Mental Health Network Greater Glasgow (MHNGG) are a collective advocacy organisation run by people with a lived experience of mental ill-health to challenge stigmas around mental health and to improve support and services in the Greater Glasgow area. We currently have a contract with NHS Greater Glasgow & Clyde to deliver ‘user involvement’ work relating to mental health services. This means we regularly talk to people currently receiving mental health support & services and their carers.

Our Friday Involvement & Support Group (F.I.S.G.) is a group of our members (people with a lived experience of mental ill-health) that meet to discuss issues of relevance to MHNGG. We discussed this issue with the F.I.S.G. and drew upon other strands of work we undertake.

**Prevalence of Social Isolation in Urban Settings:**

We think that social isolation and loneliness is endemic amongst people who have suffered a mental health crisis in the Greater Glasgow area.

**Impact of Social Isolation, best practice and potential ideas for influencing and improving policy:**

Our work over the last fifteen years has frequently and consistently illustrated that loneliness and social isolation is widespread and prevalent amongst people with a lived experience of mental ill-health, for example twelve semi-structured interviews we did for NHS GG&C looking at readmission in 2009 showed that ‘social abandonment’ of people who have had a mental health crisis was a common occurrence, even with family contacts and close established long-term friendships.

Post-mental health crisis there is little support to rebuild these social relationships and to enable social contacts to ‘come to terms’ with a person’s crisis, e.g. mediation. Some services such as the ESTEEM service in Glasgow and forensic services do attempt to address these areas but they are the exception rather than the norm. This means that a person is often deprived of a previously existing support network that if enabled post crisis could allow a person to regain their previously held relationships, strengthen informal support networks as well as challenge mental health stigmas and preconceptions.

Likewise the loss of employment due to mental ill-health often deprived a person of both income and social opportunities that are related to work, reducing a person’s means to engage fully in society and also of a ‘valid social role’ related to employment. We are also exceptionally concerned with the stigmas many of our members face in the mainstream media relating to being benefit recipients. This is exacerbated because ‘mental ill-health’ is an ‘invisible condition’ and there is a great deal of cynicism that people may be ‘faking it’ if they do not have an ‘obvious’ disability.
The social impact of welfare reform is that many of our members face financial exclusion and poverty. This in turn further marginalises them and reduces their ability to engage socially and use this to stay mentally well.

The media campaign against welfare recipients also reinforces ‘self-stigma’ and wider social stigmas and some of our members have even faced verbal abuse and hostility in the streets. We recognise this abuse is a form of hate crime and more must be done to challenge this.

Many people also face work-place related mental health stigmas and inflexibility of support for their mental health condition (often only delivered ‘9-5, Monday to Friday’) is a significant barrier in re-building a person’s career. Many of our members have formally held quite specialist and demanding professional and technical positions prior to mental ill-health and been unable to sustain their career post-crisis, often for the non-medical reasons previously cited.

Peer support models delivering ‘employability’ support have been used in Glasgow but do not address stigmas present amongst employers.

The actual nature of many people’s mental ill-health can present significant social barriers for an individual.

Many of our member’s mental health fluctuates and when acutely unwell they may behave in ways that that they would not do when well.

It can also be a challenge to maintain a supportive relationship over a period of time with some people, particularly if there are a number of episodes of ill-health or the person’s is demotivated or if their lifestyle is ‘chaotic’.

It is also worth observing that some of our members have also been arrested by the police at some point as a result of being mentally unwell. These incidents do little to promote a relationship of understanding and trust within our wider society.

A reliance solely upon medication as a treatment can also be a hindrance to rebuilding a career and social networks post-crisis. Services which offer psychological support and self-management techniques for people with a mental health condition are often harder to access or have longer waiting lists than services based around medication. To illustrate, one member stated “I build my whole month around these appointments” to highlight the dearth of social opportunities he had. Another member stated of his depot injection: “The first week after the injection I can’t do much as there is too much in my system, then I have two weeks of relative wellness and then I have a week where I feel less well”.

Both of these comments illustrate to us barriers that for many people in the mental health system their pharmacological treatment primarily addresses ‘risk management needs’ but in holistic terms we struggle to address the more ‘social’ support needs.
Many of the side-effects of psychiatric medication our members also report impact upon their ability to maintain a committed adult relationship. Side-effects our members reported include significant weight gain/loss, a lack of emotional responsiveness and sexual dysfunction. A lack of intimate or even close relationships will obviously impact upon loneliness.

**We are also concerned that changes to social care provision and cuts to vital services in the community will adversely affect the ability of our members to ‘self-manage’ their wellness to the degree that many currently do (in conjunction with income loss from care charging policies and welfare reform). This will again limit a person’s ability to maintain a social role in society.**

Our members actively access peer support and ‘drop in’ facilities which they feel keep them well. These are hugely popular with our members and a preferred method of accessing social support for many. Why? Because they do not face the social stigmas they do in mainstream society, they can build a relationship with the support provider over a longer timeframe and they can proactively access these services more intensely when they feel they need to in order to maintain their wellness.

However these services are being closed and replaced with individual social care budgets that will focus upon agreed support ‘goals’. We accept that we would rather that our members be integrated to as great a degree as possible within society however it is exceptionally difficult for some of our members to do this in the face of barriers previously mentioned. The variable nature of many people’s mental health conditions also presents significant challenges for providers to deliver flexible and effective support.

We also feel that it will be beyond the remit of social care providers to challenge widespread social stigmas, change welfare policy and that budgetary cuts do little to make us think that they will recruit highly skilled and qualified staff, thus giving our members little aspiration of any real quality for social care support. This leads us to question some of the ‘aspirations’ stated by providers for these services and this is unlikely to change until support services are truly designed around the wishes, needs, assets and aspirations of the individuals and are effectively funded to deliver on these.

Our members acknowledged the value of services such as befriending which could motivate and support a person to engage socially. It was felt that these services also enabled people to take ‘supported risks’ such as going to new places and doing new things. These allowed the restoration of ‘structure’ in one’s life and the regaining of lost confidence with the reaching out to new (potential) support networks at a person’s own pace.

One of the risks of social isolation our members cited was this loss of ‘structure’ in one’s life; this meant that it was easy for them to ‘drift’ and for their lives to pass them by. Having regular flexible opportunities, such as say a peer support group, an interest or a college course, impacted upon other aspects of their lives and began to ‘fill’ the days with positive things rather than being home alone doing nothing and being removed from society.
We feel that in social terms a small amount of the right kind of support can go a long way, but this requires empathy, flexibility, sensitivity and time to develop, just like any relationship. This kind of support is the key to achieving long-term change and many social ‘outcomes’ relate to ‘recovery’ in mental health. Social support is also where services and support are least developed and most vulnerable to cuts. We need to recognise this and to be prepared to co-produce new ways to enable people to become part of their wider society. Society benefits and we have no doubt that this would lead to significant improvements in the quality of life of our members as well as cost savings for the NHS and other support providers in the long-run.

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