

Creating partnerships to improve community mental health and well-being in an area of high deprivation: lessons from a study with high-rise flat residents in east Glasgow

Key words:
community;
mental health;
well-being;
deprivation;
partnerships;
inequalities;
Scotland

There are significant inequalities in mental health, with mental health problems and poor mental health more common in areas of deprivation. Current policy in Scotland acknowledges the impact of social and environmental factors on community mental health and well-being and the need for public mental health to engage with regeneration initiatives. This study, based in a low-income community in east Glasgow, assesses what factors influence community mental health and well-being and how to develop partnerships to address these issues. It involved a workshop with community planning agencies and residents' groups in east Glasgow, an action research project with local residents and a validation event with local residents. The study found that social circumstances influenced mental health and well-being, with people having concerns about their neighbourhood and environment, with antisocial behaviour emerging as a major factor contributing to residents feeling unsafe, isolated and unhappy living in the area. At the same time, residents talked a lot about how happy they felt about the community they were part of and the important role that social capital can play in low-income areas in promoting well-being. The study also highlights the need for partnerships between health and other sectors and the importance of ensuring multi-agency working that embeds public mental health within the agendas of housing and regeneration sectors. Finally, it demonstrates that action research between partner agencies and communities will be more effective in identifying key issues and that within such a process, there is more likely to be 'buy in' from these agencies to bring about social change.

RESEARCH

Neil Quinn

Senior Lecturer, School of Applied Social Sciences, University of Strathclyde, UK

Hannah Biggs

Researcher, Scottish Development Centre for Mental Health, UK

Correspondence to:

Neil Quinn
Senior Lecturer
University of Strathclyde
Sir Henry Wood Building
76 Southbrae Drive
Glasgow G13 1PP
UK

Email: neil.quinn@strath.ac.uk

There is a strong body of evidence that lower socio-economic status is associated with poorer mental health. The poorest fifth of the UK population is twice as likely to be at risk of developing mental health problems as those on average incomes

(Fryers *et al*, 2003; Palmer *et al*, 2003). Furthermore, experiencing mental health problems can lead to an increased risk of poverty and social exclusion (Social Exclusion Unit, 2004). Rogers and Pilgrim (2003) highlight three key issues in understanding the mental health impact of socio-economic inequalities:

1. 'social divisions', where mental health problems both reflect deprivation and contribute to it
2. 'social drift', where the social and ecological impact of adversity, including the impact of physical health problems and the cycle of invisible barriers, prevent or inhibit people from benefiting from opportunities
3. 'social injuries', with mental distress an outcome of demoralisation and despair.

Higher national levels of income inequality are linked to a higher prevalence of mental illness (Pickett *et al*, 2006), with relative deprivation creating physiological responses to chronic stress through the damaging impact of low status on social relationships and through a range of behaviours seen as a direct or indirect response to the social injuries associated with inequalities (Wilkinson, 1996; 2005). There has been an increasing focus on the psycho-social dimensions of poverty, for example not being able to participate in the life of the community (Zavaleta, 2007), feeling a lack of control of life choices (Myers *et al*, 2005) and an overall sense of well-being largely determined by income equality, trust within the population and voluntary and political engagement (Thompson, 2007). As such, working for equality produces benefits that are widely shared across all income groups (Wilkinson & Pickett, 2007).

Within a Scottish context, the Government's *Towards a Mentally Flourishing Scotland: Policy and action plan* (Scottish Government, 2009) acknowledges the important influence of social and environmental factors in shaping community mental health and well-being. A person's socio-economic position can influence risk and protective factors for mental health and well-being (Friedli, 2009). For example, living with persisting social, economic and environmental pressures (eg. accessibility of quality housing, employment, local service and amenities, physical environment and community relations) can lead to a sense of powerlessness and have an adverse effect on mental health and well-being. As a result, public mental health needs to address the structural factors that are the catalysts for poor mental health. Moreover, mental health improvement needs to engage with regeneration and community planning initiatives.

This study

East Glasgow, the location of this study, has one of the highest levels of deprivation in the UK and as such, the population are at greater risk of poor health and well-being (NHS Health Scotland,

2004). Positive Mental Attitudes (PMA) is the NHS mental health improvement programme for east Glasgow and is responsible for taking forward a range of public mental health initiatives within the local area (Quinn & Knifton, 2005). PMA is an integral part of the regeneration strategy and works closely with East Glasgow Community Planning Partnership (EGCPP), the lead regeneration agency in the area. In 2008, PMA and EGCPP discussed how to work together to understand the link between deprivation and community mental health and well-being in order to help inform how local partner agencies can work together to address issues that negatively impact on community mental health and well-being. This work was supported by the Scottish Development Centre for Mental Health.

The aims of the study were to assess what factors influence perceived community mental health and well-being and to understand the process of bringing together a number of organisations and local people to develop and inform a neighbourhood mental health improvement partnership.

Process and method

The process for developing the study involved:

1. A workshop with 20 community planning agencies and residents' groups in east Glasgow to develop a shared understanding of mental health improvement and how findings from the study could be acted upon. This group were involved in developing an appropriate research methodology and were involved as an expert reference group for the research. One of the key principles discussed among partners at the design stage was that this should not simply be a piece of research but should be an initiative that resulted in real change for local residents.
2. Undertaking an action research project with local residents in one specific locality to look at how local decision-makers could improve community well-being. This would identify lessons for these partners in order to develop a neighbourhood strategy for mental health improvement. As such, it followed the principles of social action research, a systematic effort to gather, analyse, and interpret information that describes problems and suggests solutions (Rubin & Rubin, 2008).

Sampling

The pilot area for the study is a small community of high-rise flats in an area of east Glasgow called

Sandyhills. The area was chosen because it was felt to be particularly isolated in terms of geography and in relation to service provision. In addition, the high-rise flats had a high population of older people and housed relatively large numbers of asylum seekers and refugees, so presented an interesting site for exploring issues of community cohesion and integration. Five hundred and twenty residents of the high-rise flats were invited to take part through fliers that were hand-delivered to each flat. Eighty-four residents agreed to take part, representing 16% of the population of the flats.

Method

A questionnaire was designed and one-hour interviews were undertaken with participants assessing demographic information and a series of semi-structured open questions. A survey was then conducted face-to-face by staff from all the partner agencies. Interviews were carried out between 7 and 17 August 2009 and recorded by the interviewers on paper copies of the survey. All participants were informed that any information provided would be treated as confidential and anonymous. Respondents were also informed that participation was voluntary and all questions were optional. Given that the survey was conducted with a range of ethnic groups, provision was made for interpreters to be present when required.

Analysis

The data from the interviews were analysed by carefully reading through the interviews with the research aims in mind in order to enable the identification of key themes and issues. A systematic approach to analysis was taken, which involved coding the data, going through the data to identify similar themes, elaborating a set of generalisations that cover consistencies in the data and finally linking these generalisations to a formalised body of knowledge in the form of constructs and theories (Miles & Huberman, 1994).

Validation and action planning

It was agreed to hold a second stage of research, a validation event to feedback on the results of the consultation and discuss how the issues raised in the consultation could be addressed by local services. This involved local residents coming together after the consultation to prioritise the issues and decide on the action plan.

Findings

Demographic characteristics of participants

The first stage of the process involved interviews with 84 residents. Sixty-eight per cent of participants were of working age (16–65 years) with 32% aged 65 years or older. Thirty-nine per cent of respondents stated that they were retired and 36% reported not being in work. Eight per cent of participants were in full or part-time paid work, 12% in voluntary work and four per cent in education. Seventy-seven per cent of respondents identified themselves as white Scottish or British with 22% of the survey respondents identifying themselves as being from a black and minority ethnic (BME) group, compared to only two per cent of the Scottish population. Fourteen per cent of survey respondents stated that they were asylum seekers or refugees.

Emergent themes

Most participants indicated that they are happy to live in the area (72%). The most common reason people gave for this was social connections with neighbours. Typical responses were:

'The neighbours are very nice and very kind. They will do anything for you, even though I don't see them very much.'

'If something happens neighbours are there for you.'

'Everyone looks after one another.'

Living in a quiet pleasant environment also made people feel happy living in the area.

'I like it here because it is quiet. It is good for the boys to grow up here.'

'Very good area, nice and quiet, people mix well and it's clean.'

'I like the area. It's central, it's not busy, it's not noisy.'

A significant majority were happy living in the area because they felt their accommodation was of good quality and secure, which made them feel safe living there.

'Made a good job of the flats, best in Glasgow.'

'Good to live here, because we are secure, I can come back late at night and feel secure.'

'The area is quiet and secure, good security, the flats are clean.'

A majority of respondents felt the concierge plays a vital role in making people feel happy and secure in the area.

'You feel safe because of cameras and concierges.'

'Well protected with concierge. The concierge will phone to tell me if someone is coming up, if they don't know them.'

Sixty-two per cent of respondents also feel that the area offers them appropriate levels of access to the services, information and opportunities that they need in their day-to-day lives, including having a say in local issues that are important to them. Again, the concierge was seen to play a vital role in this, by acting to include and inform those who may otherwise feel isolated.

'The concierge are very good as we are not [from] this country, they help us with everything.'

'The concierge is wonderful ... every morning they phone up to see how you are, let people know what's happening.'

'The concierge do a very good job, helpful bunch of boys. Get a call every morning to make sure I'm okay, makes you feel glad.'

'The concierge is an excellent service, especially for elderly, just lift a phone and they will help you with anything.'

A minority of residents in Sandyhills feel isolated, unsafe on the street, uninvolved and uninformed about community decisions and services. For example, 37% feel that they do not have a say about things that are important to them and 22% do not feel safe on the street. One reason given for people feeling isolated was that people felt that there is not a sense of community in the area because people 'keep themselves to themselves'.

'I don't know anyone in my own landing, it's a lonely place.'

'I don't feel it is a community.'

Others feel that racism causes people from ethnic minorities to feel isolated from the community and unsafe.

'I feel that the ethnic community are shunned. They should be more integrated, invited to be involved.'

'A lot of people are racist and don't realise why people are here from other countries.'

'No support, no job, can't speak English. Scottish people call us beggars if we ask for help.'

Antisocial behaviour was also identified as being a major cause of people feeling unhappy and unsafe living in the area and contributed to people feeling isolated.

'Nobody listens, I've reported antisocial behaviour and nothing gets done.'

'Younger people cause a lot of animosity. It's frightening walking on the landing and down the back stairs because of young people hanging around and drinking.'

'Because of the junkies and alcoholics and the fighting that goes on, people don't want to know.'

Validation findings

Stage two involved a validation event with local residents, attended by 45 local people. People came together to reconsider the initial study questions, explore the issues raised in more depth and what could be done to address these issues. From this approach, a richer, deeper and different set of priorities emerged. The priorities identified included: improving safety and reducing antisocial behaviour; the need to improve access to drinking water within the flats; the importance of reducing isolation and promoting community cohesion; and providing better information on services, such as housing, employment and money advice.

Discussion

We know that social circumstances influence mental health and well-being (Friedli, 2009) and this is borne out by the study in which the concerns people raised about their neighbourhood and environment, such as lack of opportunities, services and support. In particular, antisocial behaviour was identified as contributing to residents feeling unsafe, isolated and unhappy living in the area and reducing the bonds of community and social networks, which impacts on people's mental health and well-being. This supports recent studies suggesting a significant relationship between inequality and levels of violence, trust and social

capital (Wilkinson & Pickett, 2006). Therefore, addressing these issues would be likely to have an effect on the mental health of the community as a whole as well as those individuals who experience mental ill health.

Interestingly, some of the issues raised correspond to very basic needs as indicated in Maslow's hierarchy of needs (Maslow, 1943). Clean drinking water emerged as an issue for example, something that is predominantly taken for granted in Western Europe. Good quality housing and environments were also highlighted as central to feeling happy living in the area, which has been highlighted as being important for good 'mental capital' with evidence showing that poor housing can have a negative effect on mental capital (Kirkwood *et al*, 2008). There was also a major focus on safety and security and the importance of social networks, which has been identified in other studies (Friedli *et al*, 2005). This suggests that there is a whole spectrum of issues of inequality to deal with ranging from basic human needs, to social cohesion.

However, the findings also suggest that it is simplistic to assume that living in an area of deprivation leads to poor mental health and well-being. Residents talked a lot about how happy they felt about the community that they were part of and that residents supported each other practically and emotionally. This suggests the existence of 'social capital' (Halpern, 2005) within this neighbourhood and demonstrates the important role that social capital can play in low-income areas in mitigating against negative social circumstances (Temkin & Rohe, 1998). This emphasises the importance of an 'asset-based community development approach' (Kretzman & McKnight, 1993), which focuses on the social and economic assets that already exist in a community, rather than simply concentrating on the problems.

Interestingly, the findings illustrate that the concierge plays a major role as the hub of the community in this area and therefore, the involvement of a paid worker could be pivotal in the success of addressing these issues. The concierge plays a central role in passing on information and checking up on people who may feel isolated. As a result, the concierge could be useful as a signpost to other services, and a holder of a wealth of knowledge about the community and how to support those who do not have their own networks, and to maintain the safety net for those who are currently satisfied with the service they provide.

As a result of the research, a number of initiatives have emerged to address the priorities

identified at the validation event, including: initiatives to tackle antisocial behaviour and the provision of additional outdoor lighting in the local area; plans to ensure access to clean drinking water within the flats; an extension to the programme of free and low-cost community events throughout the year; opportunities for befriending and volunteering; providing better information on housing, employment and money advice services so that local people have access to the right support; and a mental health awareness programme for asylum seekers living in the flats, which has played a valuable role for signposting asylum seekers to local services. These outcomes are a result of the partners supporting the research and demonstrate how a collaborative approach to research has such important value, even though it may be resource intensive.

In terms of the process of undertaking this study, the usefulness of adopting two different methods was highlighted. It was important to gain in-depth information from residents through the individual interviews, but then bringing together residents as a group for stage two demonstrated that when you get people together to discuss issues you get a different energy. The approach taken highlights the benefits of the social action research approach (Rubin & Rubin, 2008) taken throughout the consultation in terms of creating participation and building partnerships. Moreover, building a coalition with the major housing and regeneration providers to address mental health and well-being ensured practical, concrete steps could be taken immediately following the consultation to real changes in these living conditions, which emphasise the benefits of partnership working across sectors, responding to specific local needs, community involvement and addressing the wider determinants of health (Community Health Exchange, 2007).

This study highlights the importance of ensuring multi-agency working and embedding and mainstreaming public mental health within other agencies' agendas. A key goal in public mental health work is to encourage policy-makers across all sectors to think in terms of the 'mental health impact' of their work (World Health Organization (WHO), 2004a; 2004b). A number of areas identified by the WHO were highlighted within this study and then taken forward as a response to the findings within the programme, including a safe environment, open green space, opportunity for volunteering, opportunities for arts, leisure and physical activity, and debt advice.

There are limitations to this study. It involved a small number of residents in east Glasgow that are not necessarily representative of the wider population. Moreover, while it might be assumed that residents living in high-rise flats are likely to be among the most deprived and isolated within the local area, the strong sense of community and the positive role played by the concierge suggests that these residents possessed 'assets' that other residents in east Glasgow do not have access to and, therefore, the study may have not identified other forms of deprivation that other residents in east Glasgow may be exposed to.

However, this study highlights the need for partnerships between health and other sectors to address social and economic problems that are a catalyst for poor mental health and well-being. The approach adopted in this study demonstrates the potential of such a partnership to effect change and despite the limitations highlighted, offers a model that can be adopted by a wide range of partners to tackle mental health inequalities and to promote mental health and well-being in areas of deprivation.

Acknowledgement

The authors wish to acknowledge the support of Verona Rodgers, formerly Positive Mental Attitudes and Charlie McKay, Glasgow Housing Association, for their help in organising and supporting the research.

References

Community Health Exchange (2007) *Healthy Living Centres in Scotland: Lessons for policy and practice*. Glasgow: Community Health Exchange.

Friedli L, McCollam A, Maxwell M & Woodhouse A (2005) *Mental Health Improvement: Evidence and practice. Guide 2: Measuring success*. Edinburgh: Health Scotland.

Friedli L (2009) *Mental Health, Resilience and Inequalities – A report for WHO Europe and the Mental Health Foundation*. London/Copenhagen: World Health Organization.

Fryers T, Melzer D & Jenkins R (2003) Social inequalities and the common mental disorders: a systematic review of the evidence. *Social Psychiatry and Psychiatric Epidemiology* 38 (5) 229–237.

Halpern D (2005) *Social Capital*. Cambridge: Polity Press.

Kirkwood T, Bond J, May C, McKeith I & Teh M (2008) *Foresight Mental Capital and Well-being Project. Mental capital through life: future challenges*. London: The Government Office for Science.

Kretzman JP & McKnight JL (1993) *Building Communities from the Inside Out: A path toward finding and mobilising a community's assets*. Chicago: Center for Urban Affairs and Policy Research, Neighbourhood Innovations Network, Northwestern University.

Maslow AH (1943) A theory of human motivation. *Psychological Review* 50 (4) 370–396.

Miles MB & Huberman AM (1994) *Qualitative Data Analysis: An expanded source book* (2nd edition). Thousand Oaks, CA: Sage Publications.

Myers F, McCollam A & Woodhouse A (2005) *National Programme of Improving Mental Health and Well-being: Addressing mental health inequalities in Scotland – equal minds*. Edinburgh: The Scottish Executive.

NHS Health Scotland (2004) *Eastern Glasgow: A community health and well-being profile*. Edinburgh: NHS Health Scotland.

Palmer G, North J & Kenway P (2003) *Monitoring Poverty and Social Exclusion*. York: Joseph Rowntree Foundation.

Pickett KE, James OW & Wilkinson RG (2006) Income inequality and the prevalence of mental illness: a preliminary international analysis. *Journal of Epidemiology and Community Health* 60 (7) 646–647.

Quinn N & Knifton L (2005) Promoting recovery and addressing stigma: mental health awareness through community development in a low-income area. *International Journal of Mental Health Promotion* 7 (4) 37–44.

Rogers A & Pilgrim D (2003) *Inequalities and Mental Health*. London: Palgrave Macmillan.

Rubin HJ & Rubin S (2008) *Community Organising and Development* (4th edition). Boston, MA: Pearson.

Scottish Government (2009) *Towards a Mentally Flourishing Scotland: Policy and action plan*. Edinburgh: Scottish Government.

Social Exclusion Unit (2004) *Social Exclusion and Mental Health*. London: Office of the Deputy Prime Minister.

Temkin K & Rohe W (1998) Social capital and neighbourhood stability: an empirical investigation. *Housing Policy Debate* 9 (1) 61–88.

Thompson S (2007) *The European Happy Planet Index: An index of carbon efficiency and well-being in the EU*. London: New Economics Foundation.

Wilkinson RG (1996) *Unhealthy Societies: The afflictions of inequality*. London: Routledge.

Wilkinson R (2005) *The Impact of Inequality: How to make sick societies healthier*. London: Routledge.

Wilkinson RG & Pickett KE (2006) Income inequality and population health: a review and explanation of the evidence. *Social Science and Medicine* 62 (7) 1768–1784.

World Health Organization (2004a) *Prevention of Mental Disorders: Effective interventions and policy options. Summary report*. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf (accessed November 2010).

World Health Organization (2004b) *Promoting Mental Health: Concepts, emerging evidence, practice. Summary report*. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf (accessed November 2010).

Zaveleta RD (2007) The ability to go about without shame: a proposal for internationally comparable indicators of shame and humiliation. *Oxford Development Studies* 35 (4) 40.