

Mental Health Services in the 1990s

The climate surrounding mental health service provision in 1993 - when the City Parochial Foundation's Mental Health Programme was launched - was one of great change. Statutory purchasers and providers had been increasingly focusing on the implementation of care management guidelines in social services, and the care programme approach in the health service. At the same time, a number of high profile inquiries into individual examples of failures in community care were associated with a great deal of negative media coverage. Heightened public fear of the dangerousness of the mentally ill - coupled with suspicion of the progressive policy of transferring services from the large asylums into the community - were reflected in the Secretary of State for Health's response to the Christopher Clunis Inquiry: 'the pendulum has swung too far'. Reprovision of psychiatric services into the community nevertheless continued apace, as the Government increasingly endorsed a needs-led service, responsive to market forces, and tempered by the involvement of mental health service users in the monitoring and strategic planning of the changing services.

The chequered history of community care

The shift towards community care had begun in the 1950s, with the first large scale closures of the mental asylums in the early 1960s. In 1975 a discussion document, 'Better Services for the Mentally Ill'¹ had encouraged further moves away from large psychiatric hospitals whilst at the same time recognising that there were insufficient services in the community to support people with mental health problems.

The 1990 NHS and Community Care Act placed a requirement on local social service and health authorities jointly to agree community care plans for the local implementation of needs-based services for long-term, severe and vulnerable psychiatric patients. Subsequent DHSS Inspectorate guidance² defined the concept of 'care management' - a change which marked the introduction of the purchaser/provider division within social services, with the care manager identified as a purchaser of services, as opposed to a provider. In line with the Government's free-market ethos, 85% of the monies allocated to implement the Community Care Act, the Special Transitional Grant, had to be spent in the private or voluntary sectors.

¹ Department of Health and Social Security (1975) *Better Services for the Mentally Ill*. London: HMSO.

² Department of Health and Social Services Inspectorate (1991) *Care Management and Assessment. Summary of Practice Guidance*. London: HMSO.

Alongside the 1990 Act, the Department of Health introduced the 'Care Programme Approach' (CPA)³. This was designed 'to provide a network of care in the community' for mentally ill people, both to ensure that they had adequate support and to minimise the risk of their losing contact with services. The essential elements of the CPA were:

- systematic arrangements for assessing the health and social care needs of people accepted by the specialist psychiatric services
- formulation of a care plan which addressed the identified health and social care needs
- appointment of a key worker to keep in close touch with the patient and monitor care
- regular review, and if need be, agreed changes to the care plan.

Problems arose as a result of there being two separate systems for delivering mental health care, represented on the ground by the social services care manager, designed to be a resource manager, and the health services key-worker, engaged in service provision. Subsequent Government guidance^{4,5} was intended to resolve the difficulties, which were further complicated by the rise in GP fundholding.

Public fears and the media

Community care had acquired an unpopular image with the public. A 1993 survey of media coverage of mental health issues by the Glasgow University Media Group found that two-thirds of items related mental distress to violence, whilst audience research by the same group confirmed the belief that the strong link between mental health and violence in the public mind was largely derived from the influence of the media⁶.

At the end of 1992, three devastating incidents served to reinforce the association of dangerousness with mental illness, and with a perceived inadequacy of community care arrangements for the mentally ill: Ben Silcock, a discharged psychiatric patient with a

³ Department of Health (1990). *The Care Programme Approach for People with a Mental Illness*. London HC(90) 24/LASSL (90)11 DH.

⁴ Department of Health (1995). *Building Bridges: a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people*. London: DH.

⁵ Department of Health (1994). *Guidance on the discharge of mentally disordered people and their care in the community*. London HSG(94)27/LASSL(94)4 DH.

⁶ Philo G, Secker J, Platt S, Henderson L, McLaughlin G and Burnside J (1994). The Impact of the Mass Media on Public Images of Mental Illness: Media Content and Audience Belief. *Health Education Journal* 53; 271-81.

diagnosis of schizophrenia who climbed into the lion's den at London zoo and was badly savaged; the killing of Jonathan Zito by discharged psychiatric patient, Christopher Clunis; and the murder of 54-year-old former policeman, Frederick Graver, by a former psychiatric patient.

These incidents and their reporting in the press influenced the Government's 10-point plan (August 1993), which included new guidance on the discharge of mentally disordered people into the community, the establishment of supervision registers for patients deemed a risk to themselves or others, and a new power of supervised discharge.

The rise of the voluntary sector

The introduction of managed markets, in the health service in particular, had shifted the emphasis of the statutory services towards a more needs-led approach, giving purchasers the power to divert funds away from secondary service providers. And increasingly, Government directives were specifying that local purchasers and providers should consult with service users regarding overall improvement in local services, as well as in their own care.

In the prevailing climate, the voluntary sector was uniquely placed in several ways to provide much of the social support frequently identified by service users as a key element of mental health care. Voluntary services were at once competitive and relatively flexible in their approach, making them attractive to purchasers and users alike. And within the voluntary sector, the rise of the user movement - with its emphasis on self-advocacy and empowerment - was a highly significant and innovative development.

With its beginnings in the early 1970s in the anti-psychiatry movement, the user movement had grown exponentially. Over 10 years since 1985, the number of user groups rose from less than a dozen to an estimated 350 plus at local, regional and national levels⁷. The movement played a leading role in the Government-appointed Mental

⁷ Campbell, P (1996) The history of the user movement in the United Kingdom. In: Heller T, Reynolds J, Gomm R, Muston R, Pattison S (eds). *Mental Health Matters. A Reader*. London: Macmillan.

Health Task Force, set up in 1992 to facilitate the development of better services in the community. At a local level, representatives from user groups were becoming more involved in service planning, evaluation and training, and in providing advocacy and support, as well as a platform for the user voice. User groups both represented and modelled radically new approaches to mental health services based on the needs and wants of service users.

What did users want?

Broadly, users were calling for a decreased emphasis on illness and greater recognition of their social needs. Decent housing, adequate income and more opportunities for paid employment were high priorities. Beyond this, acceptance was the key issue: to be listened to and have their views taken seriously. To be recognised as equal citizens, to be better informed about treatment and services, and to have more opportunities to participate in the development and management of services that reflected these values. Community-based services, despite their shortcomings, were consistently preferred and engaged with by service users over hospital care^{8,9,10,11}.

The mid 1990s was an opportune time for creating a user-friendly future to support those in mental distress. Hopefully projects such as those outlined in the following pages will have helped to support that future.

⁸ Audit Commission (1994). *Finding a Place*. London: Audit Commission.

⁹ Beeforth M, Conlan E, Field V, Hoser B and Sayce L (1990). *Whose service is it anyway?* London: Research and Development for Psychiatry.

¹⁰ Rogers A, Pilgrim D and Lacey R (1993). *Experiencing Psychiatry: Users' Views of Services*. London: Macmillan.

¹¹ Rose D (1996). *Living in the Community*. London: The Sainsbury Centre for Mental Health.

The Mental Health Programme

Why a Mental Health Programme?

Community care was a recurrent theme in the Report of the City Parochial Foundation's Policy for Grants 1992-1996. As part of its five yearly policy review in 1991, the Foundation had commissioned a policy paper on community care to provide background information on the needs for care in the community in London, and recommendations as to funding. This paper identified six broad concerns:

- carer relief, respite and support
- physical access and transport to mainstream services
- enabling voluntary sector representation on planning bodies
- self-advocacy projects
- mental health day-care services
- support services for people in mental distress, particularly people from the Afro-Caribbean and Asian communities, and training of therapists from these communities.

Racism and the refugee situation were also highlighted as priorities for the future.

Three deciding factors motivated the Foundation's decision to fund a broad-spectrum mental health programme. First, the Foundation had received few grant applications in the mental health field in the recent past. Second, there were growing concerns about the needs of clients and their families in this area. And last, the statutory services for those with mental health problems were in the process of radical rethinking and re-structuring, with the potential for adverse effects on the provision of services to those in great need, such as the homeless mentally distressed.

Priorities and projects

Preparations for the Foundation's Mental Health Programme began in 1993. Early in the year, a specially convened advisory panel of mental health experts was invited to recommend priorities for grants within the programme. Four particular concerns were identified.

- Women experiencing mental health problems (of all ages).
- Young people with mental health problems, particularly young people from black and minority ethnic communities, including refugee communities.
- Accommodation projects concerned with providing specialist help for homeless people with mental health problems, especially those with continuous ongoing needs.
- Self-advocacy schemes and groups that brought together consumers of mental health services to say what they felt about those services and the way they were operating, with a view to bringing about improvements.

These priority concerns were put to a public meeting of people involved in mental health organisations in June 1993. A total of 120 people attended the meeting and endorsed the choice of priorities.

Wide publicity about the availability of funds (up to £500,000 a year over three years) for new work within the priority areas of concern resulted in 90 approaches for grants being received by the Foundation. Over half fell outside the stated priorities. Of the remainder, 20 organisations were invited to meet Foundation staff and 17 of these were invited to submit full applications. Nine organisations eventually received grants. The Foundation received no applications from organisations working with the homeless mentally ill, thus the funds allocated all went to groups working within the remaining three priority areas of concern. These were:

- The Manic Depression Fellowship
- Nafsiyat Intercultural Therapy Centre
- Peter Bedford Housing Association
- Mental Health Media
- Croydon Mental Health User Group
- Mind in Tower Hamlets
- Horn of Africa Counselling and Social Support Centre
- Brixton Sanctuary
- Islington Women's Counselling Project

With the exception of the Horn of Africa Counselling and Social Support Centre, which received funding for a feasibility study only, these organisations all received three-year grants from the City Parochial Foundation for specific mental health projects. The Brixton Sanctuary and the Islington Refugee Project of Women's Counselling projects both closed prematurely (further information on page 7). The remaining six projects, the services they have provided with Foundation funding, the project outcomes, and the problems encountered during the course of development, are described in the following pages of this report.

Monitoring and reporting

The Foundation outlined a number of monitoring and reporting systems, both to monitor the Mental Health Programme as a whole, and to assess individual projects comprising the programme. These included the following elements.

- Group meetings of the all organisations funded at the end of the first six to ten months of the programme, and thereafter twice yearly, to discuss issues and problems and exchange experiences.
- Visits to the individual projects by the Policy and Monitoring Officer, Dr Maknun Gamaledin-Ashami, every six months to assess progress.

- All projects to copy project-related documentation to the Policy and Monitoring Officer on a regular basis - and to inform him of any management changes.
- A short questionnaire to be completed every year by the managers and key workers in the individual projects, aimed at assessing the effectiveness of the grant, its impact and lessons learnt.
- Annual reports to be prepared specifically by the individual projects for the City Parochial Foundation. These to include a section detailing the profile of clients using the services.
- The Policy and Monitoring Officer and the Field Officer responsible for the programme to prepare an annual monitoring report for submission to the Monitoring Sub-Committee and other relevant City Parochial Foundation committees.

Projects that ended prematurely

BRIXTON SANCTUARY

Brixton Community Sanctuary applied for and received, in 1994, a grant of £77,735 over three years to employ a community outreach worker who would particularly work with women. This was an important initiative as members of the Sanctuary felt at the time that women were not well represented amongst their regular membership.

Sadly, the organisation suffered from the effects of one member of staff's ill health and difficulties with premises. As a result, the project came to an end when the remaining worker moved to another job in 1996.

ISLINGTON WOMEN'S COUNSELLING PROJECT

The Islington Women's Counselling Project received a grant of £92,771 over three years to employ a refugee worker to work with younger women. This exciting work began in June 1994, but unfortunately significant staff changes led the project leaders reluctantly to decide in September 1995 that they could no longer continue the work as originally envisaged.

FEASIBILITY STUDY: THE HORN OF AFRICA COUNSELLING AND SOCIAL SUPPORT CENTRE

This organisation received a grant for a feasibility study to examine the extent of mental health problems amongst refugees from the Horn of Africa, the appropriateness of existing statutory and non-statutory provision, and the health and social care needs experienced by people from the Horn of Africa suffering mental distress. The research, completed in 1995, successfully identified the particular problems faced by refugees from the Horn of Africa with mental ill-health. These have subsequently been widely acknowledged and several agencies, including the Mental Health Foundation, are working to relieve mental health and social care difficulties faced by refugees, including those from the Horn of Africa.

Manic Depression Fellowship: Expanding the MDF Self-Help Network in Greater London

Manic depression, also known as bi-polar affective disorder, is characterised by swings in a person's mood from high to low - euphoric to depressed.

In the manic phase, the person has excessive amounts of energy and feels little need for sleep. At these times they may behave in ways which can have serious consequences when the episode is past, for example leaving their job, spending a lot of money, or giving away their possessions. During a depressive episode, there is a feeling of hopelessness and despair, of lethargy, broken sleep, overwhelming negativity and difficulty in carrying on with the activities of day-to-day life.

These are, however, only episodes. People with a diagnosis of manic depression can have long periods of time without experiencing these problems, and many sufferers lead useful and productive lives. In addition, user-run groups like MDF have been instrumental in helping people with manic depression learn how to cope better with the problems arising from it, through self-management techniques and through the support and advice offered in MDF self-help groups.

The Need for an Expanded MDF London Network

Manic depression, according to World Health Organisation figures, affects 1 in 100 of the general population at some time in their life. Despite this, it is a condition about which there is considerable ignorance among the general public. As a consequence, people with manic depression can feel isolated and experience prejudice.

MDF supports an expanding network of self-help groups nation-wide. However, its presence in London in the early 1990s was under-developed, particularly in inner city areas. A total of only nine London MDF groups existed at the start of the project in 1994. In such a large centre of population, there was an obvious need for outreach to people living with manic depression, by developing the network of MDF self-help groups in the Greater London area.

Self-help and self-management

Self-help can mean two things. It can refer to an individual's efforts to cope better with whatever is troubling them, by educating themselves about the nature of their problem, for example, or by learning new ways to handle its effects.

Self-help can also involve meeting together with a group of people who have been through similar problems to offer each other mutual support and understanding. Such groups are known as self-help groups or, sometimes, support groups. Through sharing their experiences, members of MDF self-help groups learn how to cope better with the effects of manic depression. Collective self-help not only assists group members with managing their condition, but also enhances their social lives and encourages them to campaign to improve services.

People who attend a self-help group may find that it is the only space where they can be honest about their symptoms or fears without being thought of as odd by the people listening. These groups do a great deal to lessen the sense of isolation for MDF sufferers and their families and to reduce their fears about not being able to cope.

Self-management of manic depression describes the process of understanding one's mood swings, the effects they have, and at what times and how often they are likely to occur. This helps individuals to recognise signs of an approaching mood swing and take steps to cope with it better, leading to improved stability and a greater sense of control.

The London Project

City Parochial Foundation made MDF a grant of £132,732 over three years to expand their services in Greater London, by appointing a director with special responsibility to:

- raise awareness of MDF services in Greater London
- provide advice, information and access to MDF self-help groups in Greater London
- expand the network of MDF self-help groups throughout the Greater London area
- develop links and services appropriate for black and minority ethnic communities affected by manic depression
- ensure continued funding for the project and the local groups at the end of the three year City Parochial Foundation grant.

In a region that has a population of nearly seven million people, with 32 boroughs and 68 separate NHS Trusts, this represented a formidable task.

Expanding the MDF Group Network in Greater London

An MDF Director for Greater London was appointed in March 1995. Selection of a part time administrative assistant followed in November 1995.

The Director was responsible for all MDF development work in Greater London. This focused initially on the development of new MDF groups in under-developed areas. A target of six new groups by the end of year one was successfully reached.

Kingston MDF Group	launched May 1995
West London MDF Group	launched May 1995
Wandsworth MDF Group	launched September 1995
Bexley-Thamesmead-Greenwich MDF Groups launched	September 1995
Ealing MDF Group	launched March 1996
Hackney MDF Group	launched March 1996

Four further groups were subsequently established.

Enfield MDF Group	launched May 1996
Hampstead MDF Group	launched October 1996
Twickenham MDF Group	launched March 1997
Brent MDF Group	launched March 1997

Development work has since continued in Haringey and Merton.

How the Project Worked

To begin an MDF group in a new area, the Project Director would start by making contact with local people to assess the level of interest. This would include both MDF members in the area and professionals, in order to access users of the mental health services locally who might not know about MDF. Directories of local mental health services, including other voluntary organisations, were further sources of potential group members.

After consultation and discussion, a preliminary meeting might be set up, where people would be invited to find out about MDF, self-help groups and self-management of manic depression. If a number of people were interested enough to want to start a group in the area, the Project Director would work with them to help them develop their own systems for running the group and to sort out the practicalities. She would then provide ongoing support for group facilitators as the group grew. She would also offer opportunities to network with other MDF groups and their facilitators through a monthly Greater London MDF Bulletin and quarterly Network Days and Group Training Events for the region.

What Made a Group Work?

The success of a group seemed to depend on a number of different factors. For instance, if a group relied on one key individual to lead it, the absence of that person for any length of time could lead to the group's dissolution. One way of preventing this was shared leadership, with a number of people, at least two, taking turns to lead the group. This arrangement also served to relieve stress for people who were interested in becoming more involved but worried about their ability to cope.

Having shared leadership, however, sometimes led to a clash of styles or opinions as to what a group should be doing. The involvement of the Project Director, as a neutral mediator, was of key importance in enabling different views to be heard and consensus to be achieved.

For a group to be successful, members have to be sure that confidentiality will be maintained, thus new groups were encouraged to have a clear statement to this effect to which all members agreed to adhere.

Case study

"The Ealing group is beginning to thrive. We have a core membership of 12 to 18 people who attend on a regular basis. At our last meeting, members were still chatting to each other at 9.30 p.m., half an hour after the consultant psychiatrist who came to speak to us had gone home. He gave a very interesting talk. Four new members joined that evening and it would seem that regular talks from various agencies will engender new interest from outside parties and encourage additional membership.

It is the intention of the group to be as self-reliant as possible, and to organise our own speakers and so on, but we also acknowledge the superb back-up we receive from all the staff at Kingston-Upon-Thames. Ideally we would like a few more female and ethnic minority members but we are optimistic that this wish will come to fruition in the near future".

Co-ordinator, Ealing MDF self-help group

Project Successes

The availability of part-time administrative support from an efficient and reliable assistant was extremely valuable in allowing the Director to concentrate on the development and training of MDF groups. MDF's Greater London membership increased by almost 50% since the start of the project, from 820 to 1,196 members. This required a great deal of networking and public relations work on the part of the Director - travelling around, talking to people and distributing leaflets about MDF.

The Director was able to work with MDF members in local areas and effectively act as a catalyst for setting up new groups. The profile of MDF was considerably enhanced as a result: the Fellowship became much better known within mental health circles in the boroughs where new groups were formed.

The training days were both innovative and well received. They had not happened previously on a regional basis. MDF members much appreciated meeting with members from other groups throughout the London region to discuss group issues and business.

Case study

“The West London MDF - self help group aims to supplement psychiatric and community care. Contact with other sufferers and carers is immensely helpful in avoiding unpleasant experiences. By supporting each other we also assist the community psychiatric system and hospitals by leaving professional services and valuable bed space available to others. We all want to live outside institutions and this group helps enormously.

Twenty to forty sufferers and carers meet at the local community centre on the first Wednesday of every month. For most of us it is an invaluable support network - a place where the intense isolation resulting from this illness can be relieved. Most of us see the group as a lifeline, something the psychiatric services can only offer very expensively. We offer support in times of crisis, by either phoning or visiting in hospital members who have had to resort to an increasingly unhelpful and overworked system of health and community care. We also meet on the third Saturday in the month.

At group meetings literature and personal help is readily available to both sufferers and carers regarding drug treatment, the nature of the illness and how everyone copes with it. This help and information is, sadly, not available anywhere else! The opportunity to speak with other sufferers and carers to gain more insight into manic depression and how it affects others around us is unique. We often invite speakers who are professionally involved in treating or helping manic depressives.

In just a year and half the West London self help group has achieved a membership of 84 sufferers and carers”.

Co-ordinator, West London MDF self-help group

Future Work

There are still large areas of London in which MDF does not have any self-help groups - or even very many members. Future work will need to concentrate on those areas to make the most impact and to raise the profile of MDF. Ongoing effort is required to support existing groups as well as to help set up new ones. This strategy seems to have worked well so far.

Training events will need to continue to develop team working and facilitation skills, the lack of which appeared to be the common root of difficulties among the self-help groups.

One person's experience

"When I first heard of MDF, I had just come out of a long bout of depression lasting 18 months. My confidence and self-esteem were at a low ebb. I hadn't worked for two years and my social skills had become redundant due to long periods of isolation. A lot of friends had deserted me, and I them.

Going to the first meeting was a big step as I didn't feel confident amongst groups of strangers, but I was made to feel welcome and I found for the first time that I was able to speak openly and frankly about bi-polar episodes knowing that other people had been through what I'd been through - different experiences, some funny, some tragic, some downright horrendous. I did not want sympathy; just someone to listen without prejudice.

The meeting took place in someone's house around a big oval table and was informal and friendly. Interesting and informative ideas were being bandied about. I came away having made a few new friends who I still keep in touch with, and with a positive vibe about MDF.

I am now group co-ordinator in Enfield and we have attracted new members from within the borough and from a neighbouring area. I have since been to workshops on the media and mental illness and on coping with manic depression, and I've attended a supper evening at the Royal College of Psychiatrists.

I am now attending College in Tottenham studying Humanities and Social Services. I hope to sustain the members' interest in the Enfield group, to attract new members, and to obtain as much literature and information on the subject as possible".

Co-ordinator, Enfield MDF self-help group

***One person's
experience***

"I have really benefited from the support and companionship of members of our self-help group. I cycle from mania through depression twice a year and I have great difficulty keeping in touch with reality. Three members of the group keep personal contact with me and advise me on how my attitude - aggressiveness, moodiness and withdrawal - appears to the world at large. They give me invaluable help between visits to my psychiatrist. I have not even been close to entering hospital since the group began.

To return the help extended to me I regularly help sufferers in crisis and/or in hospital. Carers frequently need more help than the sufferers, particularly when the latter has gone astray while suffering mania. This is very time consuming but satisfying".

Member, West London MDF self-help group

Nafsiyat: Therapeutic Work with Young Refugees

The Need for a Counselling Service for Young Refugees

As its reputation for intercultural therapeutic work grew, Nafsiyat began receiving an increasing number of requests for help from refugees. Lack of available resources at the time meant that these requests could not be met. In 1992, research into the problems experienced by young refugees, conducted by Nafsiyat together with the Traumatic Stress Clinic, indicated that this group was particularly likely to experience problems as a result of witnessing violence and death, being separated from or losing members of their family, losing their familiar culture, language and community, and being isolated at school. Some young refugees were also thrust into the position of being carers to other siblings, increasing their stress and worry. For young refugees with families in this country, generational conflicts resulting from the young person's adaptation to English culture were also a frequent problem.

Research into the availability of services indicated a widespread lack of provision for meeting the emotional needs of young refugees, and particularly an absence of counselling services in languages other than English. Language needs were usually met through translation via interpreters - an arrangement which could frequently be uncomfortable as well as inconvenient. Little preventative work was happening. Moreover, most young refugees in contact with services were already displaying behavioural and emotional difficulties, often of a serious nature.

In addition, young refugees were frequently facing stress resulting from practical problems, such as higher than average rates of unemployment; poorer access to training as a result of unmet language needs; poor housing; and difficulties with their benefits claims and legal status.

The Refugee Project

City Parochial Foundation made Nafsiyat a grant of £148,766 over three years to establish a counselling project for young refugees. The aims were threefold:

- to provide direct psychotherapy, counselling and group work services to young refugees
- to develop support within refugee communities themselves by training potential counsellors and therapists
- to liaise with statutory and voluntary organisations to ensure that the psychological and emotional needs of young refugees were being met.

A therapist/counsellor was appointed as full-time Project Leader in January 1995. The City Parochial Foundation grant covered her salary and supervision costs, the salary of a part-time administrative assistant, and contract payments for sessional therapists.

The project leader's main roles were:

- to co-ordinate the training and work of volunteer counsellors
- to provide individual counselling/therapy and group work in schools and colleges
- to liaise with refugee community organisations and other appropriate agencies.

How the Service Worked

The Project Leader began by building on Nafsiyat's 1992 research, to establish the needs of young refugees across London. Consultation took place with diverse counselling agencies, black mental health agencies, schools, colleges, youth clubs, and refugee forums and community groups. The Refugee Project and its training opportunities for potential therapists from refugee communities were publicised through these networks.

From these beginnings, the project grew to provide a therapeutic service taking into account the stresses faced by young people from refugee communities, particularly the after-effects of trauma and loss. Ongoing work with the wider refugee communities continued to promote understanding and use of the service. Therapy was offered in a manner that made it acceptable to young refugees; for example, it would often not be referred to as therapy, and it might not take place in a therapist's consulting room. Drama, art and play would sometimes be used in addition to more conventional counselling techniques. Clients were offered flexibility in choosing a therapist; they were asked whether they wanted a man or a woman and whether they would like to see someone who spoke their own language. Most Eritrean and Ethiopian clients preferred to see counsellors who were not from their own community, even though they might have found it easier to talk in their own language, because of concerns over cultural values, including issues of confidentiality.

Group work, less intensive than individual therapy, was conducted in two schools and a sixth form college. Groups were run separately for boys and girls where appropriate, and were scheduled within school hours to make it easy for children to attend and to demonstrate the importance and value of the groups from the point of view of the school authorities.

The recruitment and training of volunteer counsellors was a major focus. Seven volunteers started training with Nafsiyat in September 1995, and most started seeing clients under supervision from January 1996. The one-year training course looked specifically at counselling issues for young refugees. Volunteers were encouraged to see the training as part of their career development. Nafsiyat is a United Kingdom Council for Psychotherapy (UKCP) recognised training centre, the volunteers received a certificate at the end of their training, and there was an option to progress to more advanced counselling training.

In addition to the training programme, the Refugee Project ran training and awareness raising sessions for outside agencies on the mental health needs of refugees, particularly in the younger age groups. There were more requests for this work than could be dealt with - the majority coming from statutory mental health care agencies. Almost all the work of the Refugee Project was focused on developing skills within the refugee communities - in order for refugees themselves to be able to provide services to their own communities in their own language. Workers and volunteer counsellors were involved in continuous evaluation of the project, whilst a refugee advisory group fed back to ensure that the diverse perspectives of the different refugee communities were represented.

Referrals *“The Project started being available for referrals from November 1995, and we were been able to offer a range of services from January 1996, when the volunteers had received an appropriate amount of preparatory training. In total we reached 129 referrals to June 1997. The central issue for many of our clients has been separation, bereavement or loss. Almost all our clients have had family members who have died, sometimes in violent incidents.”*

Project Leader, Nafsiyat Refugee Project

Case study

“A 16-year-old client came to the Centre feeling very depressed, she had left her parents in Africa and had come to England with a relative. Once in England the relative was treating her like a servant, not sending her to school and making her stay at home and look after his children. The young woman's self confidence had been decimated by this relative, and when she came to Nafsiyat she had a very low opinion of herself. She also had a lot of anger towards everyone she met, some of which was based on envy. She was described as having behavioural difficulties. She saw an English-speaking therapist at Nafsiyat on a weekly basis for 12 weeks, after which she was seen every month until the counselling gradually ended. Throughout the counselling she was able to talk about her pain and about the loss of her whole family, and to see that she had a strong attachment to the relative who was abusing her because he was the only link to her past, and to the rest of her family back home. At the end of the counselling this young woman became much more confident and is now living in her own accommodation and attending college.”

Who Used the Service?

The Refugee Project offered counselling and therapy for 129 refugee children and young adults aged 12-30, mainly from Ethiopia and Eritrea (26%), Somalia (15%), Turkey and Kurdistan (9%), Iran (9%), Sudan (5%), and Latin America (4%). The young people using the project presented a wide range of needs: some were in distress and displaying behavioural difficulties and sometimes physical symptoms; others had more deep-seated emotional problems. Some clients would be coping well with their day-to-day lives at school or college, but experiencing emotional stress and problems to do with their status as refugees; some of these young ones attended the centre, whilst others went to groups at their place of education.

The project initially received more referrals of young women than young men, but numbers subsequently roughly equalised.

Case study

“One referral was of an Turkish father and daughter, the young woman's mother had died in Turkey, although the exact nature of the circumstances are still unknown. The father and daughter were having many conflicts about their roles. The father had culturally specific expectations of how his daughter should behave, and she compared her father to how she imagined white parents behaved towards their daughters. The young woman was considered to have 'behavioural difficulties'. Both father and daughter were seen by a Turkish-speaking counsellor on a weekly basis for 12 weeks. The counselling helped them both to accept and mourn the death of their mother/wife and to see how they were blaming each other for her death. The loss of culture, language and social values was creating conflicts for the family; once they began to see how these issues were affecting them, they began to improve in their communication.”

Project Successes

Nafsiyat has always had a high standard of clinical work with clients. The new work was the outreach work and forming the team of volunteer counsellors from the refugee communities. Training of the volunteers was particularly successful. The project was able to find very high quality volunteers; all but two out of the seven original trainees decided to stay on after the training, and they made a very solid team. Nafsiyat thus met its criteria for the training - the development of skills within refugee communities.

The outreach also worked well. The clients using the service were exactly those for whom initial research had identified gaps in existing services. They came from three groups. First, unaccompanied young people - the 14 to 18 year-olds coming to this country on their own. Second, the 19 plus age group (79 in total); this group lack any statutory support, and they have deeper emotional issues than the younger age group. There were several recent suicides amongst refugees in this age group in London. Third, there were those refugees (74) who did not speak English. Being able to offer a service in the person's language was found to be very important.

Case study

"One young Eritrean man we saw was 24 years old. He had joined the army at the age of 12 and had come to this country at the age of 18. He was referred by his doctor as being depressed. The client had been in the country for six years and felt that this time had been like a dream for him. He had become preoccupied with imagining that he had a life-threatening illness; the doctors could not identify any illnesses and had put him on anti-psychotic medication. Now that he had settled he was having panic attacks and feeling very depressed. He thought these emotions were linked to his past experiences of witnessing and being involved with extreme violence, both in the army and in his community.

His past history was one of being brave and coping with all events, and as such he had found it very difficult to express his fear and sorrow about the events that occurred in his life. This fear was now beginning to take over and he felt afraid of everything, to the extent that he found it difficult to work and live his life. He received therapy for over 6 months, and was subsequently considered for long-term treatment after a psychiatric assessment at Nafsiyat. The counselling helped him to talk about all his built-up pain, anger and most importantly fear. He had witnessed people being killed from a very young age, but had always had to be brave. In the counselling he was able to explore the root of his fear, and address fear in his present life."

Future Work

Throughout the project, Nafsiyat were asked to do a surprising amount of training and supervision for other organisations. To mid-June 1997, they ran 27 workshops, conferences and one-day training sessions aimed at teachers, social workers and other counselling centres on specific ways of working with refugees as well as providing consultancy work. Nafsiyat found that teachers, for example, were keen to help refugee children but they did not know what to do. More training and workshop programmes are planned, as is continued ongoing supervision with mental health professionals working with refugees. If professionals learn how to cope with refugees hopefully services will be more appropriate for refugee communities.

Nafsiyat would also like to train more people from refugee communities. They will be running further training courses in future, with the aim of providing more resources within the communities. The hardest part of the work was establishing the project and getting recognition. That done, Nafsiyat are now seen as somewhere to send people. They have established trust - and that needs to continue.

Peter Bedford Housing Association: Creating Employment and Training Opportunities for Women

Peter Bedford HA has many years' experience in running employment and training schemes for people living in its housing projects. These schemes offer participants the opportunity to meet people, keep busy during the day; earn money to supplement benefits; develop and improve their skills; and subsequently move on to open employment or training if they wish, with full support. The schemes are designed to accommodate people whose reasons for wanting to work may be very different. Many may just want the chance to be with others during the day and do something interesting with their time. For others, however, moving into open employment or earning decent money are more important.

The Need for Women's' Employment and Training Schemes

In 1992, the Peter Bedford Trust set itself positive action targets to increase the number of women living in Peter Bedford Housing. This met with considerable success - and in the subsequent two years the proportion of women residents increased from 21 to 30%. Once established, however, the women began to demand a better range of services more appropriate to their needs. In particular, they wanted more and different work opportunities besides those already available in canteen catering and in the carpentry and upholstery workshops. The most frequent requests were for opportunities in administrative work and sewing-related activities, which were viewed as offering the most useful training to enable a return to open employment.

Consultation with other mental health agencies involved in developing employment opportunities locally confirmed that there was heavy demand from women both for training that would enable them to move into administrative work and for work activities like sewing.

Lack of access to suitable training opportunities is a significant issue for people with mental health problems - and together with stigma, acts as a considerable barrier to their joining the job market. One reason for this lack is that training agencies and colleges are not geared up to meet any additional needs for support that mental health service users may have. A key feature of the Peter Bedford HA schemes was therefore to offer women participants the opportunity to gain genuine qualifications that were recognised on the open market.

The Women's Employment and Training Projects

To attract more women into the Peter Bedford HA work schemes required new developments. The City Parochial Foundation made Peter Bedford HA a grant of £159,066 over three years to set up schemes offering employment and training for women in office administration skills and soft furnishings production.

The grant was to cover the salary for a full-time trainer/assessor for the Soft Furnishings Scheme, plus expenses for a part-time paid community service volunteer for this scheme, running costs, materials and equipment. On the administrative training side, funding covered the running costs of the scheme, the salary of a full-time receptionist and the costs of her training. Both new schemes were to offer the option of NVQ qualifications for participants.

Both schemes became operational in late February 1995, with the opening of the Peter Bedford HA new facility at Stamford Works in the London Borough of Hackney.

The Soft Furnishings Work Scheme

Participants received training to produce a wide range of high quality soft furnishing items, including curtains, cushions, covers, tablecloths, napkins, quilts and bed linens. Skills training included:

- design and pattern making
- use of tools and machinery
- cutting, machining and finishing items to a suitable standard
- use of different textiles and fabrics
- team-working
- time keeping and reliability
- working to instructions and deadlines.

Training was delivered on site, by the workshop supervisor and volunteer assistant. The emphasis was very much on the production of high quality goods that could compete with others on the retail market. Positive feedback from sales was found to be very important in maintaining morale as well as in planning production. Good planning of retail outlets and opportunities was vital for this purpose as well as for bringing revenue into the scheme.

The scheme accommodated up to six participants a day, five days a week. As part of the programme, the workshop supervisor became a trained NVQ assessor, giving participants the opportunity to gain an NVQ in Manufacturing Products from Textiles. Overall, around 20 people participated in the scheme, and by popular demand, three days were designated 'women only days'. The Soft Furnishings Scheme proved popular beyond expectations: towards the end of the project there were waiting lists to join the scheme on 'women only days'.

Positive feedback

"We get very positive feedback from participants in the Soft Furnishings Scheme. The training there is of a very high standard. Overall, it is one of our most successful work schemes ever."

Project Leader, Peter Bedford Women's Employment and Training Schemes

What the users thought

'It's therapeutic. I'm not working at the moment - coming here gives me something to do and somewhere to go. You learn new skills.'

Christine, attending just over a year

'My social worker recommended Peter Bedford to me... I think Soft Furnishings is brilliant - otherwise I'd be stuck indoors looking at four bare walls. Being stuck indoors is like looking at paint dry. Being a single bloke, there's more chance to make friends. I've made friends here - before I didn't know anybody. Since I've been working here I've got more confidence.'

Derek, attending 3 months

'I like meeting people; I like doing the things I do like sewing and making cushions and bags and sheets.'

Pamela, attending nearly 2 years

'Before I came to the Soft Furnishings Work Scheme I'd go to day centres. It's been a change in my life coming to the work scheme; I've quietened down a lot. Money I've never had - the work scheme wages help me to save up.'

Marian, attending for over a year

'I feel fine here... I can pay for my holidays. I learn sewing here Hilary told me that she could help me to be trained in sewing and get a job.'

Anne Marie, attending 6 months

The Administrative Training Work Scheme

The Administrative Training Scheme was set up to offer three administrative training posts to women living in Peter Bedford Housing. One was a full-time paid post based and managed within the office administrative team at the Hackney site, and operated on a one-year contract basis, such that each trainee could complete an NVQ Level 2 in Business Administration during their term. Two further part-time 'feeder' posts, based at Peter Bedford's Legard Road site in Islington, paid the post-holders allowances only as benefit supplements. The feeder posts were designed to be less intensive, offering women the experience to be able to make an informed choice about whether they might want to take up the intensive post at the Hackney site.

The full-time administrative worker had the support of Peter Bedford's employment worker who was also an NVQ assessor. The employment worker provided individual on-the-job support and assistance with applying for open employment to move on to when the one year contract was coming to a close. Among the advantages of this post was that it demonstrated the organisation's ongoing commitment to full participation by tenants in the running of the organisation, and provided participants and enquirers with a first point of contact who was particularly 'user-friendly' when they came to pay their rent or see staff at the office.

The first post-holder successfully moved into open employment at the end of her twelve-month contract. The second took up the post after working on one of the 'feeder posts', and then completed eight months of the one-year contract before moving on to paid employment outside the organisation. The reception and administrative support services they provided were of a high standard, and both gave very positive feedback about their experience of the post.

Over the course of the scheme, the Peter Bedford HA office became a City and Guilds accredited assessment centre for the delivery of the Business Administration NVQ.

Project Successes

The Administrative Training Scheme was successful both in terms of providing administrative support at the Peter Bedford Association's new Hackney site, and in enabling participants to go out and get follow-on jobs. Similarly, the introduction of the Soft Furnishings Work Scheme substantially increased the overall usage of work schemes by women at Peter Bedford HA. Over 30 women were involved in the two new schemes since start-up in February 1995, representing a third of all the women participants at Peter Bedford HA. Targets for ethnic minority participation were maintained amongst the new women: 20% were from black or other ethnic minority groups, and 14% were Irish.

There were notable changes in the atmosphere at Peter Bedford HA with the increased involvement of women, according to the Project Leader. Staff noticed a positive impact on the organisation's culture as the environment became more welcoming. The new Soft Furnishings Scheme made Peter Bedford HA a much friendlier place for both women and men to come to.

Future Options

The Soft Furnishings Scheme has gone from strength to strength both in terms of participant satisfaction and demand for places, hence the scheme is something Peter Bedford HA would like to develop further. Continued implementation of the NVQ training is also planned in both the Business Administration and Soft Furnishings Work Schemes to the point where people are gaining these qualifications on a steady basis.

Peter Bedford HA is expecting to improve the marketing of the goods produced in the Soft Furnishings Scheme by changing the location of their retail outlet. Suitable shop-front premises have been identified and secured on a busy local high road. The income generated is hoped to offset some of the costs of the scheme.

Cutbacks in the Peter Bedford Association's core funding in 1996 necessitated considerable restructuring and operational down-sizing to enable the organisations basic services to remain open. Further funds are required to maintain staffing and management of the women's training schemes, and to expand these services to meet the demand from participants. Both increased management capacity and support functions would be needed to achieve these aims.

Case study

Janet had been living long-term on an acute psychiatric ward. She liked life on the ward and was very institutionalised and reluctant to move out. The only time she had been discharged to an independent living flat she had been re-admitted 24 hours later with acute alcohol poisoning, having drunk one and a half bottles of spirits. It was felt she was too much at risk to be discharged into an unsupported setting again. In spite of her preference for living in the hospital her key worker was seeking a community placement for her due to increasing pressure on acute beds, but was reluctant to push her out feeling that this would lead to guaranteed failure. However, he could not find her a suitable placement. Peter Bedford was suggested to her, and she came to visit and reluctantly agreed to start a trial period in the Soft Furnishings Work Scheme. The ultimate aim was for her to move into Peter Bedford housing.

Janet would come with her worker from the ward initially for a morning a week, her history of extreme distress in new situations indicated that she would need a great deal of support to attend the project, so it was planned for the worker to be around if Janet became distressed, but not to actually come into the workshop with her.

Initially Janet could not spend more than 10 minutes in the workshop - her distress included physical symptoms such as vomiting. The expectation was that Janet would at some point refuse to come, and there was concern around allowing Janet to undergo an experience she found so distressing. But after attending a few times, she actively wanted to continue, and all concerned decided to support her in this.

Gradually, over a period of months, Janet was able to spend longer periods in the workshop. Her level of distress became manageable, then finally disappeared altogether. She began to learn the skills needed to produce things in the workshop, actively take part and enjoy the work. Her motivation to move out of the hospital increased as a result. She willingly moved into Peter Bedford housing six months after starting her placement in Soft Furnishings. She now lives in Peter Bedford housing and continues to attend the Soft Furnishings Scheme regularly.

Mental Health Media Project: Headlines, Getting the User Voice into the Media

The Need to Improve Press Coverage of Mental Health Issues

By the early 1990s, service providers had begun to recognise that users of mental health services were vital partners in developing mental health provision to meet people's needs. However, media attitudes to those with mental health problems lagged far behind. Emotive terms like 'psycho', 'nutter' or 'lunatic' were continuing to be used by journalists on a daily basis in reporting on mental health issues, feeding public ignorance and fear rather than encouraging respect and understanding.

Even when journalists avoided sensationalism, the views of mental health service users were largely ignored, or canvassed only to provide personal testimony to add human interest to a story. Any serious debate of mental health issues tended to be seen as a dialogue between health professionals and politicians, ignoring the views of service users both as experts in their own care needs - and as sources of informed comment on the broader issues.

Lack of resources amongst mental health charities and user groups had generally meant that they had no press officer or public relations/media strategy - making it very difficult indeed to get the user voice into newspapers running mental health stories. Since the media had been shown to be a powerful influence on public attitudes to mental health (see page 2), it was reasoned that funding targeted at improving media coverage of the issues would be bound to improve public attitudes somewhat towards those in mental distress.

Care-less community

A new report, 'Living in the Community', on users' experience of community care, found that users thought the media was the single most important source of stigma. Researcher Diana Rose said "mental health organisations must work with the media, the most powerful means of public education we have, to encourage more positive images of mental health".

Headlines, June 1996

The Headlines Project

The City Parochial Foundation granted MHM £101,776 over three years to run a new initiative - the Headlines project.

The project brief was to redress the balance of press coverage of mental health issues, by working closely with both journalists and user led groups in the Greater London area. Funding covered the appointment of a media relations officer with a specific remit to promote users' views and voices, and to develop a core group of service users with good media skills to liaise with the press.

There were three key objectives:

- to empower users through providing media-skills training and back-up support to enable them to get their voice over in the press; support elements to include the regular production of a newsletter - 'Headlines' - reporting media successes and campaigns and targeted at London-based user groups
- to encourage responsible reporting of mental health issues, for example by networking with professionals
- to discourage irresponsible journalism, for example by orchestrating co-ordinated campaigns of complaint.

The project commenced in August 1994, with the appointment of two journalists job-sharing the media relations officer post. This arrangement changed first in March 1996 when a new media relations officer was appointed as sole post-holder, and again in December 1996, when the media relations officer left Headlines and a user development worker was appointed for 3 days a week in his place. For the final 8 months of the project, monies saved on the worker's salary were used to cover the costs of equipment and training involved in starting to develop a user network on the Internet.

Empowering Users and Promoting the User View

The two media relations officers initially undertook considerable development work, beginning with the recruitment of user groups to participate in the project. Media skills training was developed, and a system of ongoing support, advice and information exchange between user groups and the Headlines workers was established.

Basic media skills training was run as a one-day workshop, designed to provide the skills and support for maximising positive local press coverage. Elements of the training included:

- background information on how the press works and how to work with them for maximum impact
- planning a media strategy
- interview skills training
- writing a press release.

About 35 user groups in the Greater London area participated in the basic training - and Headlines ran advanced workshops for groups already active in media work who wanted to further improve their press skills, for example in learning how to deal with journalists when it came to more controversial issues, such as combating so-called NIMBY (not in my back yard) campaigns against proposed mental health facilities.

Once user groups were involved in press work, the Headlines media relations officer would remain available for advice on getting a story into the press - providing information on press contacts for specific stories for example, and looking at press releases to see if there was a better angle worth pursuing.

Other support services included the production of a user-written leaflet, 'You, the press and mental health', the compilation of an information pack on facts and figures surrounding mental health and violence, and regular updates on the work of Headlines and its associated network of user groups via the Headlines newsletter, produced bi-monthly.

What the users thought

Two years ago when Headlines started there had been no formal contact with local newspapers. A member of our group went on the very first training day on writing press releases, and the skills learnt there have been used ever since by the group. The training really helped us focus on the importance of the media.

Most valuable has been the training in showing how to pitch a press release. Whereas in the past we would have just picked up the 'phone to contact a newspaper, we now do a formal press release. It seems to work, as the local paper does get back to us.

I think the media work with Headlines has helped the group to focus on its image. Acquiring skills and confidence in dealing with the media has affected the whole organisation. Members now know how to send a formal press release, and nobody gives anything out to a journalist on the 'phone.

Group Leader, Bromley User Group

Confronting Irresponsible Journalism

Headline's brainchild, 'Response', was a letter writing campaign which aimed to challenge negative reporting of mental health issues in the press. Response had its first try-out in June 1995, when a letter to the Independent sparked outrage in the mental health user movement. A series of telephone calls galvanised user groups into rapid action. The Independent received a flood of letters from psychiatrists, and groups as diverse as Mind, the Manchester based Schizophrenia Media Agency and local user groups. Several letters were published over the ensuing few days - enough to keep the issue in the public eye.

In June 1996, the Press Complaints Commission (PCC) made its first ever ruling against a newspaper for its use of offensive language in a mental health story, following a barrage of complaints from service users in the Response campaign. The press watchdog decided that the Daily Star had broken Clause 15 of its code of practice by referring to user, Paul Fahy, as a 'raving nutter' and a 'loony', after he kissed Princess Di on the cheek on a visit to Liverpool. The reason for Fahy's mental distress, the death of his father, was buried in a tiny box at the end of the five-page story.

Following the ruling, the Headlines' Project Leader was fortunate enough to be able to publicise the problem of press complaints and mental health service users in an interview for Radio Four's programme, 'Mediumwave'.

What the users thought

I have found Headlines' advice and support to be excellent, and the newsletter good and informative.

The work with Headlines has certainly flowed into other areas. For example I learnt a great deal from the very first letter I did with [former project leaders] Tim and Susannah, who altered the layout to make it more effective. The culmination of this for me was the publication of a recent letter of complaint I wrote as a member of Headlines' Response Group to the Daily Express over an article headed. 'How years of blunders have set free maniacs to butcher and rape the public'. My letter to the Deputy Editor, Jean Carr, was used in its entirety.

Group Leader, The Consumer Forum, Hammersmith

Networking with Professionals

Bridge-building with sympathetic journalists was relatively slow to progress, though there were some successes. Not surprisingly, Headlines found links with the broad-sheet newspapers and more left-wing social issues magazines easier to establish than with the tabloids - and the strategy of pursuing the best-chance outlets paid off. Some journalists even began to approach Headlines for leads on mental health stories.

In another important step in encouraging responsible reporting, the NUJ Ethics Committee gave their agreement for Headlines to produce new guidelines for journalists on reporting mental health issues. The relaunch of a mental health press officers' forum also helped in the exchange of information and ideas.

User groups reported a number of successes in promoting positive press coverage by working with members of the press. A leading member of the Bromley User Group, for example, said she managed to persuade a BBC radio journalist to take a different line of questioning, moving away from questions based on an exclusively medical view of mental health, after she had talked about the issues from a user perspective, following advice from Headlines.

The experience of one user group

Media work is very important in mental health. We are in receipt of such bad press the majority of the time that it is necessary to work constantly to redress the balance and re-educate the public not to think of all mental patients as murderers!

We have worked very positively with our local paper, the Croydon Advertiser, for example in a campaign for single-sex locked wards at our local hospital, and more recently over the dire Mental Health Act Commission report received by Warlingham Park Hospital. The furore created by the Advertiser's report resulted in the appointment of more qualified staff for the hospital, a Mental Health Act worker and ward clerks.

Problems remain in persuading the media to report positively on mental health stories such as World Mental Health Day and the Defeat Depression campaign. It is a question of keeping up the pressure.

We do hope this project continues and indeed expands to cover the whole country. So many of us suffer mental health problems these days that constant efforts must be made to do away with stigma thus making it easier for community care to work. The community has to be helped to care and the media is the foremost way to reach the public at large.

Group Facilitator, Croydon Mental Health User Group

The benefits of training

I found Headlines' media skills training particularly useful in understanding how journalists operate, as well as the pressures they are under. It has also helped in dealing with calls from TV people, and in understanding the tight deadlines they have to work to.

There has been a knock-on effect in terms of giving MDF members who went on the course more confidence and support in dealing with the press. It has been very empowering.

Group Leader, Manic Depression Fellowship, Greater London

Project Successes

The media skills training at Headlines significantly raised the skills level of the user groups, so that they were much more confident in dealing with the media and promoting the user view. Back-up support from the Headlines Project was an important factor in their success.

In terms of combating irresponsible journalism, the PCC decision on the Fahy case was of national significance. There were other notable successes. The appearance of black user consultant Les Bailey, on Channel Four's late-night discussion show, 'Weekly Planet', was extremely powerful. His reasoned approach meant that he came over as an expert on mental health in his own right - in direct contradiction to the conventional media representation of mental health service users - particularly black users - as mad, bad and dangerous.

Future Options

In the light of the successes of the Headlines project, MHM are proposing to develop the work of Headlines into a national project countering stigma - for which three years' funding has been secured from the Department of Health. This would employ two workers. The first would be a media relations officer whose brief would be to produce a newsletter for national distribution, maintain and develop links with journalists and run a national press liaison service. The second would be a user development worker, responsible for building national connections with user groups and running Headlines' media skills training days. The setting-up of a novel project linking user groups across the country via an Internet web site and mailing list will be a key part of their brief.

Croydon Mental Health User Group: Campaigning for Better Mental Health in Croydon

The Need for a Mental Health User Group in Croydon

In 1992, the London Borough of Croydon and Croydon Health Commissioning Agency produced a strategy document outlining the proposed development of mental health services locally¹². The report assessed the prevalence of mental health problems in the region, suggesting that mental distress affected up to a third of people in the local community, but that only around 10% were in touch with the mental health services. Much larger numbers experiencing mental health problems went undetected. The figures suggested were:

- mental distress in the community 80,000-100,000
- mental distress among GP attenders 73,000
- mental disorders recognised by GPs 32,000
- mental disorders treated by the mental health services 6,000
- annual admission to hospital 1,000

The report also highlighted the need for user involvement in the planning and evaluation of local mental health services, previously called for nationally in the Health of the Nation White Paper and Patient's Charter.

The driving force behind CMHUG derived from the anger of a number of service users at the way in which services were organised without regard to users' views. The evolution of the group began when the local Mind association nominated one of its staff members responsible for developing user involvement in planning. As early as January 1992, there were meetings with service users to see how user involvement and advocacy could be developed. The first Users' Forum was convened in May 1992 at Warlingham Park, the local psychiatric hospital, from which a steering group emerged to take forward the development of a Patients' Council. From the Patients' Council, interest grew in other aspects of mental health services locally. The linking of these different groups and individuals led to the formation of CMHUG.

CMHUG received its first funding from local Joint Finance, which allowed it to set up its own office. Even then, much of the group's time was spent struggling for resources rather than on substantive work. It was felt that the best way to address the need of enabling user involvement in Croydon would be to consolidate and expand the group, and that this would require further funds that were not available locally.

¹² London Borough of Croydon and Croydon Health Commissioning Agency (1992). Strategy for mental health service development 1993/4-1996/7.

The CMHUG Project

The City Parochial Foundation granted CMHUG £91,504 over three years to open its office full time, with a paid administrator. This would allow the group to respond more readily to calls for help and user input. At CMHUG's request, the grant money was to be paid to Croydon Mind who would take on the role of employer for the administrator, administer the finances and take part in the steering committee.

The funding would allow CMHUG to:

- develop and expand its involvement in shaping local mental health services via membership of steering groups, working parties, joint planning and strategy reviews, and participation in staff recruitment
- develop its campaigning work on mental health issues
- continue to facilitate the Users' Forum and Patients' Council
- provide 'therapeutic earnings' of up to £15 a week (as allowed by social services) to volunteer workers who would otherwise be unemployed
- purchase computer equipment and other office equipment
- develop its publicity via leaflets, posters and a regular newsletter 'Talking Treatment'
- undertake public awareness-raising campaigns
- expand its liaison work with other user groups
- develop and enhance skills within the group, such as advocacy and administration skills
- provide training to mental health workers on user issues.

Vision and Values

CMHUG believed that users should be at the centre of mental health services planning, and that anger about existing services should be channelled constructively. When consulting or advising, CMHUG never used a criticism-only approach, instead giving credit where it was due, as well as offering positive ideas for change. CMHUG was not separatist, but saw a need to work in partnership with health and social services in order to effect change. The group's efforts to make allies paid off, ensuring that local senior management supported CMHUG from the beginning.

How CMHUG Worked

CMHUG was involved in almost every aspect of mental health services in Croydon. For example, to ensure effective user participation in planning services at least two or three CMHUG representatives attended all planning meetings on mental health. Projects CMHUG was involved with included:

- The Croydon Mental Health Service Re provision Programme
- The Mental Health Policy Development Group for the Croydon Community Care Plan
- The Farleigh Unit Review at Warlingham Park Hospital
- The Section 117 Aftercare Planning Group
- The development of user groups in mental health resource centres borough-wide
- The development of Croydon Young People's Centre
- The Safe House Project Group
- The Section 136 (Police Powers) Place of Safety Policy Development Group
- The Welfare Benefits Working Group.

CMHUG was also involved in monitoring both social services and mental healthcare provision, commissioned by Croydon Social Services and the Community Health Council, respectively.

CMHUG had a strong campaigning arm, which aimed to promote mental health, public awareness of mental health issues, and understanding of the user perspective amongst mental health service workers. CMHUG ran stalls and floats on a number of public occasions, including the Croydon Carnival and World Mental Health Days. They were also involved in setting up a London-wide user forum as a resource for mental health service user groups in the capital, together with Good Practices in Mental Health, the UK Advocacy Network (UKAN) and the UK Federation of Small Mental Health Agencies.

CMHUG also provided a support and information service for individual service users, which they saw as a key part of their work. They received, on average, between one and three calls a day from people in distress requiring support. There was considerable two-way traffic between the CMHUG steering group and its wider membership, with CMHUG being able to canvass views on the needs of mental health service users via their members, and feed these back to the authorities formally via reports, committees and working groups.

Operating Style

Internally, CMHUG avoided hierarchies, and planned by consensus as a team. They set formal objectives and worked to them until their aims were achieved. They avoided long-term plans, sensing that these could lead to a shift away from their consensus approach. In their view, avoiding long-term plans also allowed them to be instantly reactive to local circumstances.

The group was aware that its lack of formal structure could make it difficult for others to understand how CMHUG worked and how they could work with them. However, CMHUG was firmly of the view that their lack of structure was not an issue for them, but only for others. CMHUG's view was that hierarchy could be destructive in user groups, and they felt that their achievements demonstrated the effectiveness of their democratic approach.

The group's paid administrator was employed by MIND. The rest of the work was done on a voluntary basis by members, and all information in the office was open to everyone. There was only one written policy, on equal opportunities. However, group members acknowledged that there were unwritten rules: members did not disagree with each other in public, for example, and did not make reference to personal experiences in planning meetings.

Project Successes

When the City Parochial Foundation awarded its grant in 1994, CMHUG had six members and an office staffed by volunteers three mornings a week. By December 1996, there were 235 members, two adjoining offices staffed five days a week, two phones, two computers and a part-time member of staff. The funding allowed CMHUG to campaign effectively, put across the user viewpoint, and gain respect for its work. At the same time, the funders always supported CMHUG in the direction the group wanted to go, in particular, backing its increasing emphasis on public awareness raising.

The volume of work undertaken by the group was tremendous, with the result that CMHUG had a major impact on mental health services locally. Some notable successes have included:

- production of a video on young people's mental health (a second video, on self-harm, was begun)
- production of a training pack on promoting young peoples' mental health aimed at schools, colleges and youth clubs
- reversion to single-sex wards at a local psychiatric hospital, after an independent evaluation of mixed sex wards commissioned by CMHUG
- research into users' needs for mental health crisis services (results available 1997)

- provision of awareness training sessions for nurses, occupational therapists and GPs
- successfully campaigning, along with Mind in Croydon and the Community Mental Health Council, for Croydon Health to become part of the Bethlem and Maudsley Group Mental Health Trust
- assistance with the NHS clinical audit of mental health services in Croydon
- open days held twice a year for members and prospective members
- public awareness raising work on World Mental Health Day and for the Defeat Depression Campaign.

Case study

My three 'holidays' in Croydon's local psychiatric institution were as enlightening as they were horrifying. I could not conceive that such degradation and inhuman treatment were possible in what passes for a civilised society.

I have to say I was treated very well, possibly because I am white, middle-class, middle-aged and fairly articulate, but what I saw happen around me made me determined to try for change. How psychiatry can justify its existence when basically it has not changed much in 200 years beats me entirely. A Parliamentary Select Committee in 1815 advised that aggressive and depressive patients should not be mixed. This still happens in 1996 so what have we learned?

I made three very good friends in my time at Warlingham Park Hospital, and this saw the origins of the Croydon Mental Health Users' Group, thanks to help and encouragement from Mind in Croydon. We now have nearly 250 members and a reputation for a positive and constructive contribution to the improvement of mental health services locally.

Government has to realise its responsibility to persuade every citizen of the benefits of good mental health. Life can be a nightmare these days, especially for the young, and we need a national mental health promotion campaign to address some of these difficult issues. Mental health has to be dragged out of the closet and discussed. So my brain works differently from yours, so what? Ninety per cent of the time I can still make a useful contribution to the world at large!

Social psychiatry has definitely been kicked into touch by the experts so let's have a bit of common sense in all this! The majority of us break down for social reasons and need practical help to pick up the pieces.

CMHUG Founder Member

Why user groups are important

“The Users' Group not only focuses minds on the needs of people with mental health problems, but also provides a type of occupational therapy for those who join and support it”.

CMHUG member

“CMHUG provides support to many people, both friends and strangers. This can lead to pressure, and times of difficulty, as well as success and comradeship. It is a credit to the group's strength that it can both support and inform”.

CMHUG Support & Development Worker

Future Work

CMHUG would like to develop its outreach to people in mental distress and continue its educational and mental health promotion drives, particularly in schools. Though awareness raising work is difficult to monitor, CMHUG has noted that people still feel very uneasy talking about mental health issues. Hence members are also keen to expand this area of work.

Given CMHUG's notable achievements to date, it seems likely that the group will continue to make the voice of service users heard both locally and on a wider scale.

Daryeelka Maanka: Mind in Tower Hamlets' Mental Health Service for the Somali Community

The Need for a Somali Mental Health Project

In the early 1990s, the needs of the Somali community in Tower Hamlets (an estimated 12,000 people) were acute. There were exceptionally high rates of unemployment, illiteracy and poor housing. Many Somalis were refugees who faced complex practical, legal and psychological issues - including problems arising from language barriers, immigration issues, and difficulties with benefits claims. Many were also severely distressed as a result of the civil war in their homeland and the traumas of being uprooted and separated from their families and friends, as well as being isolated in Britain.

At the end of 1992, the Black and Ethnic Communities Advisory Committee of Mind in Tower Hamlets commissioned the London School of Economics Community and Health Research Group to carry out a study of mental health needs amongst the main ethnic communities in Tower Hamlets. Their report made a special plea on behalf of the Somali community, and the main recommendations of this report were incorporated into a funding proposal submitted to the City Parochial Foundation.

The Project

The City Parochial Foundation granted Mind in Tower Hamlets £175,118 over three years to set up a specialist Somali mental health project, focusing on the 16-30 age group. The overall aim was to improve the mental health of Somalis in the London Borough of Tower Hamlets through early intervention and liaison.

The funding paid for the recruitment, training and employment of two full-time Somali workers - a man and a woman, and provided a development budget for the running of social drop-in sessions, outings and other activities suggested by the users.

The initial targets for the project were:

- to provide an information and advice service for users and mental health workers
- to offer intensive support and advocacy to individual clients
- to set up a number of drop-in and living skills groups
- to produce and distribute mental health information leaflets in Somali and in English
- to organise training workshops for workers on issues affecting the mental health of the Somali community.

How Daryeelka Maanka Worked

The Project commenced its operations in July 1994 with the appointment of two workers to the preventative team funded by the City Parochial Foundation. A third Somali worker, funded through Mental Illness Specific Grant (MISG), focused on Somalis with long-term mental health problems. All three workers were supervised by Mind's Support Services Manager, with advisory input from a specially convened Somali mental health steering group.

Intensive support to individuals and advocacy took most of the workers' time. This ranged from help with practical issues raised by language barriers, to complex immigration and benefits issues and intensive emotional support. The outreach work also involved providing support to Somali people in the local psychiatric hospital, and street work with homeless people and persistent street drinkers in the Whitechapel area.

The workers ran several group sessions for the Somali community: a weekly all-day women's therapy group, a women's woodwork group, a media skills group, and a luncheon group. The groups were organised in such a way as to be congruent with Somali values and experience and acceptable to people who were not used to using mental health services. The women's group, for example, had health and fitness sessions and Somali dancing, and provided both collective and individual counselling opportunities. The groups were well received by the local Somali community: members seemed to value greatly the experience of having a safe and mutually supportive space in which to express things that would traditionally be kept private.

The information and advisory service initially attracted an average of 160 phone calls a week, of which roughly 100 were from members of the public and 60 were from professionals. The volume of calls decreased somewhat in the third year of the project, since other Somali workers had been employed to deal with legal issues and welfare rights in the borough.

The project workers provided health awareness sessions to Somali students, and training to health and social care professionals on Somali mental health issues. In addition, representatives from the project attended a number of planning groups working to develop local services for the Somali community.

Who Used the Service?

Two-thirds of Somalis who used Daryeelka Maanka were men: in 1995-96, for example, there were 145 men to 62 women. Over 50% of those using the Project were under 30 years old. Over 40% were not in stable accommodation, often living on a temporary basis with family and friends, whilst over 30% lived alone.

The vast majority of the Project's users (over 80%) had no previous contact with the statutory mental health services. This was probably indicative partly of the low awareness of professional mental health services amongst members of the Somali community and partly of the stigmatisation of mental health problems and hence mental health services in Somali culture. The majority of the Project's users found out about Daryeelka Maanka through community networks; around 48% were self-referrals, some of whom may have originally been referred by their families.

Project Successes

In terms of providing information and advice, Daryeelka Maanka exceeded its targets. The original target was to provide for 500 people per annum: in the first two years, the project received calls from an average of 125 people per week. In addition to information sheets and leaflets, the project produced a quarterly newsletter for the Somali community from early 1996. In terms of intensive individual support, it provided twice the original target amount. The group sessions were likewise very popular and well attended, which was particularly encouraging in the case of the women's groups; Somali women on the whole are traditionally much more difficult to engage with mental health services.

One of the great successes of the project was that people from the Somali community were increasingly willing to come forward and seek help. Thus a need for raising awareness of mental health issues within the community was met by the project, along with many of the mental health needs of individuals. Daryeelka Maanka developed to a stage where its staff were also working effectively with the statutory mental health services, providing an essential bridge for the Somali community. The support of the workers to community members with severe mental health problems was provided in close liaison with the community mental health teams and their statutory key workers.

Future Work

Now that there are other Somali workers in Tower Hamlets, Daryeelka Maanka will continue with two project workers instead of three. There is scope to run more women's groups, to develop the men's work, and to strengthen effective co-working with the statutory services and their community mental health teams. Overall, Mind in Tower Hamlets feel that it has evolved a good combination of services for the Somali community with Daryeelka Maanka, and would like to continue with the project in order to meet now identified mental health needs within the community.

Case study *Magood is a women in her mid-thirties. She is married and has four small children, the oldest being five years. She looks after the children adequately when she is not too depressed. She is not known to the locality CMHT (Community Mental Health Team) and rarely visits her GP. She is, however, extremely depressed. She is confused and isolated, does not read or write, and apparently does not want to improve her situation through education.*

Her husband chews khat, but he refuses any help. He causes Magood a lot of problems. He hits her because she does not seem to be interested in the world. He blames her for everything that goes wrong.

Magood first came to Daryeelka Maanka in March 1996 for help with letters. She hardly discloses anything, even though she knows that the project worker is a mental health worker and she brings her personal letters to read. She now attends the woodwork group regularly and sometimes comes to the lunch club. Her children come with her to Open House and play with the toys in the creche; at home they have no toys or television. Woodwork and the creche are quite important for Magood's survival. Some evenings she does not do any woodwork, but just sits and listens to the other women.

Daryeelka Maanka are providing Magood with on-going support.

Case study

Jama Osman came to Britain in 1989, suffering from severe injuries from gunfire. During the civil war he had witnessed corruption, looting, false imprisonment, soldiers raping women. He took part in an uprising, and was caught and tortured, but escaped. In later fighting he was hit in the back of the head by a bullet which came out of his mouth, destroying his palate. He escaped to Britain for medical attention, and had two major operations. When the treatment was completed he was discharged and allocated a flat on the seventh floor of a block. He spoke little English, was worried about relatives in refugee camps and caught up in the civil war, and he was isolated. He became lonely and frustrated. He began to want to go back to Somalia, despite all its dangers.

He approached Daryeelka Maanka in February 1995. He was having flashbacks of traumatic events, including scenes of family members being killed in front of him. He had financial difficulties. He was chewing khat six nights a week, leaving him lethargic and demotivated each day. His large family, fifteen brothers and ten sisters, were mostly spread around refugee camps in East Africa. Letters from them asking for financial help added to his worries. As the only member of the family living outside of East Africa, he was perceived as being rich. Every letter he received to which he was unable to respond added to his depression.

The Daryeelka Maanka project worker, Abdirashid, helped him to obtain disability benefits. They were back-dated, so Jama Osman was able to send some money to his family, which made him happier. Abdirashid also helped him to obtain a travel permit.

Through this period Abdirashid was concerned about Jama Osman's mental health, and was eventually able to accompany him to his GP, who referred him to a consultant psychiatrist. The psychiatrist referred him to the locality Community Mental Health Team. He was diagnosed as suffering from post traumatic stress disorder. Through the project Jama Osman is now getting computer training and attending the Somali lunch club at Open House. Gradually he has become more confident. Abdirashid is now trying to get him re-housed.

Lessons for the Future

Many valuable lessons were learnt during the course of the Mental Health Programme, both by project workers and managers, and by the funders. Since many of the themes that emerged recurred across projects, they are documented collectively here, rather than in the reports of individual projects. Key points that emerged can be summarised as follows.

- Management needs to be very flexible and supportive if small-scale voluntary and user-run projects such as these are to succeed. Both refugee and advocacy groups work in different ways from professional health and social care services, and professionals need to appreciate the differences.
- Outreach to black and minority ethnic groups from largely white organisations can be hampered by cultural and ethnic differences and by racism, and tends to be most successful when efforts are made to engage these groups on their terms.
- Refugee mental health projects are a completely new area and, as such, offer a particular challenge above and beyond the development of a service.
- In operating a mental health service for refugee communities, flexibility is essential in terms of the type of services offered and the way they are run if they are to engage members of the community they are intended to reach. Counselling services in particular often need to be complementary to providing practical care. A holistic approach will be the norm rather than the exception.
- Appropriate counselling and mental health support skills exist within refugee communities, and can be effectively engaged in serving those communities if recruitment strategies are carefully planned.
- Countering the stigma associated with mental health problems is a key part of the work of any voluntary agency. The importance of awareness-raising work should not be underestimated in this regard.
- There is a vital role for funders and purchasers in supporting the growth and development of small voluntary and user-led projects, and thereby expanding choice for users and potential users of services in their constituencies.
- Consistency of staffing in advocacy and refugee projects such as these is essential in order to enable the work to become established.
- Funders need to allow adequate time for the development of new projects, and funding contracts should not restrict this important work. A five-year funding period may be more appropriate than three years in allowing sufficient time for such projects to set up and establish themselves.

Outreach to Black and Minority Ethnic Communities

A priority for the projects was to develop means of reaching out to black and minority ethnic peoples in Greater London. For largely white groups, there appear to be three key blocks to significant progress in this work.

- Racism and the oppression of labelling. There is substantial evidence to indicate that most black users have negative experiences of using mental health services. Research by Mind and other bodies reveals extensive institutional racism within the services.
- Lack of cultural accessibility. Cultural and language differences can mean that fundamental concepts of mental illness - symptoms, causes, forms of treatment - do not translate easily, and that the Western medical model of mental illness alienates people in some communities.
- Stigma and community exclusivity. Mental illness in any form is highly stigmatised and therefore mostly unacknowledged amongst particular minority groups, for example, the Chinese, and many African communities. Coupled with this is an established trend for support groups to remain based within and exclusive to particular communities.

Both the Manic Depression Fellowship (MDF) and Mental Health Media experienced initial difficulties in making contact with black and minority ethnic service users. In addition to the major obstacles identified above, indicators from the MDF Greater London Project suggested a particular reluctance amongst black people to acknowledge or accept the label 'manic depression' in addition to that of service user. Yet acceptance of the condition ('ownership of') is the key motivation for self-help group participation. To find a way of developing this work, MDF employed a black outreach worker to conduct a piece of action research involving MDF contacts in Waltham Forest and Hackney, two London boroughs with high ethnic minority populations. A report of the findings is currently in preparation.

In the case of the Headlines project at Mental Health Media, initial difficulties in establishing links with black user groups were felt to be due in part to the fact that there are fewer user-led black groups in operation. With persistence though, Headlines eventually made links with three projects. This was achieved through contact with Tower Hamlets Mind, during discussions about holding an event on the subject of black users and the media; through a new Forum for African-Caribbean Users, supported by Good Practices in Mental Health, for which Headlines helped to secure coverage in 'The Voice'; and finally through the Islington based 'Lambo' African and Caribbean Centre, in training members and providing press support for World Mental Health Day.

Refugee Issues

Nafsiyat and Daryeelka Maanka, the Somali mental health project at Mind in Tower Hamlets, highlighted a number of common issues that are likely to arise in future mental health work with refugee communities. These were as follows.

- Concepts of mental health and illness are frequently alien to these communities.
- Mental illness is often highly stigmatised. This was a particular problem amongst the Somali community in Tower Hamlets, where signs of mental distress are seen as weakness.
- The concept of counselling is often unfamiliar. In their home country individuals are much more likely to talk to a friend or relative, and the idea of discussing personal issues with a stranger can seem very odd. Cultural barriers will also often discourage people from accessing such a service. Counselling is unheard of in the Somali culture: one is not supposed to express emotion, thus many Somalis in distress tend to display physical symptoms instead.

In light of these factors, Daryeelka Maanka had to be extremely flexible in its approach, providing more than just a mental health service. Groups, for example, were organised around fitness or skills training, whilst one-to-one work was operated within very flexible boundaries in order to gain the trust and confidence of members of the community it was designed to serve. The drawback with this approach was that the project workers could be very overstretched by demand. However, it did demonstrate a need for better understanding of mental health status in the Somali community.

The Nafsiyat refugee project encountered many of the same issues in their work with children and young people. A number of observations were made as to what was required for successful work with young refugees. These were as follows.

- Therapy services offered to a sibling along with a client or to a small family group can improve take up of the service by young refugees.
- Boundaries need to be defined in working within school and college settings; agreements on what children are told as to the limits of confidentiality should be made in advance with the school and clearly stated to the children.
- Evaluating group work with young children demands a different approach from the usual; children aged 12 -14 have difficulty in completing a written evaluation form - so to ensure that evaluation takes place, a one-off evaluative discussion session is recommended at the end of a group work series.

A particularly encouraging finding from the Nafsiyat project was the relative ease with which volunteer trainee counsellors were recruited. The project co-ordinator was repeatedly told that it would be a difficult undertaking to recruit sufficient volunteers with appropriate skills from the refugee communities. In fact, there were more suitable applicants than places available on the first training course, and all those recruited had some background in counselling training prior to starting the course. On the down side, it did take the project longer than anticipated to recruit the volunteers. The message Nafsiyat would wish to share is that health and social care agencies need to think carefully about their recruitment strategies and whether they are presenting information in places where members of refugee communities are likely to see it and respond. A proactive approach is required.

Management Issues

All-round flexibility on the part of managers and purchasers is essential in order to ensure the workability of small-scale voluntary and user-led projects. Management can help to support the development of such groups, but cannot and should not insist on their complying with the standards of planning, assessment and presentation of well established organisations as they develop.

Key management issues in the projects have included:

- lack of monitoring and evaluation
- difficulties in setting realistic or clear objectives
- lack of a professional management structure and ethos, as well as a lack of understanding of the organisational systems governing the care network in which they operate.

Monitoring and evaluation

Lack of monitoring and evaluation was an issue for the majority of projects, and is of particular concern since it can affect the ability of such projects to secure continued funding. This is in some part due to the frequently pragmatic and informal structure of small voluntary and user-led advocacy projects, together with their emphasis on service development rather than provision. The City Parochial Foundation supported all groups in developing systems by setting up two joint workshops on monitoring and evaluation, and by providing a consultant who visited all the groups individually to help them develop their own systems.

Resistance to complying with provider requirements on monitoring can also mean that such groups are unable to provide the materials specified by funders as part of a funding agreement. The Croydon Mental Health User Group, for example, operated a policy of not asking any details about new members personal lives, a practice developed in response to members' previous experience in having to relate the same information to mental health professionals repeatedly as they were going through the system. Thus they were not able to show who used their service in terms of mental illness diagnoses, a common requirement now that health policy stresses the need for targeting people with severe mental illness. CMHUG did not want to operate in a way that resembled statutory services - and their strategy was not to compromise on this issue. CMHUG would acknowledge that they have been unusually lucky in their funders who have worked with them in a way that has empowered them to create their own approaches

Learning the system

Lack of understanding of the procedures, laws and unwritten rules governing the system(s) in which they operated was problematic for many projects. For MDF and CMHUG, establishing good links with Health and Social Services providers helped to foster mutual understanding and support the groups' acceptance and development. For Mental Health Media, providing training in media skills to advocacy projects helped to promote understanding of how journalists operated and the pressures they were under, and thus facilitate effective use of the media by these groups.

For the refugee projects, the workers also needed to learn the systems governing the communities which they were serving - and to act as a bridge between these and the systems used by the mental health professionals they came into contact with. Operation of the Somali mental health project, in this regard, was associated with a raft of cultural and management issues which required a great deal of flexibility on the part of both management and workers to resolve. The white professional ethos simply did not apply to the way the project needed to be run, either in terms of working styles, time management, or boundaries and confidentiality. There was also the issue that the workers could become isolated, being managed by a white person in a non-Somali organisation. Moreover, supervision and monitoring are alien to Somali culture and have sometimes felt to the workers like a lack of trust. Realising this, Mind offered external supervision by Somali supervisors to project workers, and this was well taken up. Regular supervision sessions and close yet flexible management led to a growing appreciation of the difficulties on both sides.

The working style of the Somali mental health project was markedly different from that of statutory services in that the approach taken to the mental health needs of Somalis by the project workers was a holistic one. They did not operate boundaries between mental health and practical problems, but would undertake advocacy and counselling with an individual, as well as providing practical support with the tasks of daily life and immigration applications. Their flexibility extended to the hours project workers were available, the people they worked with (they were not able to restrict their work to the 16-39 age group), and where they worked. Needless to say, workers in the statutory services could often find this approach baffling and fail to understand the varied roles of the project workers. This necessitated a lot of awareness-raising work amongst statutory and voluntary services workers which was helpful in building bridges between the Somali community and the professionals.

Objective setting

Setting realistic objectives was problematic for two of the projects in different ways. First, MDF initially set an objective of three new self-help groups in each of 33 London boroughs over three years. Within the first eight months, however, this was recognised to be unrealistic, and the targets were revised by agreement with the funders.

Second, Peter Bedford HA severely underestimated the time needed to set up as an NVQ assessment centre for both of its women's employment and training schemes. For the administrative training scheme, where NVQ training was an integral part of the post, this had an adverse effect on the project schedule. That this happened was not entirely surprising: there are few mental health employment schemes that offer participants the opportunity to gain NVQs, thus the Peter Bedford Organisation did not have a body of knowledge and experience to draw on in their planning. Implementation of NVQs is a long process requiring provision of NVQ induction training for the trainer/assessor, the development of policies, procedures and practices in line with the standards, and the initial piloting of the NVQ training scheme with one or two participants to enable the trainer to gain their assessor qualification. A further issue is that for any NVQ training centre, individual students have different needs. Peter Bedford HA accordingly found that their trainees required considerably different degrees of support and widely varying timetables for achieving successive stages of their NVQ. These factors need to be taken into account by agencies planning to implement NVQs for their users, since they can mean that timetables and work schedules slip considerably from those originally planned.

Implementing NVQ training nevertheless had many benefits for the Peter Bedford Housing Association, in terms of developing management systems for a productive and competent workplace, guiding the identification of training needs for individuals, and giving participants the opportunity to gain a qualification. Based on their experiences of setting up the NVQ in Business Administration, the process ran much more smoothly second time around.

Countering stigma

Stigmatisation of mental illness remains an enduring problem, creating a barrier to normal life in the community for mental health service users, and forming a backdrop for all the mental health work of the projects in this programme.

Different projects have had different approaches to dealing with stigma. At Peter Bedford HA, the emphasis is on empowerment, and involving the participants in every aspect of the work. MDF are very open about their work, promoting a network of support groups to create a sense of solidarity and lessen the isolation of sufferers. The Somali refugee project chose to play down the mental health aspects of their work in order to attract people to the project who might otherwise not have felt able to attend. Mental Health Media and CMHUG both took a direct approach to countering stigma and raising public awareness about mental health issues.

Stigma for service users is closely linked to media coverage of mental illness and mental health issues. The media consistently fail to reflect the true facts that:

- mental distress is a poor predictor of violent behaviour
- the number of murders committed by people with mental illness is very small - and has remained steady for approaching 40 years, whilst the number committed by the rest of the population has more than doubled
- people with mental distress are far more likely to harm themselves than other people.

In this climate, misleading reports of mental health issues are the norm, rather than the exception. The Confidential Inquiry into Homicides and Suicides by Mentally Ill People¹³ found 34 cases of homicide committed over a three-year period by people who had been in

¹³Confidential Inquiry (1996). Report of the Confidential Inquiry into homicides and suicides by mentally ill people, London, Royal College of Psychiatry.

contact with psychiatric services within the previous year. Of the 22 cases which could be followed up in detail, the Inquiry found that only two were random killings by strangers, only half had been in psychiatric hospital at all that year, and none had been discharged from a long-stay institution into the community. Nevertheless, subsequent reports of this research in the press were fairly uniformly inflammatory. 'Sick and dangerous', ran the headline in the Daily Mail; 'Mad policy', said the Daily Star; and 'Free to Kill', said the Sun. In fact, only about six of this country's 700 killings each year (less than 1%) are committed by people who have been in psychiatric hospital in the previous year.

Mental Health Media have made good headway in supporting local groups to counter the barrage of negative media coverage and establish increasingly strong media profiles that were listened to by the local press.

CMHUG likewise ran a number of awareness-raising events to reach the public directly, and promote an alternative image of mental health service users as capable individuals taking charge of their lives.

Conclusions

Small-scale voluntary and user-led projects offer the potential for user-friendly, user-orientated services that are less formal and less stigmatising than statutory mental health services, and can provide a true alternative to the health and social care that is framed by the traditional medical approach. Such projects often represent the cutting-edge of a needs-led service and, as such, can give a lead to service development on the ground, as well as providing a grass-roots influence on statutory services planning.

Lack of resources, however, can make such alternative services extremely vulnerable. Limited funding can often mean that they depend on one or two key individuals whose input is crucial to their continued success. Difficulties in acquiring ongoing funding can be repeatedly encountered, particularly when groups are unfamiliar with the language and operational procedures of potential funders. Flexible and supportive management is required on the part of managers and purchasers if such services are to survive as an integral part of the network of community care.

Project Details

MANIC DEPRESSION FELLOWSHIP: Expanding the MDF Self-Help Network in Greater London

Project leader: Karen Campbell
 CPF grant: £132,732 over three years
 Further information from: Karen Campbell, Greater London Director, Manic Depression Fellowship, 8-10 High Street, Kingston-upon-Thames, Surrey KT1 1EY. Tel: 0181 546 0323

NAFSIYAT: Therapeutic Work with Young Refugees

Project leader: Gita Patel
 CPF grant: £148,766 over three years
 Further information from: Gita Patel, Nafsiyat Intercultural Therapy Centre, 278 Seven Sisters Road, Finsbury Park, London N4 2HY. Tel: 0171 263 4130

PETER BEDFORD HOUSING ASSOCIATION: Creating Employment and Training Opportunities for Women

Project leader: Brian Dawn
 CPF grant: £159,066 over three years
 Further information from: Brian Dawn, Peter Bedford Housing Association Limited, Legard Works, Legard Road, London N5 1DE. Tel: 0171 226 6074

MENTAL HEALTH MEDIA: Headlines: Getting the User Voice into the Media

Project manager: Radhika Bynon
 CPF grant: £101,776 over three years
 Further information from: Radhika Bynon, Mental Health Media, The Resource Centre, 356 Holloway Road, London N7 6PA. Tel: 0171 700 8131

CROYDON MENTAL HEALTH USER GROUP: Campaigning for Better Mental Health in Croydon

Project leader: Jane Field
 CPF grant: £91,504 over three years
 Further information from: Jane Field, Croydon Mental Health User Group Steering Committee, Cornerstone House, 14 Willis Road, Croydon CR0 2XX. Tel: 0181 665 0210

DARYEELKA MAANKA: A Mind-Led Mental Health Service for the Somali Community in Tower Hamlets

Project leader: Val Ford
 CPF grant: £175,118 over three years
 Further information from: Val Ford, Support Services Manager, Mind in Tower Hamlets, 13 Whitethorn Street, London E3 4DA. Tel: 0171 537 7284

