongside re-voiced and connective lines created by the lead researcher, producing a composite poetic narrative rather than the account of any one participant. The poem does not introduce new evidence; instead, it translates the chapter's findings into an accessible public form, foregrounding the human consequences of where investment is made, what is recognised as crisis, and the quieter social and relational conditions that protect wellbeing beforehand. In this way, testimony is used not simply as illustration but as a means of creating awareness, stimulating dialogue and retaining the emotional and ethical force of lived experience alongside the report's analytical account.

Before Crisis Counts D. A. Palmer

Before
crisis counts,
there is a life.
A rent
rise.
A missed call.
A job lost.
A child gone quiet.
A carer still awake.
Before
crisis counts,
there are warnings
that do not look
urgent enough.
A school
notices.
A GP listens.
A neighbour asks.
A community group
keeps the kettle on
with funding
that ends in March.
Prevention
has to start
much earlier.
Everyone
knows.
So the
question
is not knowledge.
It is
power.
Who is
heard
when money moves?
Whose
pain
counts
before it becomes
an emergency?
Crisis
has numbers.
Crisis has thresholds.
Crisis has proof.
Meaningful work
can be
a core pillar
of good mental health.
So is
housing.
So is safety.
So is dignity.
So is somewhere
to belong
without explaining
why you came.
The
system
counts crisis
because crisis
arrives loudly.
Prevention
arrives quietly.
A room.
A wage.
A call answered.
A workplace adjusted.
A person remembered.
A door open
before breaking point.
Before
crisis counts,
someone is still
reachable.
Before
crisis counts,
something can still
change.
Prevention
is the choice
to change
the conditions
so fewer people
have to prove
how close
they came
to not
surviving.



Collaborative Interpretation Workshop
June 2026

Chapter 9. Collaborative Interpretation: Refining the Findings and Relational Model

“I’ve loved being part of this…I mean what’s the point in being here if I don’t contribute. I want to contribute as much as I can. I do have a voice here.” (Co-researcher)

Chapter Summary

The four themes presented in the preceding chapters were developed through analysis of the survey, lived-experience interviews, focus groups and strategic stakeholder interviews. Consistent with the lived-experience-led and co-produced methodology underpinning the study, however, these emerging interpretations were not treated as the endpoint of analysis. Before the findings, conceptual model and recommendations were finalised, they were returned to lived-experience participants and co-researchers through a collaborative interpretation workshop.

The purpose of this stage was not to ask participants to approve or validate a completed analysis. Instead, it provided an opportunity to challenge the emerging interpretation, identify areas requiring greater emphasis, consider whether important experiences had been overlooked and explore the implications of the findings for public mental health policy and practice. The workshop did not generate an additional overarching theme. Rather, it strengthened and refined the four existing themes, added specificity to the analysis of fragmented systems and geographical inequality, developed the emerging Relational Model of Public Mental Health and directly influenced the priorities subsequently translated into the report’s recommendations.

Participants particularly reinforced the importance of relationships and belonging, accessible community infrastructure, the wider social and economic foundations of mental wellbeing, continuity between services, more equitable access to community-based support and greater investment in prevention before crisis. Discussion of differences between boroughs also brought greater attention to unwarranted variation in community mental health provision and to the principle that people should not need to understand complex organisational structures before they can access help. Collaborative interpretation therefore operated as an extension of the analytical process rather than as conventional member checking. By bringing lived-experience knowledge back into the interpretation of the emerging evidence, the process strengthened the credibility, practical relevance and conceptual development of the research and provided an important bridge between the empirical findings and the discussion that follows.

From Emerging Findings to Collaborative Interpretation

A defining principle of the Thrive LDN Public Mental Health Research Project was that lived experience should influence not only the questions asked and the evidence collected, but also the meaning attributed to that evidence. As set out in the Methodology and Ethical Governance chapter, collaborative interpretation formed the final stage of the analytical process. Following initial thematic analysis, the four emerging themes and an early version of the Relational Model of Public Mental Health were shared with lived-experience participants and co-researchers before the analysis and recommendations were finalised. This approach reflected the distinction between involving people as contributors to research and recognising them as contributors to knowledge production.

Returning emerging interpretations to participants is established within qualitative research as one means of strengthening credibility and trustworthiness (Lincoln and Guba, 1985; Birt et al., 2016). Within lived-experience-led research, however, collaborative interpretation can extend further by enabling people to question researchers' assumptions, contribute alternative explanations, identify practical implications and shape the way findings are ultimately communicated and used (Beresford, 2007; Rose, 2013; Faulkner et al., 2019; Palmer et al., 2009).

Ten people took part in the collaborative workshop: four lived-experience participants recruited through Mind in London and six co-researchers involved in the wider research programme. The workshop was co-facilitated by the Research Lead and members of the co-research team. Participants considered the four emerging themes, the connections between them and the developing Relational Model of Public Mental Health. They were encouraged to identify omissions, question emphasis, offer examples from their own experiences and communities and consider what the findings meant for policy, commissioning and practice. Two collaborative mapping exercises were also undertaken to explore the relationships, community assets, wider social conditions and characteristics of systems that participants believed were necessary for good public mental health. The workshop therefore began with the emerging findings, but did not assume that the researchers' interpretation of those findings should be regarded as definitive. The central question was not simply "Are these findings correct?" but "What do these findings mean when they are considered alongside lived experience, and what needs to change as a result?"

Testing and Refining the Emerging Interpretation

There was strong recognition across the workshop that the four themes reflected participants' own experiences and the wider realities they observed within their families, communities and professional lives. Participants recognised the importance of relationships and social connection, the cumulative effects of wider social and economic pressures, the difficulties created by fragmented systems and the need to invest earlier in prevention. As one participant reflected:

"I can definitely relate to these. It makes sense that connections and relationships are central to good mental health. We are definitely fragmented in our neighbourhoods, our communities and London as a whole. I see it more and more…and more and more people are struggling because of the economy whilst becoming increasingly isolated."
(Collaborative interpretation workshop participant)

No participant identified an overarching theme that they believed to be fundamentally inaccurate, nor did the workshop generate a fifth theme. However, agreement was not treated as the principal outcome of the process. Discussion rapidly moved towards where the analysis required greater emphasis, what additional examples could illuminate the findings and how apparently separate problems interacted within people's everyday lives. Participants particularly reinforced the extent to which mental health was experienced through accumulation rather than through isolated events. Financial insecurity affected relationships and opportunities for social participation. Caring responsibilities influenced employment and income. Poor physical health reduced people's capacity to remain connected. Fragmented support weakened trust, while strong relationships and accessible community organisations could buffer some of the effects of adversity. This strengthened the emerging interpretation that public mental health could not be adequately understood by placing housing, employment, relationships, community participation, health and services into separate categories. Participants' accounts instead pointed towards continuing interaction between them.
The workshop therefore provided an important analytical transition. The four themes remained distinct enough to describe important areas of experience, but collaborative interpretation strengthened the case for understanding them as elements within a wider relational system.

Fragmented Systems, Unequal Access and the Burden of Navigation

One of the most substantial refinements concerned participants' experiences of navigating mental health and community-based support. The preceding findings had already identified fragmentation as an important source of distress. Participants described repeated assessments, having to retell personal stories, difficulties understanding referral pathways, poor communication between organisations and uncertainty about where to seek help.

The workshop added greater specificity by highlighting geographical variation across London. Participants described similar forms of community-based crisis support operating under different names, including Crisis Cafes, Safe Havens and other community crisis alternatives, but with considerable variation in opening hours, eligibility criteria, referral arrangements and relationships with statutory services. Some services accepted self-referral, while others required access through crisis teams or other statutory pathways. Evening and weekend provision differed considerably between boroughs, and participants questioned why people living only a short distance apart could experience markedly different access to support. One participant described the situation:

"It's hugely complicated. Some boroughs have Crisis Cafes and others don't. Some are commissioned and others have no provision at all. Some are open late, whilst others close at nine or ten o'clock. Some have direct links with ambulance services, some are clinically led and others operate more like an out-of-hours day centre. Greater clarity, greater consistency and even starting with a common name would make a real difference."
(Collaborative interpretation workshop participant)

Another described current provision as a: ***"postcode lottery."*** (Collaborative interpretation workshop participant)

Participants were not arguing that every borough should operate an identical service. Indeed, there was recognition that local flexibility and innovation are important. The concern was instead with unwarranted variation: differences in accessibility, availability and navigation that cannot readily be explained by differing community need and which can make support unnecessarily difficult to access. Participants repeatedly returned to the view that people experiencing distress should not first have to understand the architecture of the mental health system. As one participant explained:

"We should be able to get the right support at the right time without first having to understand the system or know the name of a particular service or how to access it."
(Collaborative interpretation workshop participant)

This discussion strengthened the earlier analysis of fragmentation in an important way. Fragmentation was not experienced only as poor communication between organisations. It also existed geographically through differences in provision, temporally through differences in opening hours, organisationally through different referral thresholds and linguistically through multiple names for apparently similar forms of support. At the point at which people were most emotionally overwhelmed, they could therefore also be required to undertake the greatest amount of system navigation.

The principle of No Wrong Door emerged strongly from these discussions. Participants argued that responsibility for navigating the system should sit primarily with organisations rather than with individuals experiencing distress. Wherever a person initially seeks help, the system should take greater collective responsibility for supporting them towards an appropriate response.

This did not imply creating a single centralised pathway or removing local discretion. Rather, participants emphasised a common set of principles: timely access, compassionate responses, continuity, clearer communication, equitable availability and stronger collaboration between statutory, voluntary and community organisations.

The workshop therefore shifted the emphasis of the emerging recommendations from simply improving individual services towards reducing unnecessary variation and designing systems that are easier for people to navigate.

Refining the Relational Model of Public Mental Health

Participants were also invited to consider the developing Relational Model of Public Mental Health, which is discussed further in Chapter 10. The model had emerged through synthesis of evidence across the survey, interviews, focus groups and stakeholder interviews. It sought to explain public mental health not as a linear pathway between risk, illness and treatment, but as a dynamic process shaped by the interaction of relationships, community environments, wider social and economic conditions and systems of support.

Participants strongly recognised this interconnected interpretation. One participant reflected:

"I think this brings everything together. It shows that mental health isn't just about services or treatment or therapy. It's about the people around us, the places we live, whether we feel connected, whether we have somewhere to go, someone to talk to, someone to keep an eye on and whether our communities work together. That's what I think good mental health really looks like." (Collaborative interpretation workshop participant)

Participants particularly responded to the model's rejection of a simple linear trajectory. People described moving between periods of wellbeing, greater pressure, distress, support and recovery as relationships and circumstances changed across their lives.

The workshop nevertheless moved beyond asking whether the model "made sense". Participants considered what the different components meant in practical terms and what might be missing if the framework were to be used beyond the research itself.

The collaborative mapping exercises were particularly important in this regard.
Working independently in smaller groups, participants identified the conditions that they believed enabled people and communities to maintain good mental health. Despite working separately, the two groups repeatedly identified similar priorities. Their contributions were subsequently synthesised into the following framework.

The consistency between the two mapping groups was notable. Participants returned to connected communities, trusted relationships, accessible neighbourhood places, joined-up organisations, economic and social security, prevention and equitable access.

Importantly, participants rarely began by describing specialist mental health interventions. Their discussion repeatedly moved towards the ordinary places in which relationships are created and maintained.

Table 9.1. Co-produced framework identifying the conditions participants considered essential for good public mental health

Participant-generated priority	Examples identified through collaborative mapping	How participants felt this supports mental wellbeing	Implications for policy and practice
Connected community places	Libraries, community cafes, community hubs, parks, green spaces, neighbourhood venues, local meeting places	Create opportunities for connection, reduce loneliness, and provide safe and welcoming places to meet.	Protect and invest in accessible community spaces as part of London's public mental health infrastructure.
Relationships and belonging	Families, neighbours, friendships, peer support, volunteering, trusted conversations, lived experience, community groups	Build trust, identity, confidence, resilience and mutual support.	Recognise relationships as protective public mental health assets, rather than informal additions to care.
Joined-up systems	“No wrong door”, partnership working, continuity, communication, simpler pathways, integrated support	Reduce confusion, improve navigation and provide earlier access to support.	Strengthen collaboration across statutory, VCSE and community organisations, whilst reducing fragmentation.
Community participation	Volunteering, community involvement, arts, music, creative activities, co-production, shared learning	Increase purpose, confidence, inclusion and opportunities to contribute.	Invest in participation, co-production and community leadership.
Trusted community organisations	Faith organisations, voluntary organisations, neighbourhood groups, community cafes, local charities	Provide trusted entry points into support, particularly for marginalised communities.	Recognise VCSE organisations as equal partners within London's mental health system.
Social foundations of wellbeing	Housing, employment, education, transport, financial security, funding for community organisations	Create the stability that enables people to maintain good mental health.	Embed mental health across wider social and economic policy.
Prevention before crisis	Early intervention, youth work, schools, social prescribing, local activities, accessible information	Support people earlier and reduce escalation into crisis.	Shift investment towards prevention and community capacity building.

What Participants Identified as Relational Infrastructure

Libraries were described as:

"safe places and important for communities and connections."
(Collaborative interpretation workshop participant)

One participant said that people need:

"somewhere just to belong."
(Collaborative interpretation workshop participant)

Green spaces were valued because they offered somewhere to:

"get away from it all, a place you can go outside and just breathe."
(Collaborative interpretation workshop participant)

Participants identified community cafes, social enterprise cafes, volunteering, arts and music activities, sports groups, faith communities, local charities and neighbourhood organisations as settings where people develop confidence, purpose and relationships.

These environments were therefore understood not simply as amenities but as part of London's relational infrastructure: the physical, social and organisational environments through which supportive relationships become possible. Participants also placed these community assets firmly within a wider social context. Housing, employment, education, transport and financial security were discussed alongside relationships and community connection.

One participant explained:

"The financial situation since COVID has worsened, as have community divisions, unemployment, young people without jobs, the loss of opportunities and the fact that so many people can't access affordable housing. That's the starting point."
(Collaborative interpretation workshop participant)

The implication was clear. Community connection cannot compensate indefinitely for structural insecurity. Strong relationships and neighbourhood resources may protect wellbeing, but the conditions within which those relationships exist also matter profoundly.

Good public mental health therefore requires both relational resources and social foundations.

The Erosion of Relational Infrastructure

A further insight arising from the collaborative discussion concerned the cumulative loss of community infrastructure. Participants reflected on the closure or reduction of local spaces, groups and organisations that had previously enabled everyday social contact. One participant observed:

"I mean all these social outlets, clubs and spaces have all closed over the last ten years. They've been gradually erased." (Collaborative interpretation workshop participant)

This was significant because participants did not describe such closures simply as a loss of leisure opportunities. They understood them as a loss of the places and structures through which relationships are made possible. A closed library, community centre, youth group, cafe or neighbourhood organisation can therefore have effects that extend beyond the individual facility. Its loss may mean fewer opportunities to meet other people, participate in community life, ask for informal help, volunteer, encounter trusted professionals or maintain a regular reason to leave the home.

These effects are unlikely to appear immediately within conventional mental health service activity data. Nevertheless, participants' accounts suggest that gradual erosion of local relational infrastructure can reduce the protective resources available to individuals and communities and may increase vulnerability to isolation and distress over time. This interpretation strengthened an important proposition within the developing Relational Model: investment in community infrastructure should not be regarded as separate from public mental health investment. Such spaces form part of the environments within which prevention happens.

From Collaborative Interpretation to Action

The workshop also had a direct influence on the recommendations arising from the research. Participants consistently argued that improving public mental health did not necessarily require the continual creation of additional standalone programmes. There was substantial concern that London already contains considerable expertise, community provision and examples of good practice, but that these resources are too often poorly connected, unevenly distributed or dependent on insecure funding. Their emphasis was therefore on strengthening what enables systems and communities to function relationally.

This included clearer pathways between organisations, greater continuity, recognition of community and voluntary organisations as integral partners, more sustainable investment in neighbourhood resources and a stronger focus on support before crisis. Consideration of Crisis Cafes, Safe Havens and other community alternatives strengthened the recommendation to reduce unwarranted variation and adopt principles such as No Wrong Door. Participants' reflections on libraries, cafes, green spaces, arts, volunteering and local community groups reinforced the importance of recognising relational infrastructure as part of public mental health provision. Their accounts of housing, employment, education, transport and financial security further supported the argument that public mental health cannot be the responsibility of mental health services alone.

Participants also challenged assumptions about where prevention begins. Rather than locating prevention primarily within early clinical intervention, they described prevention as the creation of circumstances in which people are more able to remain connected, participate, feel secure and access support before difficulties become overwhelming.
In this interpretation, prevention includes healthcare, but it also includes secure housing, meaningful employment, supportive schools, financial stability, accessible local spaces, opportunities for participation and relationships that allow people to recognise and respond to distress early. Investment in such conditions is therefore not peripheral to mental health strategy. It is part of public mental health itself.

From Emerging Model to Co-produced Framework

One of the most important outcomes of the collaborative interpretation workshop was the further development of the Relational Model of Public Mental Health. The model did not originate in the workshop itself; its initial structure had emerged inductively through analysis across the survey, interviews, focus groups and stakeholder evidence.

The workshop instead provided an opportunity for lived-experience participants and co-researchers to test, challenge and extend that emerging interpretation.

Participants strongly recognised the model's emphasis on interconnectedness and reinforced the central importance of relationships, community infrastructure and wider social and economic conditions. Their contributions also moved the model beyond explanation towards practical application. Rather than considering only what mental health services should be provided, participants encouraged a broader set of questions about the conditions that enable good mental health: whether people have access to relationships and a sense of belonging; whether community infrastructure supports those relationships; which social and economic pressures restrict participation and wellbeing; how easily people can move between informal, community and statutory support; where fragmentation creates additional distress; and where opportunities for prevention are being lost. This changed the status of the model. It was no longer simply a researcher-developed interpretation of the findings, but a collaboratively refined framework shaped through dialogue with people bringing direct lived experience. Their involvement strengthened both its explanatory value and its relevance to commissioning, neighbourhood development, partnership working and service redesign.

What Collaborative Interpretation Contributed

The collaborative workshop did more than establish that participants recognised the emerging findings. It introduced an additional layer of lived-experience scrutiny at a point when the interpretation, conceptual model and recommendations were still open to challenge and change.

The process strengthened the analysis in several interconnected ways. Participants examined the four emerging themes against their own experiences and those of their communities, adding greater depth to the ways in which relationships, inequality, fragmentation, community resources and wider social conditions interacted in everyday life. Their contributions also shifted the emphasis of the analysis, bringing greater attention to geographical variation in provision, consistency of community-based crisis support, No Wrong Door approaches and the importance of relational infrastructure. At the same time, they helped clarify the practical meaning of the Relational Model and how it might be applied beyond the research. These refinements subsequently shaped the recommendations, ensuring that they reflected not only patterns identified within the original datasets, but also what lived-experience participants and co-researchers believed those findings required from policy, commissioning and practice.

This stage of the research also illustrates a wider methodological point. Lived-experience involvement is often concentrated at the beginning of research, through consultation on research questions, or within data collection. Yet some of the most consequential interpretive decisions occur later, when patterns are named, explanations are developed, priorities are established and recommendations are formulated. Collaborative interpretation created a deliberate space for lived-experience expertise within precisely this stage of knowledge production.

This did not remove the interpretive responsibility of the Research Lead, nor did it eliminate differences in power between researchers, organisations and participants. Equally, agreement within one workshop cannot establish that the findings represent every Londoner or every community. Rather, the value of the process lay in exposing the emerging interpretation to an additional and distinctive form of scrutiny: participants were able to consider the findings not only as analytical categories, but in relation to their own experiences of distress, recovery, services, communities, inequality and everyday life. In this way, collaborative interpretation strengthened both the credibility and the practical relevance of the final analysis, while ensuring that lived-experience expertise continued to shape the research at the point where meaning, priorities and implications were being decided.

CREATIVE OUTPUT | Research Poetry as Knowledge Translation

The following poem is presented as a composite creative knowledge-translation output developed from the collaborative interpretation workshop and the themes refined through it. It draws on participant and co-researcher testimony about listening, contribution, disagreement, shared meaning-making and the right to influence interpretation before conclusions are fixed, combining these accounts with thematic synthesis and creative revoicing (Palmer, 2026). The poem does not represent a verbatim account of any one participant or introduce new findings; rather, it uses testimony and crafted connective language to make visible the relational and methodological significance of co-produced interpretation. In this way, the creative output supports awareness of how lived-experience knowledge can move beyond consultation to shape what is understood, prioritised and ultimately acted upon.

At the Table D. A. Palmer

At first
I thought listening
meant knowing
what to say next.
Then I learnt
to leave the silence.
To let somebody stop.
Start again.
Lose the sentence.
Find another one.
To say,
take your time.
It doesn't have
to be perfect.
Because sometimes
the important thing
is not the question.
It is what happens
when nobody rushes
to fill the space.
A story comes out
differently
when it isn't being corrected.
When nobody turns it
into a diagnosis,
an outcome,
a number on paper.
So we listened.
We heard what worked.
What didn't.
Who was waiting.
Who had given up asking.
Who found somewhere
they finally felt safe.
And then something changed.
We weren't only
collecting stories.
We were carrying them
into the room
where meaning gets decided.
Asking:
Have we understood this?
What have we missed?
What needs to change?
That is the difference.
Not being invited in
when the report is finished.
Not one quotation
in somebody else's conclusion.
A chair.
A question.
Time to disagree.
The right to say:
that isn't quite
what we meant.
And to be heard
before the answer
is written.
There is room
for my voice here.
Not because
somebody gave me one.
Because this time
there was space
for it to matter.

The following chapter develops this interpretation in greater depth through the Relational Model of Public Mental Health. Drawing together the empirical findings and their collaborative refinement, it considers how a relational perspective can extend existing public mental health theory and provide a framework for prevention, commissioning, policy and practice.

Chapter 10: Discussion – Towards a Relational Model of Public Mental Health

“Mental health isn’t created in hospitals, clinics or surgeries. It’s created in families, communities and the places where people belong.” (Service User)

Chapter Summary

This chapter brings together the four empirical themes presented in the preceding findings chapters and their subsequent refinement through collaborative interpretation with lived-experience participants and co-researchers. It develops the principal conceptual contribution of the study: that public mental health is best understood as a relational process rather than as the product of isolated determinants or healthcare services alone.

The findings are interpreted through a relational perspective in which relationships are not treated simply as one determinant of mental health among many, but as a central mechanism through which wider social, economic and environmental conditions are experienced, interpreted and negotiated. Public mental health therefore emerges through the continual interaction between relationships, relational infrastructure, wider social conditions, systems of support and opportunities for prevention across the life course.

Building on evidence generated through the survey, lived-experience interviews, focus groups and strategic stakeholder interviews, and subsequently challenged and refined through collaborative interpretation, the chapter presents the final Relational Model of Public Mental Health. Rather than depicting a linear pathway from risk to illness and recovery, the model conceptualises mental wellbeing as dynamic, reciprocal and continually shaped by changes in people, relationships, places, social conditions and systems.

The chapter moves from empirical interpretation to conceptual explanation. It locates the model within existing public mental health theory, examines its contribution to contemporary debates concerning prevention and inequalities, demonstrates its application through a worked example and considers its implications for theory, commissioning, policy, practice and future research.

From Themes to Theory: Understanding Public Mental Health as a Relational Process

Individually, the four themes presented in the preceding findings chapters reinforce a substantial body of public mental health literature. Participants described the protective value of relationships and belonging, the cumulative impact of social and economic adversity, the emotional labour of navigating fragmented systems and the importance of strengthening prevention. Considered collectively, and subsequently explored through collaborative interpretation, these findings suggest something more significant: public mental health is not best understood as a collection of separate influences, but as a dynamic relational process through which different aspects of everyday life continually interact. Across interviews, focus groups and stakeholder discussions, participants rarely separated their experiences into discrete categories. Financial insecurity affected family relationships; caring responsibilities influenced employment and social participation; declining physical health reduced confidence and independence; fragmented services undermined trust; and supportive communities could buffer the impact of adversity.

These experiences accumulated, overlapped and reinforced one another over time, demonstrating that public mental health is experienced as an ongoing and reciprocal process rather than as a series of isolated risks.

The collaborative interpretation stage strengthened this reading of the findings. Lived-experience participants and co-researchers similarly understood mental wellbeing as shaped through the interaction of relationships, wider social and economic conditions, community infrastructure and systems of support. Their reflections added particular emphasis to accessible community spaces, continuity and trust, unwarranted variation between areas and the need to create conditions for wellbeing before people reach crisis. Collaborative interpretation therefore did not generate a separate explanation; it sharpened the relational account emerging from the empirical data and informed the final conceptual model.

This interpretation is consistent with ecological models of health, which emphasise reciprocal relationships between individuals and their wider social environments (Bronfenbrenner, 1979), and with evidence demonstrating that the social determinants of health profoundly influence population mental wellbeing (Marmot, 2010; Allen et al., 2014; WHO, 2022). The present findings extend these perspectives by illustrating how structural influences become meaningful within everyday life. Poverty, unemployment and poor housing were not experienced simply as abstract determinants. They affected relationships with partners, children, friends, neighbours and communities, reduced opportunities to participate and gradually eroded confidence, hope and belonging. Structural disadvantage was therefore experienced relationally.

This relational interpretation also offers a different perspective on the role of mental health services. Although participants valued timely access to compassionate and effective care, services were rarely portrayed as the sole source of wellbeing. Instead, they formed one component within a much broader ecology of support that included families, neighbours, voluntary organisations, peer networks, faith communities, community cafes, libraries, parks, schools and workplaces. These everyday settings were not peripheral to public mental health; they were places in which relationships were formed, sustained and restored, often long before specialist intervention became necessary.

The central insight is therefore more than the claim that relationships matter, but that they provide an organising mechanism through which wider determinants are experienced and negotiated. Existing frameworks frequently position relationships alongside housing, education, employment and income as one determinant among several. The findings presented here suggest a more integrated interpretation: relationships connect these wider influences, shaping how hardship is experienced, how people participate in community life, how they navigate systems and how recovery becomes possible.

This interpretation is closely aligned with the accompanying London public mental health evidence review and service mapping, which similarly concludes that effective approaches are relational because trust is built through people who understand the lives in question. Crucially, however, the review also identifies the limits of relational approaches: relational capacity should be treated and funded as infrastructure, but it cannot substitute for decent housing, secure income or good work. Its conclusion is therefore complementary to the present model, sustain the relationships and community capacity that make prevention possible, while also changing the material conditions that relationships alone cannot reach (Higgins and Woodhead, 2026).



Collaborative Interpretation Workshop
June 2026

The Relational Model of Public Mental Health

The Relational Model of Public Mental Health emerged inductively through integration of evidence from the survey, lived-experience interviews, community focus groups and strategic stakeholder interviews, and was subsequently challenged and refined through collaborative interpretation with lived-experience participants and co-researchers. It therefore represents an empirical synthesis of the study's findings rather than a framework imposed on the data through existing theory.

The model conceptualises public mental health as dynamic rather than linear. Participants described moving repeatedly between periods of wellbeing, adversity, recovery and renewed challenge as relationships, personal circumstances and environments changed over time. This interpretation aligns with life-course perspectives recognising that health trajectories are shaped through cumulative experiences (Ben-Shlomo and Kuh, 2002), whilst extending these approaches by demonstrating how changing relationships influence people's capacity to navigate, respond to and recover from those experiences.

Relationships occupy the centre of the model. Across every component of the study, feeling connected, valued and understood emerged as fundamental to maintaining mental wellbeing. Family, friendships, neighbours, peer support, volunteering, trusted professionals and everyday conversations fostered hope, identity, practical support and a sense of belonging. Relationships therefore functioned not simply as one protective factor among many, but as the means through which participants interpreted adversity, sought support and experienced recovery.

Surrounding these relationships is relational infrastructure, a central concept developed through the study. Relational infrastructure refers to the physical, social and organisational environments that create opportunities for supportive relationships to develop, flourish and endure. Libraries, parks, community cafes, neighbourhood organisations, faith communities, peer-support groups, volunteering opportunities, youth provision, arts activities and community hubs consistently emerged as places where trust, participation and belonging were fostered. This interpretation complements theories of social capital (Putnam, 2000; Kawachi and Berkman, 2001), asset-based community development (Kretzmann and McKnight, 1993) and salutogenesis (Antonovsky, 1979), whilst extending them by locating these community environments explicitly within an empirically derived public mental health framework.

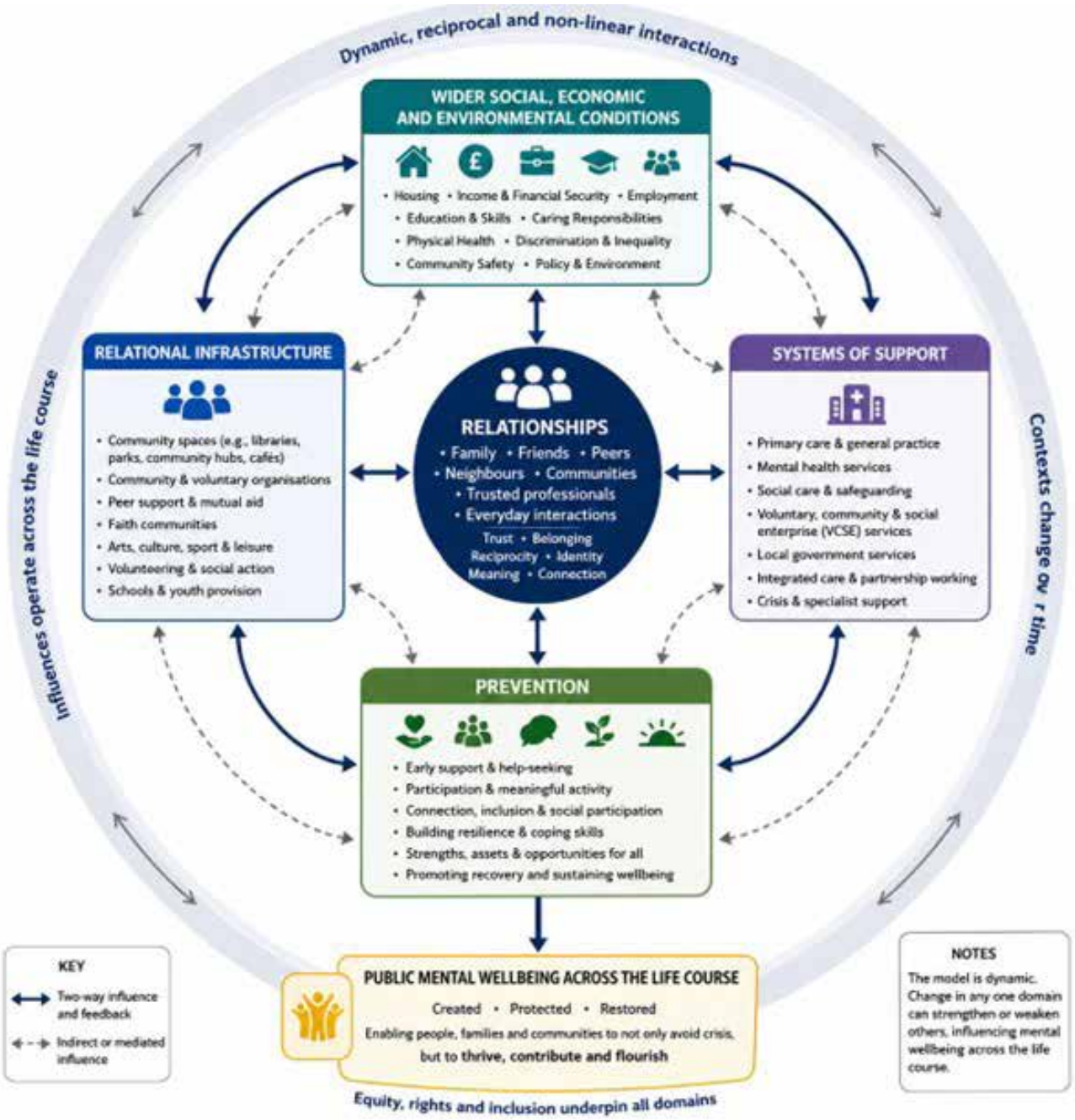
These relational environments exist within wider social, economic and environmental conditions. Housing, employment, education, caring responsibilities, financial insecurity, discrimination and physical health were experienced not as isolated influences but as interconnected pressures that accumulated over time, progressively reducing emotional resources and opportunities for participation. Whilst this supports extensive evidence concerning the social determinants of mental health (Marmot, 2010; WHO, 2022), the present study shows how structural inequalities become emotionally significant through their effects on belonging, participation, identity and supportive relationships.

Formal mental health services form another important element of the model, but they are not its defining feature. Participants demonstrated that experiences of care were shaped not only by the availability of services, but by the quality of the relationships developed within them. Trust, continuity, shared decision-making and feeling recognised as a person strengthened engagement and recovery, whereas fragmented pathways, repeated assessments, inconsistent thresholds and poor communication could compound existing distress. These findings resonate with relational approaches to healthcare (Beach, Inui and the Relationship-Centered Care Research Network, 2006; Suchman, 2006) and suggest that relational continuity should be understood as a therapeutic resource rather than simply an organisational objective.

The final component of the model concerns prevention. Participants consistently described prevention as the conditions that enable individuals and communities to remain mentally well, rather than intervention only after difficulties have escalated. Secure housing, meaningful employment, supportive schools, financial security, accessible community spaces, opportunities for participation and strong social relationships were all understood as relevant to public mental health because they reduced adversity while strengthening belonging, opportunity and connection.

Together, these elements form an interconnected relational system in which relationships, 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 Relational Model of Public Mental Health

Figure 10.1 should be read as an empirically derived interpretive framework rather than as a tested causal or predictive model. The relationships shown are grounded in the present study, but their relative strength and operation are likely to vary across populations, places and stages of the life course and require further empirical application and evaluation. Nor does the model imply that relational resources can compensate for structural disadvantage; rather, it draws attention to the ways relational and material conditions interact, and to the need to strengthen both.

One further caution applies specifically to the relational interpretation advanced here. Recruitment ran largely through Mind in London, local Mind organisations, Healthwatch networks, which are independent of Mind, and wider community networks, and 88.0 per cent of survey respondents reported current or previous mental health difficulties. A sample assembled in this way may be predisposed to describe wellbeing in relational and community terms, and it would be circular to treat the prominence of relationships in the data as evidence of their importance without acknowledging that. This is a recognised feature of experiential and community-recruited samples rather than a defect peculiar to this study (Beresford, 2007; Kalathil, 2011). Three features of the evidence make the finding harder to explain by recruitment alone.

The strategic stakeholder interviews were conducted with people who had no comparable proximity to community mental health provision, yet they reached similar conclusions about community infrastructure and continuity. Participants who valued community support most highly were often the same people describing its recent loss, which is a different claim from a general preference for community solutions. The accompanying evidence review and service mapping, which drew on published literature and service data rather than on this sample, converged independently on the relational character of effective provision while insisting on its limits (Higgins and Woodhead, 2026). The relational reading is also consistent with established work on connectedness in recovery, peer support and community-centred approaches to health (Leamy et al., 2011; Repper and Carter, 2011; South et al., 2019). The finding should nevertheless be read as strongest for Londoners who retain some connection to community organisations, and as requiring testing with populations reached through other routes.

Applying the Relational Model of Public Mental Health: A Worked Example

Figure 10.1 makes the model's reciprocal structure visible. The following composite example, synthesised from patterns identified across the survey, lived-experience interviews, focus groups and stakeholder discussions, shows how changes in one part of the system can affect several others at the same time, and how different opportunities for prevention may emerge across a person's life.

Consider a woman in her early fifties who works part-time whilst caring for an elderly parent and supporting an adult son experiencing mental health difficulties. As her caring responsibilities increase, she reduces her working hours, resulting in greater financial insecurity. Rising household costs make it increasingly difficult to participate in social activities, whilst emotional exhaustion and disrupted sleep begin to affect her physical health and confidence. Gradually, she withdraws from friends, community activities and opportunities that had previously provided support, connection and enjoyment.

Viewed through the Relational Model, these experiences are not separate problems requiring separate solutions. Financial insecurity increases stress within caring relationships whilst simultaneously reducing opportunities for social participation.

Increasing caring responsibilities make employment more difficult to sustain, further reducing household income and limiting opportunities to maintain supportive relationships. Declining physical health reduces confidence to engage with community activities, weakening the very networks that previously buffered adversity. Each experience reinforces the others, and the sequence is seldom simple.

The model also identifies where prevention may occur. If relational infrastructure remains accessible, this trajectory may begin to change before distress escalates into crisis. A community cafe, local library, walking group, peer-support programme, volunteering opportunity or faith community may provide opportunities to reconnect with others, access practical advice, rebuild confidence and regain a sense of purpose. These settings do not replace specialist mental health services; rather, they create relational conditions through which wellbeing can be strengthened and sustained before specialist intervention becomes necessary.

Conversely, where community infrastructure has been reduced through the closure of shared spaces or loss of local organisations, opportunities for early support become more limited. The loss of libraries, neighbourhood organisations, youth provision, community groups and other local assets is therefore not simply a loss of amenity. It represents erosion of the relational environments through which trust, belonging, reciprocity and informal support are generated, reducing communities' collective capacity to protect mental wellbeing.

If specialist support becomes necessary, the quality of formal services becomes another influence on the trajectory. Fragmented pathways, repeated assessments, inconsistent thresholds, long waiting times and poor communication risk compounding existing distress by weakening trust and forcing people to navigate disconnected systems. By contrast, services organised around continuity, compassion, trusted relationships and effective partnership with community organisations can reinforce existing strengths, reconnect people with wider networks of support and facilitate recovery.

The example illustrates the central proposition of the Relational Model: mental wellbeing is shaped through continual interaction between relationships, community environments, wider social conditions and systems of support. Movement through the model is neither fixed nor predictable; people may move repeatedly between wellbeing, adversity, support and recovery as circumstances change. The value of the model lies in making these reciprocal interactions visible and in identifying multiple points at which preventive action may strengthen the conditions that enable individuals, families and communities to remain well, participate and flourish.

Rethinking Prevention: From Services to Relational Infrastructure

One of the most important implications of the study concerns the way prevention is understood. Conventional public health frameworks distinguish between primary, secondary and tertiary prevention, focusing on reducing risk, identifying difficulties earlier and preventing relapse (Institute of Medicine, 1994; Campion et al., 2020). These approaches remain important, but the findings suggest that they represent only part of the prevention agenda. Participants understood prevention not simply as earlier clinical intervention, but as the conditions that enable individuals, families and communities to remain mentally well before crisis develops.

Opportunities for prevention arise throughout everyday life rather than only at the point of formal service contact. Supportive relationships, accessible community spaces, meaningful participation and practical support can interrupt the accumulation of adversity long before distress becomes overwhelming. Prevention therefore emerges as a continuous social and relational process rather than a discrete intervention delivered before treatment.

This interpretation aligns with public mental health literature demonstrating that mental wellbeing is shaped substantially outside healthcare systems (Marmot, 2010; Allen et al., 2014; WHO, 2022). The present findings extend this literature by demonstrating that wider social conditions influence mental wellbeing through their effects on connection, participation and belonging. Housing, employment, income and education matter not only as material determinants, but because they shape people's opportunities to sustain relationships, participate in community life and fulfil valued social roles.

The concept of relational infrastructure provides a way of understanding this process. Community cafes, libraries, parks, neighbourhood organisations, volunteering, peer support, faith communities, youth provision and arts activities are preventative not because they are clinical interventions, but because they create environments in which trust, reciprocity and belonging can develop. Within the model, these community environments are therefore understood as part of the relational architecture through which population mental wellbeing is created and sustained.

This perspective also reframes resilience. Resilience emerged as something supported collectively through relationships, accessible community resources and responsive systems, and not principally as an individual capacity to withstand adversity. Participants demonstrated considerable endurance in the face of financial hardship, caring responsibilities, declining physical health and fragmented services. Endurance alone, however, is not prevention. Prevention requires the relational, social and economic conditions that allow people to rest, reconnect, contribute, seek support and recover before crisis becomes unavoidable.

The accompanying London public mental health review reaches a complementary practical conclusion. It identifies short funding cycles as a threat to the trust and continuity on which relational work depends, and argues that community and peer-led capacity is more sustainable when communities have genuine ownership and secure resources over time (Higgins and Woodhead, 2026). This reinforces the present study's argument that prevention should be built with communities and supported through durable relational infrastructure.

Importantly, prevention should be understood as more than reducing the likelihood of mental ill health. Participants described wanting opportunities not simply to survive difficult circumstances, but to belong, contribute, maintain meaningful relationships and live fulfilling lives. Public mental health therefore encompasses the creation of environments in which individuals, families and communities are able not only to avoid crisis, but to flourish.

The Relational Model therefore broadens the prevention question. It asks not only how services can intervene earlier, but how communities, organisations and public policy can create the relational and material conditions that enable people to remain well, participate fully and flourish across the life course.

Contributions to Public Mental Health Theory

The principal contribution of the present study is not the identification of previously unrecognised determinants of mental health. Housing, employment, education, financial insecurity, discrimination, social isolation and community participation have long been recognised within public mental health literature (Marmot, 2010; WHO, 2022). Rather, the study contributes an integrated explanation of how these established influences interact to shape population mental wellbeing.

1. Public mental health as a relational process

Existing public mental health frameworks acknowledge interactions between individuals and wider social environments. The present study extends this perspective by conceptualising public mental health as a dynamic and reciprocal process rather than as the cumulative effect of separate determinants. Its first contribution is therefore explanatory: it focuses attention on interaction, change and movement across the life course.

2. Relationships as the integrating mechanism

A second contribution concerns the specific position of relationships within that process. Existing frameworks commonly present relationships alongside housing, employment, education and income. The findings suggest that relationships also operate as an integrating mechanism: they shape how structural conditions are experienced and negotiated, how people participate and seek support, and how adversity or recovery is given meaning in everyday life.

3. Relational infrastructure

A third contribution is the application and development of relational infrastructure as a public mental health construct. Previous research has demonstrated the importance of social capital (Putnam, 2000; Kawachi and Berkman, 2001), salutogenesis (Antonovsky, 1979; 1987), asset-based community development (Kretzmann and McKnight, 1993) and community assets (South et al., 2019). Building on these perspectives, the present study uses relational infrastructure to describe the physical, social and organisational settings through which supportive relationships develop, are sustained and contribute to population mental wellbeing. Its contribution lies in locating these environments explicitly within an empirically derived public mental health model and showing how they interact with material conditions, systems of support and prevention.

4. Reconceptualising prevention

The fourth contribution concerns prevention. Rather than locating prevention primarily within healthcare systems, the study conceptualises it as strengthening the relational, social and economic conditions that enable individuals, families and communities not only to remain mentally well, but also to participate, contribute and flourish. This places community infrastructure, opportunities for connection and everyday participation within public mental health itself rather than treating them as supplementary to clinical intervention.

5. Methodological contribution

The study contributes methodologically through its collaborative approach to interpretation. Rather than using member checking solely to validate findings (Birt et al., 2016), the collaborative interpretation workshop became an extension of the analytical process. Lived-experience participants and co-researchers refined the emerging interpretation, challenged assumptions, strengthened the conceptual model and shaped its practical implications. This demonstrates how collaborative interpretation can contribute not only to credibility, but also to conceptual development and knowledge production.

6. The Relational Model of Public Mental Health

These contributions culminate in the Relational Model of Public Mental Health. The model introduces no new determinants. Its contribution is a new way of understanding how established determinants interact through relationships, relational infrastructure, wider social conditions, systems of support and prevention. It offers an empirically grounded and collaboratively refined conceptual framework capable of informing future theory, research, commissioning, policy and practice.

The following chapter translates this relational explanation into an evidence-informed agenda for policy, commissioning and practice, identifying where action is required across communities, public services and the wider social conditions that shape mental wellbeing.



Chapter 11: Recommendations

“Rather than asking how services respond once people become unwell, we need to ask how society and communities create the conditions that enable people to remain mentally well.” (Strategic Interview)

From Evidence to Action: A Relational Agenda for Public Mental Health

The recommendations presented in this chapter are intended to be read as a single, integrated agenda for improving public mental health. They reflect the central finding of the Thrive funded London Public Mental Health Research Project: mental wellbeing is created not only through access to effective healthcare, but through relationships, belonging, participation and the wider social conditions in which people live their everyday lives.

The evidence consistently demonstrates that improving population mental health requires a shift from predominantly reactive systems towards a preventative, relational and community-centred approach. Whilst high-quality mental health services remain essential, they represent only one part of a wider public mental health system that also includes families, neighbourhoods, schools, workplaces, voluntary organisations and local communities. Strengthening these everyday sources of connection and support is fundamental to reducing inequalities, preventing distress and enabling people to thrive.

The Relational Model of Public Mental Health offers an evidence-informed framework for bringing together prevention, integrated care, action on the wider determinants of health and lived-experience leadership within a coherent approach to system transformation. It provides policymakers, commissioners and practitioners with a practical way of aligning services and investment around the conditions that participants identified as most important for mental wellbeing.

Chapter 10 introduced the Relational Model of Public Mental Health to explain these findings, positioning relationships as a central mechanism through which wider social, economic and environmental conditions are experienced and negotiated across the life course. This chapter translates that evidence into practical recommendations for Thrive LDN, policy, commissioning and practice.

The recommendations are intentionally interconnected. They do not propose isolated service improvements or additional programmes, but a coherent shift towards a more preventative, relational and community-centred approach to public mental health. Improving population mental health requires coordinated action across health services, local government, housing, education, employment, planning, the voluntary and community sector and local neighbourhoods. Responsibility therefore extends well beyond specialist mental health services. and supportive communities could buffer the impact of adversity.

Each recommendation is grounded in the evidence presented throughout this report and reflects priorities identified by participants during the collaborative interpretation workshop. Collectively, they provide an evidence-informed framework for strengthening the relational conditions that enable individuals and communities to thrive.

Rather than asking how services respond once people become unwell, these recommendations ask how society can create the conditions that enable people to remain mentally well.

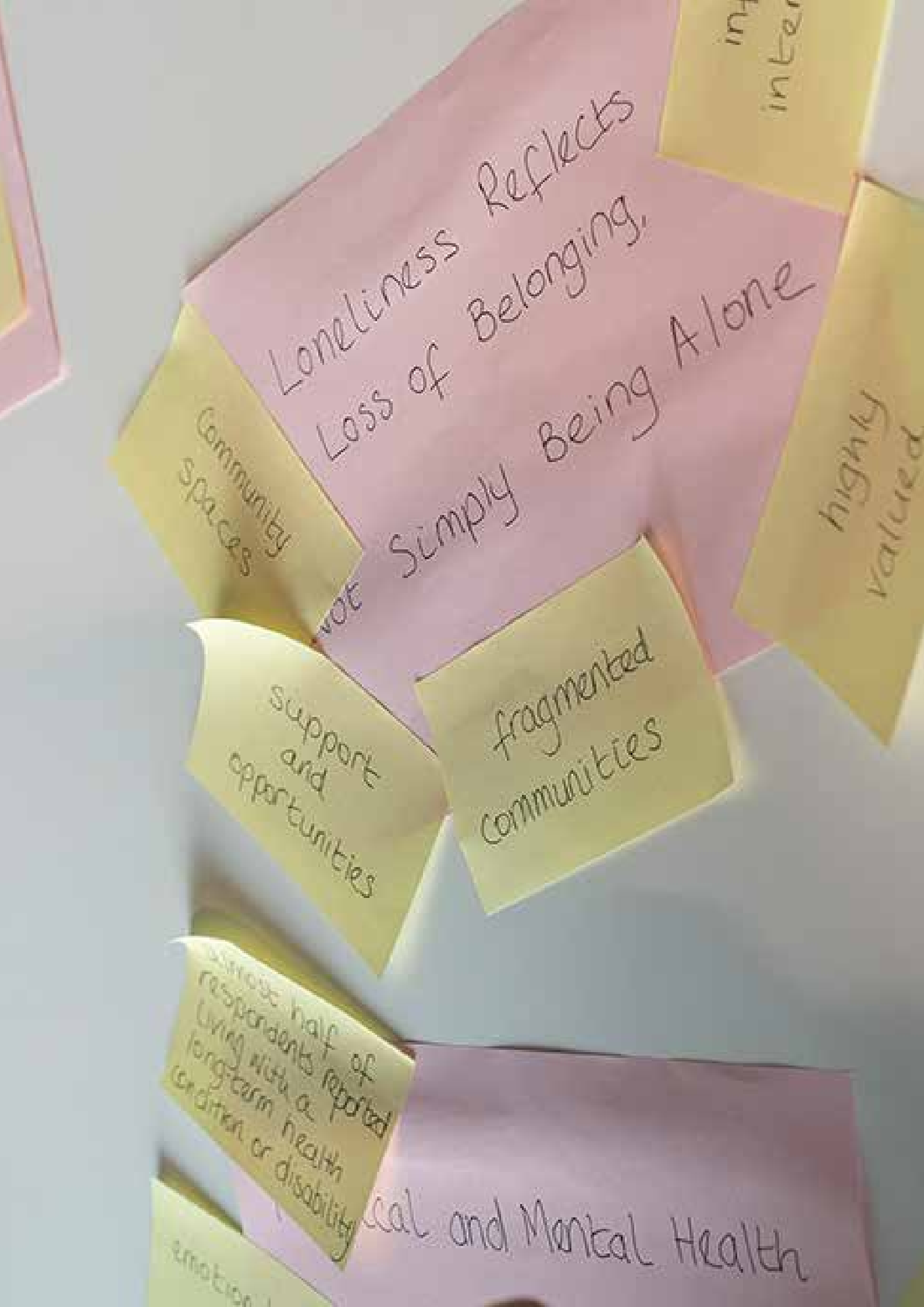
Table 11.1 Summary of Recommendations

Recommendation	PRINCIPAL FINDING ADDRESSED	STRATEGIC OBJECTIVE	LEAD ORGANISATIONS	Suggested indicators
1. RELATIONSHIPS AT THE CENTRE OF PUBLIC MENTAL HEALTH POLICY	Relationships are the strongest protective factor for mental wellbeing.	Position relationships, belonging and social connection as core public mental health assets.	Greater London Authority, Thrive LDN, Integrated Care Boards, London borough Public Health Teams, Office for Health Improvement & Disparities	Community connectedness, loneliness, volunteering, peer support participation, wellbeing scores
2. INVESTMENT UPSTREAM: MAKING PREVENTION THE DEFAULT	Mental health deteriorates as everyday pressures accumulate.	Increase investment in early intervention and prevention to avoid crisis.	NHSE London Region, Integrated Care Boards, Directors of Public Health, London boroughs	Earlier access to support, reduced crisis presentations, improved wellbeing, reduced emergency admissions
3. BUILD RELATIONAL NEIGHBOURHOODS	Community spaces and neighbourhood organisations are places where mental wellbeing is created and sustained.	Strengthen neighbourhood infrastructure and community capacity as part of London's public mental health system.	Local authorities, Integrated Care Boards, VCSE organisations, Primary Care Networks, social prescribing teams, London Plus	Community participation, neighbourhood belonging, volunteering, reduced loneliness, equitable access to community assets
4. DESIGN SYSTEMS AROUND PEOPLE RATHER THAN ORGANISATIONS	Fragmented services increased emotional burden through repeated storytelling, poor continuity and complex navigation.	Create integrated, person-centred systems based upon continuity, coordination and trusted relationships.	Integrated Care Boards, NHS providers, local authorities, primary care networks, VCSE providers	Improved continuity of care, reduced repeated assessments, patient experience, coordinated pathways

Recommendation	PRINCIPAL FINDING ADDRESSED	STRATEGIC OBJECTIVE	LEAD ORGANISATIONS	Suggested indicators
5. RECOGNISE LIVED EXPERIENCE AS ESSENTIAL EXPERTISE	Co-production strengthens research quality, interpretation and practical relevance.	Embed lived-experience leadership across research, commissioning, governance and service redesign.	Thrive LDN, Greater London Authority, Integrated Care Boards, universities, VCSE sector, Institute for Health & Care Research (NIHR), peer led organisations, Mind co-researchers Public Involvement & Engagement Standards, London HE Strategy, Nothing About Us Without Us	Paid lived-experience roles, co-produced programmes, influence on decision-making, diversity of representation
6. MEASURE WHAT MATTERS	Successful support through belonging, trust, participation, continuity and hope rather than service activity alone.	Develop relational outcome measures alongside traditional performance indicators.	Greater London Authority, Directors of Public Health, academic partners Thrive Policies: Public Health Outcomes Framework, London HR Strategy, ICS Population Health Management Approaches	Relational wellbeing framework adopted, belonging, trust, participation, continuity, community connectedness
7. ADOPT THE RELATIONAL MODEL OF PUBLIC MENTAL HEALTH	The study's empirically derived framework explains how relationships connect wider determinants to mental wellbeing.	Use the Relational Model to guide future policy, commissioning and system transformation across London.	Greater London Authority, London Integrated Care Boards, London boroughs Policies – HR approaches, ICS Strategies, community centred public health approaches	Adoption within strategies, integrated commissioning, neighbourhood partnerships, improved population wellbeing

Principles for a Relational Public Mental Health System

The recommendations presented in this chapter are underpinned by six principles derived directly from the findings of the Thrive LDN Public Mental Health Research Project. Together, they provide a practical interpretation of the Relational Model of Public Mental Health and establish the foundation for the recommendations that follow. These principles are mutually reinforcing, and they reflect the consistent view of participants that mental wellbeing is created through the interaction of relationships, communities, social conditions and responsive public services.


Loneliness Reflects
Loss of Belonging,
not Simply Being Alone
Community spaces
support and opportunities
fragmented communities
highly valued
and Mental Health

Principle 1: Public Mental Health Begins Long Before Crisis

Participants described mental wellbeing as developing through everyday experiences rather than isolated crises. Financial security, housing, employment, education, caring responsibilities, physical health and opportunities for social connection all influenced emotional wellbeing long before specialist services were required. Public mental health policy should therefore prioritise prevention by creating the conditions that enable people to remain well, rather than intervening only after problems have escalated.

Principle 2: Relationships Are the Foundation of Mental Wellbeing

Across every stage of the research, relationships emerged as the strongest protective influence on mental wellbeing. Family, friends, neighbours, peers, volunteers and compassionate professionals provided trust, belonging and practical support that enabled people to cope with adversity. Conversely, loneliness, isolation and fragmented relationships consistently undermined wellbeing. Public mental health policy should therefore recognise relationships as fundamental assets rather than secondary outcomes of effective services.

Principle 3: Prevention Requires Strong Communities as Well as Strong Services

Participants repeatedly identified neighbourhood organisations, community and social enterprise cafes, libraries, parks, faith communities, schools and voluntary organisations as places where mental wellbeing was created and sustained. These settings enabled people to connect, participate and seek support before reaching crisis. Investment in community infrastructure should therefore be recognised as an essential component of public mental health rather than an optional addition to clinical services.

Principle 4: Systems Should Adapt to People's Lives

Participants frequently described the emotional burden of navigating fragmented services, repeating traumatic experiences and coordinating communication between organisations. A relational public mental health system should place responsibility for coordination on organisations rather than individuals, prioritising continuity, compassion and integrated pathways that are easier to access and navigate.

Principle 5: Lived Experience Is Essential Expertise

The study demonstrated that lived experience strengthened every stage of the research, from data collection and interpretation to the development of practical recommendations. Experiential knowledge should therefore be recognised alongside professional and academic expertise within policy, commissioning, research and service redesign. Meaningful co-production requires influence, not simply consultation.

Principle 6: Public Mental Health Is Everybody's Responsibility

The findings demonstrate that mental wellbeing is shaped by decisions made across housing, employment, education, planning, transport, welfare, culture, public health and healthcare. Improving population mental health therefore requires coordinated action across government, statutory services, the voluntary and community sector, employers and local communities. Public mental health is a shared societal responsibility.

These six principles provide the framework for the recommendations that follow. Together they call for a shift from predominantly reactive models of care towards a preventative, relational and community-centred approach that recognises relationships, belonging and participation as the foundations of population mental health.

From Empirical Findings to Recommendations
Place Relationships at the Centre of Public Mental Health Policy

The strongest and most consistent finding across the London Public Mental Health Research Project was that relationships are the foundation of mental wellbeing. Participants rarely described good mental health as being created through services alone. Instead, they identified trusted relationships with family, friends, neighbours, peers, colleagues, volunteers and compassionate professionals as the resources that enabled them to cope with adversity, seek support and maintain hope.

Equally, loneliness, social isolation and fractured relationships were associated with declining wellbeing and increasing emotional distress. Relationships should no longer be viewed simply as one protective factor among many.

They represent the social infrastructure through which wider determinants, including housing, employment, financial security and physical health, are experienced. Public mental health policy should therefore recognise relationships, belonging and social connection as central public health assets.

Recommendation

Future London public mental health strategies should explicitly place relationships, belonging and community participation at the centre of policy, commissioning and service planning. Alongside maintaining access to high-quality clinical care, investment should support the community settings where trusted relationships are formed and sustained, including peer support, volunteering, community organisations, libraries, faith groups, arts and cultural activities, neighbourhood hubs and social prescribing.

Improving public mental health also requires collaboration beyond healthcare. Decisions relating to housing, planning, transport, education, employment and community development should routinely consider their impact on social connection and community wellbeing, recognising that these sectors play a fundamental role in creating the conditions for good mental health.

Lead organisations

Greater London Authority; NHS England London; Integrated Care Boards; London boroughs; Directors of Public Health; voluntary, community and social enterprise (VCSE) organisations.

Indicators of success

- Increased community connectedness and sense of belonging.
- Reduced loneliness and social isolation.
- Increased participation in peer support, volunteering and community activities.
- Greater investment in community infrastructure.
- Improved population wellbeing.

Shift Investment Upstream: Make Prevention the Default

Participants consistently described declining mental wellbeing as the result of cumulative pressures rather than isolated crises. Financial insecurity, insecure housing, caring responsibilities, poor physical health, loneliness, discrimination and employment pressures interacted over months and often years, gradually reducing resilience before individuals reached crisis point. Negative changes were recognised long before formal support was sought but there were few opportunities to access timely help.

These findings suggest that current systems often intervene too late. Earlier practical, emotional and community-based support could have prevented deterioration and reduced the need for more intensive interventions. Prevention should therefore become the organising principle of public mental health rather than an aspiration sitting alongside crisis response.

Recommendation

Public mental health policy should prioritise sustained investment in prevention, shifting resources towards early intervention and neighbourhood-based support that addresses the social, practical and relational factors influencing mental wellbeing before people reach crisis.

This should include:

• strengthening neighbourhood prevention through integrated partnerships between health, local government and the voluntary sector;

• expanding access to practical support, including debt advice, housing support, employment services and carers' support;

• strengthening access to specialist employment support, including advice on reasonable adjustments, support for people experiencing mental health difficulties, neurodivergence, disability or long-term health conditions, and fairer routes into work for young people facing low confidence, lack of experience, stigma or repeated exclusion;

• increasing investment in peer support, community development and social prescribing;

• targeting additional resources towards communities experiencing the greatest inequalities and cumulative disadvantage; and

• embedding mental health considerations across wider public policy, recognising that housing, education, employment, transport and planning all contribute to population wellbeing.

Investment in prevention should complement, rather than replace, specialist mental health services, creating a more balanced system that supports people earlier while maintaining timely access to clinical care when needed.

Lead organisations

NHS England London; Integrated Care Boards; Greater London Authority; London boroughs; Directors of Public Health; VCSE organisations.

Indicators of success

• Increased access to early support and preventative services.

• Reduced mental health crisis presentations and emergency admissions.

• Increased uptake of community-based support.

• Improved population wellbeing.

• Reduced inequalities in mental health outcomes.

Build Relational Neighbourhoods

Neighbourhoods were identified as places where mental wellbeing was either strengthened or undermined. Libraries, parks, community cafes, faith organisations, schools, peer support groups and voluntary organisations were repeatedly described as places where people developed trusted relationships, found purpose and experienced a sense of belonging.

Participants also emphasised that these neighbourhood assets provided opportunities for early support before problems escalated. Where community infrastructure was weak, inaccessible or unevenly distributed, loneliness, isolation and social exclusion became more common. Strengthening neighbourhood capacity is therefore an investment in prevention as well as community development.

Recommendation

Integrated Care Boards, local authorities and community partners should adopt neighbourhood-based approaches that strengthen community infrastructure and create more opportunities for connection, participation and mutual support.

This should include:

• providing sustainable, longer-term investment for community organisations;

• developing neighbourhood partnerships between statutory services, voluntary organisations and local residents;

• ensuring community spaces are inclusive, culturally appropriate and accessible;

• supporting volunteering, peer support and community leadership; and

•identifying and investing in neighbourhoods experiencing the greatest social isolation and inequality.

Neighbourhoods should be recognised as a primary setting for improving population mental health rather than simply locations where services are delivered.

Lead organisations

Greater London Authority; Integrated Care Boards; London boroughs; Primary Care Networks; VCSE organisations; local community partnerships.

Indicators of success

• Improved continuity of care.

• Reduced repeated assessments.

• Better service user experience.

• Improved coordination between organisations.

• Reduced disengagement from mental health services.

Design Systems Around People Rather Than Organisations

Whilst participants valued individual professionals, they described the experience of navigating mental health services as fragmented, repetitive and emotionally exhausting. Many recalled having to retell traumatic experiences to multiple professionals, coordinate communication between organisations and manage complex referral pathways whilst already struggling with their mental health. Many felt responsible for navigating the system themselves, with little sense of being supported by an integrated one. These findings suggest that the experience of seeking help can itself influence mental wellbeing. Continuity, trust and coordinated care were consistently associated with more positive experiences, whereas fragmented pathways often led to frustration, disengagement and loss of hope.

Recommendation

Mental health services should be designed around people's lived experiences rather than organisational boundaries. Integrated Care Boards, NHS providers, local authorities and voluntary organisations should work together to create coordinated pathways that minimise repetition and prioritise continuity of care.

Key actions include:

- reducing repeated assessments and repeated storytelling wherever possible;
- improving information sharing and coordinated care planning across organisations;
- increasing continuity by enabling people to build sustained relationships with trusted practitioners;
- introducing warm handovers between services rather than relying on self-referral; and
- ensuring digital innovation strengthens rather than replaces human relationships.

The responsibility for navigating complex systems should increasingly rest with organisations rather than the individuals seeking support.

Lead organisations

Integrated Care Boards; NHS providers; Primary Care Networks; London boroughs; VCSE organisations.

Indicators of success

- Improved continuity of care.
- Reduced repeated assessments.
- Better service user experience.
- Improved coordination between organisations.

Recognise Lived Experience as Essential Expertise

A defining feature of this study was the involvement of people with lived experience throughout the research process. Co-researchers contributed to study design, data collection, interpretation and the development of these recommendations, demonstrating that experiential knowledge strengthens both the quality and relevance of public mental health research. Participants described feeling unheard within services and excluded from decisions affecting their care. They argued that lived experience should not be viewed as personal testimony alone, but as a legitimate form of expertise alongside professional, clinical and academic knowledge.

Recommendation

People with lived experience should become equal partners in the leadership, design, commissioning, delivery and evaluation of public mental health policy and services.

This should include:

- embedding lived-experience leadership within governance and commissioning structures;
- providing appropriate remuneration, training and ongoing support for lived-experience roles;
- ensuring co-production influences decisions rather than simply informing consultation exercises;
- increasing opportunities for lived-experience researchers, educators and peer leaders; and
- improving the diversity and representation of lived-experience leadership across London's communities.

Meaningful co-production should become routine practice rather than an optional addition to service development.

Lead organisations

Thrive LDN, Greater London Authority; Integrated Care Boards; London boroughs; universities; research organisations; VCSE organisations.

Indicators of success

- Increased paid lived-experience leadership roles.
- Greater representation within governance and commissioning.
- Demonstrable influence on policy and service design.
- Improved diversity within lived-experience leadership.
- Routine evaluation of co-production impact.

Measure What Matters

Participants rarely defined successful mental health support by waiting times or numbers of appointments. They described success in relational terms: feeling listened to, maintaining trusted relationships, belonging within communities, participating in meaningful activities and having confidence that support would be available when needed.

Existing performance measures capture only part of what matters. If public mental health policy goal is to strengthen prevention, communities and relationships, then evaluation frameworks must measure these outcomes alongside traditional indicators of service activity and clinical performance.

Recommendation

Public mental health systems should adopt a broader outcomes framework that measures relational wellbeing alongside existing clinical and organisational indicators.

Future evaluation should include:

- belonging and community connectedness;
- trust and continuity of support;
- participation in community life and volunteering;
- confidence in navigating local services;
- experiences of coordinated care; and
- population measures of loneliness and social isolation.

Embedding relational outcomes within commissioning frameworks will ensure that organisations are recognised and rewarded for strengthening the social conditions that protect mental wellbeing, not simply for delivering services.

Lead organisations

Greater London Authority; Integrated Care Boards; Directors of Public Health; Office for Health Improvement and Disparities; academic partners; VCSE organisations.

Indicators of success

- Adoption of a relational outcomes framework.
- Routine reporting of belonging and community connectedness.
- Inclusion of relational outcomes within commissioning.
- Improved population measures of trust and participation.
- Evidence that commissioning increasingly supports preventative and community-based approaches.

Adopt the Relational Model of Public Mental Health as a Framework for System Transformation

The development of an empirically derived Relational Model of Public Mental Health that explains how relationships connect the wider social, economic and environmental factors influencing wellbeing is a major contribution of this research.

The Relational Model provides a practical framework for bringing together prevention, neighbourhood health, action on the wider determinants of health, integrated care and lived-experience leadership within a single, coherent approach to improving population mental health.

Recommendation

The Relational Model of Public Mental Health should be adopted as an organising framework for future policy, commissioning and system transformation across London.

Rather than developing separate initiatives for prevention, neighbourhood health, community development and integrated care, organisations should use the Relational Model to align investment and decision-making around the factors that participants consistently identified as creating and sustaining mental wellbeing.

Implementation should include:

- embedding relational principles within London-wide and local public mental health strategies;
- aligning commissioning with prevention, community participation and relational outcomes;
- strengthening collaboration between health services, local government and the voluntary and community sector;
- using the model to inform neighbourhood health partnerships and integrated care; and
- supporting future research to test and refine the model in different populations and settings.

The model should be viewed as a practical framework for improving population mental health rather than simply a theoretical contribution.

Lead organisations

Greater London Authority; Integrated Care Boards; London boroughs; Directors of Public Health; universities; research organisations; VCSE organisations.

Indicators of success

- Adoption of the Relational Model within London and local strategies.
- Greater alignment between prevention, neighbourhood health and community development.
- Increased collaboration across statutory and voluntary sectors.
- Commissioning frameworks that explicitly reflect relational principles.
- Improvements in population wellbeing, community connectedness and mental health outcomes.

Chapter 12 Conclusion: People Need People

This report began with a clear purpose: to better understand the challenges, pressures, worries and conditions shaping mental health and wellbeing across London, and to explore what would help people and communities to stay well, before distress reaches crisis.

Across the research, the answer that emerged was clear, consistent and deeply human. Mental health is not created by services alone. It is shaped through the everyday conditions in which people live: the relationships they have, the communities they belong to, the pressures they carry, the support they can access, and the systems they are required to navigate. Across survey responses, lived-experience interviews, community focus groups, strategic stakeholder interviews, co-researcher involvement and collaborative interpretation, participants showed that mental wellbeing is created, undermined and restored through the interaction of relationships, wider social conditions, community infrastructure and systems of support.

The central message of the project is captured in the title of this report: People Need People. This phrase is not intended as a slogan. It is the core finding of the research. Participants consistently described relationships as fundamental to good mental health. 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 cope with bereavement, financial insecurity, caring responsibilities, poor physical health, discrimination, loneliness and uncertainty. They created belonging, recognition, practical support, hope and continuity.

At the same time, the absence or erosion of relationships often intensified distress. Loneliness was rarely described simply as being physically alone. It was experienced as emotional disconnection, lack of trust, loss of community, absence of meaningful conversation and the feeling of having no one to notice or respond when things became difficult. For many participants, loneliness existed alongside financial pressure, housing insecurity, poor physical health, caring responsibilities and difficulties accessing support. It was both a cause and consequence of declining wellbeing.

The study therefore challenges narrow or individualised understandings of mental health. Participants did not describe mental distress as arising only from personal vulnerability, diagnosis or isolated life events. More often, they described the accumulation of everyday pressures. Rising living costs, debt, insecure housing, work stress, caring responsibilities, physical illness, bereavement, stigma, discrimination, digital exclusion and fragmented services were experienced as overlapping pressures that gradually reduced emotional resilience. Many people were not suddenly pushed into crisis by one event. Rather, they became worn down over time.

This has important implications for public mental health. If mental wellbeing is shaped gradually through everyday life, then prevention must also begin in everyday life. Prevention cannot be understood only as earlier referral, faster access to treatment or more clinical provision, although timely mental health support remains essential. Participants argued that by the time people reach specialist services, many opportunities for prevention have already been missed. Prevention begins much earlier: in homes, schools, workplaces, neighbourhoods, community organisations, peer networks, primary care, faith spaces, local services and ordinary relationships.

The findings demonstrate that prevention is relational. It depends upon whether people have someone to talk to, somewhere to go, something meaningful to do, practical help when pressures build, trusted places where they feel welcome, and systems that respond before problems escalate. Participants did not reject professional support.

They valued compassionate, timely and effective services. However, they also made clear that services form only one part of a wider public mental health system. Families, neighbourhoods, libraries, parks, community cafes, voluntary organisations, peer groups, schools, workplaces and faith communities all contribute to the conditions in which mental wellbeing is protected.

This wider ecology of support is conceptualised in this report as relational infrastructure. Relational infrastructure refers to the places, organisations, activities and social environments that enable supportive relationships to develop and endure. These are not peripheral to public mental health. They are part of the public mental health system itself. When community spaces are accessible, trusted and inclusive, they create opportunities for connection, participation, belonging and early support. When they are absent, underfunded or inaccessible, people are more likely to become isolated and unsupported until their needs become more acute.

The research also highlights the emotional burden created by fragmented systems. Participants frequently described support systems that were difficult to navigate, overly reliant on repeated assessments, inconsistent in communication and too often organised around institutional boundaries rather than people's lives. Many people found themselves repeatedly explaining painful experiences, coordinating information between services, waiting for support, or trying to understand complex pathways while already experiencing distress. This was not usually experienced as a failure of individual practitioners. Indeed, many participants spoke warmly about professionals who listened, cared and stayed alongside them. The problem was more often structural: systems that made continuity difficult and placed responsibility for navigation on those least able to carry it.

For this reason, improving access cannot be measured only by the presence of services or the length of waiting lists. The way support is experienced matters. Continuity, trust, being remembered, not having to retell painful stories, being believed and being treated as a whole person were described as central to good support. Fragmentation therefore represents more than an organisational inconvenience. It can undermine the very relational processes through which recovery, hope and engagement are sustained.

The Relational Model of Public Mental Health developed in this report brings these findings together. It offers a way of understanding mental wellbeing as a dynamic process shaped by the interaction of relationships, relational infrastructure, wider social determinants, systems of support and prevention. The model does not replace existing evidence on the social determinants of health. Instead, it helps explain how those determinants are experienced in everyday life. Poverty, housing insecurity, discrimination, caring responsibilities and poor physical health matter profoundly, but their impact is often felt through their effect on relationships, participation, belonging, identity and hope.

This relational understanding provides an important contribution to public mental health policy and practice. It suggests that the task is not simply to identify individual risk factors or expand services in isolation. The task is to strengthen the conditions that enable people and communities to remain connected, supported and able to participate. This requires coordinated action across health services, local government, housing, employment, education, planning, primary care, the voluntary and community sector, and local neighbourhoods. Public mental health is a shared responsibility.

The study also demonstrates the value of lived-experience-led and co-produced research. The involvement of co-researchers strengthened the project from design through to interpretation. Their contribution helped shape the questions, deepen engagement, test emerging findings and ensure that the analysis remained grounded in lived experience rather than institutional assumptions.

The collaborative interpretation process further strengthened the credibility and practical relevance of the findings by returning emerging analysis to those closest to the issues being explored. This showed that lived experience is not simply a source of data. It is a form of expertise.

This is one of the most important lessons from the project. Public mental health research should not only study lived experience. It should work with lived experience as a source of knowledge, interpretation and change. When people with lived experience are properly supported, paid, respected and involved from the beginning, they help produce research that is more honest, more grounded and more useful. This approach should not be exceptional. It should become part of how public mental health evidence is generated, interpreted and used.

The report should be read with appropriate caution. It 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 is not a statistically representative prevalence study and does not claim to capture every community, borough or experience in full. Participants were largely recruited through Mind in London, local Mind and partner networks, meaning that some voices and communities may be more visible than others. These limitations do not reduce the value of the findings, but they clarify how they should be used: as a grounded, triangulated, lived-experience-led body of insight to support sense-making, strategic planning and further inquiry.

Several areas would benefit from deeper exploration. These include poverty and housing insecurity, digital exclusion, unpaid caring, men's mental health, physical health inequality, culturally specific forms of support, community infrastructure, young people's experiences, and local variation between boroughs in access to preventative and community-based support. The findings presented here provide a strong foundation for future work, but they should be seen as the beginning of a wider process of listening, learning and action.

The recommendations set out in the previous chapter translate this evidence into a relational agenda for public mental health. They call for relationships to be placed at the centre of policy; for investment to shift upstream; for relational neighbourhoods and community infrastructure to be strengthened; for systems to be designed around people rather than organisations; for lived experience to be recognised as essential expertise; for outcomes to measure what matters to people; and for the Relational Model of Public Mental Health to guide future strategy, commissioning and system transformation across London.

These recommendations require a shift in emphasis. They do not suggest that mental health services are unimportant. On the contrary, timely, compassionate and effective services remain vital. However, the findings show that services alone cannot create mentally healthy communities. Public mental health must be built across the whole system of everyday life: through secure homes, supportive relationships, inclusive communities, meaningful participation, accessible places, coordinated services and social conditions that enable people to live with dignity. Ultimately, this report argues for a more human understanding of public mental health. It asks policymakers, commissioners, practitioners and communities to look beyond crisis response and consider the conditions that allow people to remain well. It asks systems to recognise that people do not experience mental health as separate from money, housing, work, illness, caring, loneliness, grief, stigma or community. It asks us to understand that being heard, connected and valued is not a soft addition to public mental health, but central to it.

The findings point to a simple but powerful conclusion. If London is serious about improving public mental health, it must invest not only in services, but in the relationships, communities, systems and everyday conditions that enable people to feel connected, supported and able to thrive. People need services. People need safety. People need fairness. People need hope. But above all, people need people.

Afterword: Creative Revoicing – Returning the Research to Public Voice

The formal conclusion of this report brings together the study's findings, conceptual contribution and implications for public mental health. This Afterword deliberately takes a different form. *People Need People* was developed by the Lead Researcher as a final example of creative revoicing (Palmer, 2026), drawing together recurring themes, participant testimony and the emotional meanings expressed across the survey, lived-experience interviews, focus groups, co-researcher reflections and collaborative interpretation. It does not present new findings, nor does it represent the account of any single participant. Instead, it offers a composite poetic rendering of what was heard across the research.

Selected words and phrases from participant testimony are woven through newly written poetic language. Their inclusion is intentional: not to speak on behalf of participants, but to allow lived experience to remain present within the public communication of the research. In this sense, creative revoicing operates as a form of arts-based knowledge translation, carrying evidence beyond conventional analytical prose while retaining a clear relationship to the themes and testimony from which it emerged. The draft was shared with co-researchers and lived-experience contributors for reflection and sense-checking, helping to ensure that its emotional and political emphasis remained accountable to the research.

The poem was authored by D. A. Palmer and subsequently recorded by the Lead Researcher with Asima, one of the project's lived-experience co-researchers. Bringing the two voices together in the recording moves the research into a public-facing form intended to support engagement, reflection and awareness. The report therefore closes not with another analytical summary, but by returning its central findings to voice, testimony and public listening.

Listen to People Need People
People
D. A. Palmer

Italicised quotations reproduce participant testimony; the remaining lines are creative revoicing of themes and meanings developed across the research.

They tell us to be resilient.
As if resilience were endless.
As if resilience pays the rent.
As if resilience fills an empty fridge.
As if resilience shortens a waiting list.
As if resilience can hold together
a life that is slowly coming apart.
And when resilience fails,
they tell us to breathe.
To download an app.
To practise gratitude.
To sit quietly with our thoughts.
"But mindfulness can't end poverty, mate."
Mindfulness can't stop an eviction.
Mindfulness can't heat a cold flat.
Mindfulness can't bring back a youth centre.
Mindfulness can't undo loneliness.
Mindfulness can't create time.

for the woman caring for her mother,
her children,
her partner,
and herself,
all at the same time.
People are not struggling
because they have forgotten how to cope.
People are struggling
"because there is pressure from every direction".
Pressure from debt.
Pressure from housing.
Pressure from not having housing.
Pressure from work.
Pressure from finding work.
Pressure from caring.
Pressure from illness.

Pressure from systems
that ask people to prove
they are suffering
before they are worthy of help.
So people carry things.
They carry grief.
They carry fear.
They carry exhaustion.
They carry responsibility.
They *carry everybody else's needs.*
And they carry them for so long
they forget the weight is there.
"Holding everything together all the time."
"You become everyone else's support."
"There's no space to fall apart yourself."
Listen.
These are not complaints.
They are witness statements.
A record of what it feels like
to live in a society
where survival is becoming
full-time work.
Again and again,
the same words appeared.
"*Trying to survive rather than live."*
"Everything feels harder now."
"There's never any breathing room."
"Everyone seems to be coping alone."
Not alone because people want to be.
Alone because somewhere along the way
we forgot something important.
We closed the places.
We cut the services.
We sold off the spaces.
We turned neighbours into strangers.
We replaced community
with transactions.
And then we wondered
why people were lonely.
One Londoner said:
"The environment we live in,
psychologically,
physically
and politically."
Not what's wrong with people.
What's happening to them.
Because mental health
does not begin in a clinic.
It begins in homes.
In streets.
In workplaces.
In cafes.
In schools.
In families.
In whether people feel safe.
In whether people feel seen.In whether people belong.

And yet,
through every story,
every interview,
every conversation,
another truth appeared.
People survive because of other people.
A friend who phones.
A neighbour who notices.
A volunteer who listens.
A peer who says,
"Me too."
A space where nobody has to pretend.
A place to sit.
A place to talk.
A place to be human.
Perhaps that is what we have forgotten.
Not a new intervention.
Not a new diagnosis.
Not a new strategy.
Something older than all of them.
Something we have always known.
People need security.
People need dignity.
People need hope.
People need somewhere to belong.
And through all of it,
people need people.
Because when everything else is stripped away,
when the services end,
when the funding disappears,
"when life becomes almost too heavy to carry",
it is other people
who help us carry it.
And perhaps that is where any serious
conversation
about mental health must begin.
Not with resilience.
Not with mindfulness.
Not with another strategy.
With each other.

People need people

Listen to Poem

Acknowledgements

“This has been a remarkable project from start to finish. We have approached it with care, integrity and a genuine commitment to doing things properly. We have created space for experiences that are too often hidden, and for voices that are too often unheard. We have listened, learnt and been changed by the process. Everyone involved should feel proud of what has been achieved.” Dr David Palmer, Research Lead.

From Evidence to Action: A Relational Agenda for Public Mental Health

This report would not have been possible without the generosity, honesty and commitment of the many people who contributed to the Thrive LDN Public Mental Health Research Project.

First and foremost, we would like to thank everyone who took part in the research. This includes those who completed the public mental health survey, participated in lived-experience interviews, attended focus groups, contributed to the collaborative interpretation workshop, or shared their professional and strategic perspectives through stakeholder interviews. Many people spoke about experiences that were personal, painful or difficult to put into words. We are deeply grateful for the trust they placed in the project and for their willingness to share their experiences in order to help improve public mental health for others.

We would particularly like to acknowledge the contribution of the lived-experience co-researchers, whose insight, skill, creativity and commitment shaped the research throughout. The co-research team brought lived experience, professional knowledge, community understanding and reflective challenge to the project. Their contribution strengthened the research questions, recruitment, engagement, interviews, interpretation and dissemination of the findings. We are grateful to:

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Special thanks are due to Lucy Dodd, Strategic Lead for Mind in London, for her substantial support throughout the project. Lucy played a vital role in recruiting lived-experience co-researchers through the Mind in London and local Mind networks, coordinating communication with co-researchers and interview participants, supporting interview arrangements, undertaking some interviews, and helping to ensure that the project remained connected to local Mind organisations, lived-experience communities and wider public mental health partners across London. We are grateful to the Minds in London network for supporting the project, promoting participation and helping to connect the research with people and communities across the capital.

Their involvement was essential to the reach, credibility and lived-experience grounding of the study.We would also like to thank Healthwatch partners for helping to promote the survey and support wider engagement. Their contribution helped extend the reach of the research and ensured that more Londoners had the opportunity to share their views and experiences.

We are deeply grateful to Thrive LDN for funding and supporting this research. Thrive LDN's commitment to prevention, participation, lived experience and public mental health made the project possible. We particularly acknowledge the support, encouragement and thoughtful challenge provided by Thrive LDN colleagues throughout the study.

Thanks are also due to colleagues from the Centre for Mental Health and members of the project steering group, whose guidance helped ensure that the work remained strategically relevant, methodologically robust and grounded in the realities of public mental health policy and practice. We would like to thank Dr Lucy Williams, a valued friend and colleague, for reading draft chapters and providing thoughtful feedback. Her careful engagement with the emerging report strengthened the clarity, coherence and quality of the final work.

We are also grateful to colleagues at Mind in Bexley and East Kent for supporting the research. Particular thanks are due to the clinical lead and wider colleagues who provided advice, encouragement and practical support throughout the project, and to Gill Holmes for her assistance with administration and coordination.

Finally, we would like to acknowledge the Mind in Bexley Research and Ethics Advisory Board for providing ethical oversight and governance. Their guidance helped ensure that the research was conducted with care, sensitivity and respect for participants, co-researchers and the wider communities involved.

This report is the product of many contributions. It reflects not only formal research activity, but also conversation, trust, generosity, lived experience, professional insight and a shared belief that public mental health must be shaped by the people and communities most affected by it.
Declarations and Ethical Statements.

Declaration of Interests

The Lead Researcher, Dr David Palmer, is Chief Executive of Mind in Bexley and East Kent and was involved in the Mind in London steering arrangements connected to this research. These roles provided relevant professional, organisational and public mental health context for the study and are declared in the interests of transparency.

The research was conducted as a co-produced, lived-experience-led public mental health research, with analysis grounded in data collected from survey respondents, lived-experience interview participants, focus groups, strategic stakeholders, co-researchers and the collaborative interpretation process. No financial or personal interests were identified that are considered to have inappropriately influenced the design, conduct, analysis or reporting of the study.

Funding Statement

This research was funded by Thrive LDN. Thrive LDN supported the commissioning and development of the project but did not determine the findings or conclusions. The analysis, interpretation and recommendations presented in this report are based on the data collected through the research process and the collaborative interpretation undertaken with lived-experience participants and co-researchers.

Ethics Statement

Ethical oversight for the study was provided through the Mind in Bexley Research and Ethics Advisory Board. The research involved potentially sensitive topics, including mental distress, loneliness, bereavement, financial insecurity, caring responsibilities, discrimination, fragmented services and experiences of exclusion. For this reason, ethics was treated as an ongoing process rather than a single approval event.

The study was conducted in accordance with principles of informed consent, confidentiality, safeguarding, participant autonomy, dignity, respect and minimisation of harm. Participants were provided with information about the purpose of the research, what participation involved, how their data would be used, and their right to decline to answer questions or withdraw from participation where applicable.

Consent and Confidentiality

All participants provided informed consent before taking part in the research. This included survey respondents, interview participants, focus group participants, strategic stakeholder interviewees and co-researchers. Where participants were invited to take part in additional activities, such as collaborative interpretation, photography, recording or creative dissemination, separate or renewed consent was sought as appropriate.

Although participants provided consent, findings have been presented with care to protect confidentiality. For ease of reporting and to minimise the risk of identification, participant names have been anonymised or replaced with pseudonyms except where individuals have explicitly agreed to be named in relation to their role or contribution. Identifying details have been removed or amended where necessary to protect participants, communities and organisations.

Data Availability Statement

The dataset generated through this study is not publicly available because it contains sensitive qualitative material and potentially identifiable participant accounts. Anonymised extracts and summary data may be available from the Lead Researcher upon reasonable request, subject to confidentiality, ethical approval, participant consent, data protection requirements and the purpose of the request.

Research Team and Contribution Statement

The study was led by Dr David Palmer, Research Lead for the Thrive LDN Public Mental Health Research Project. Dr Palmer designed and led the overall research process, developed the methodological framework, oversaw ethical governance, conducted analysis across the survey, interview, focus group, stakeholder and collaborative interpretation data, and wrote the report. The research was developed and delivered as a co-produced and lived-experience-led study. Lived-experience co-researchers contributed to the development of the research questions, survey design, recruitment materials, interview approach, interpretation of findings and creative dissemination.

Co-researchers also undertook lived-experience interviews, supported engagement with participants and contributed to the collaborative interpretation process. Their contribution was central to ensuring that the research remained grounded in lived experience and that the findings reflected the realities, language and priorities of those closest to the issues being explored.

Lucy Dodd, Strategic Lead for Mind in London, played a significant role in the delivery of the project. Lucy supported the recruitment of lived-experience co-researchers through the Mind in London and local Mind networks, helped coordinate communication with co-researchers and interview participants, supported interview arrangements, and undertook some interviews as part of the research process. Her role was essential in enabling participation, maintaining links with the Mind in London network and ensuring that the project was delivered sensitively and effectively.

The wider research process was also supported by Thrive LDN, Mind in London, local Mind organisations, colleagues from the Centre for Mental Health, Mind in Bexley and East Kent colleagues, and members of the project steering group. These partners provided advice, support, challenge and practical assistance throughout the project. However, the analysis, interpretation and final report were led and written by the Lead Researcher, informed by the data, co-researcher contributions and collaborative interpretation with lived-experience participants.

Safeguarding and Participant Wellbeing

Given the sensitive nature of the research, safeguarding and participant wellbeing were considered throughout. Participants were reminded that they did not have to answer any question that felt uncomfortable and could pause or stop their involvement where needed. The research team remained alert to distress and signposted participants to appropriate sources of support where necessary.

Co-researchers were also supported through preparation, reflective discussion and ongoing check-ins. This was important because lived-experience-led research can carry emotional weight for those involved in both sharing and hearing difficult experiences.

Use of Creative Materials

Creative outputs connected to the study, including poetry, photography, audio recording or potential exhibition materials, were developed with additional care and consent. Participants were not required to take part in creative or public-facing dissemination. Where individuals contributed to creative outputs or agreed to be photographed, separate consent was sought for the specific use of those materials.

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Contact

For further information about this report or the research dataset, please contact:

Dr David Palmer
Research Lead, Thrive LDN Public Mental Health Research Project
Chief Executive, Mind in Bexley and East Kent
Canterbury Christ Church University, Canterbury, UK

Email: dpalmer@mindinbexley.org.uk

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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

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