Editorial

Gill Coverdale

The importance of well-being in children and young people

It is some years ago that, while still in clinical practice as a School Nurse and Primary Care Group Nurse Board Member, I was able to pursue my passion for meeting the needs of young people within the community I worked. Following a piece of stakeholder engagement and research, I was able to lead, with service users, the development and implementation of a walk in advice service for the young people in the local area. We called this WACY (the name the young people it was serving decided was the best and most appropriate). What was most exciting was that it was a service designed by the young people it was to serve and it was multi-professional in its delivery. We were able to engage the local GPs and practice nurses; school nurses and health visitors; social services team; the fabulous local community psychiatric nurses; the educational psychologist; the local police constable and, most of all, the wonderful youth workers. The clinic ran weekly at the local health centre, and we had a rota for all the professionals involved. The weekly sessions always had the school nurse and the youth worker and then a combination of two professionals from the rest of the multi-professional team. We always had access to one of the local GPs and an arrangement that any young person could be referred to that GP (a big step in a complex arrangement of GP provision). I am pleased to say that we always had clients, although one would like to think no-one needed us!

Why am I talking about this, in my first editorial? Well, we expected that most of our "walk ins" would be sexual health related, however, what we had more than anything else, were behavioural and social issues which were resulting in emotional and mental ill health and distress. Fortunately, most of these came to us at a stage before crises, and we were able, for most of the time, to either make an urgent referral to our CAMHs' colleagues, or "head off at the pass" a serious breakdown in mental health, due to the multi-professional expertise we had at our disposal.

I naively thought that almost two decades on, services like the one I describe above would be mainstream and we would be in a position where early intervention was the norm. Sadly, almost 20 years later research by the Children's Society (2017), shows that a significant minority of children in the UK have low levels of well-being, which they argue has the devastating potential to have a severe impact on their childhood and life chances, as well as on the families and communities around them.

What is a relief is that there appears to have been a resurgence in public interest in mental health, which has been placed in the spotlight by the Royal Princes Harry and William's openness on the impact of their bereavement following the sudden and tragic death of their mother Princess Diana 20 years ago in August. They have talked candidly of the subsequent impact on their mental health and well-being.

Personally I prefer the term mental wealth and emphasising the positive aspect of mental health and also the importance of emotional well-being. My own doctoral research exploring the promotion of emotional well-being lays testament to this interest (Coverdale and Long, 2015).

In the policy spotlight too, especially in the run up to the general election, MPs were calling for school children to have more time for the promotion of well-being (WiredGov, 2017). However, in spite of this fundamental right, the findings from the joint inquiry into children and young people's mental health, the health and education committees found that financial pressures are restricting the provision of mental health services in schools and colleges. They cite that there is little time, resource or opportunity to support emotional and mental well-being in schools

following cut backs on the provision of mental health services, such as in-school counsellors and school nurses, despite a growing prevalence of mental ill health among children and young people.

There is clear evidence that half of all cases of mental illness in adult life start before the age of 15 and that one in ten children aged between 5 and 16 have had a diagnosed mental disorder (WiredGov, 2017). It is also acknowledged that schools and colleges have a front line role in promoting and protecting children and young people's mental health and well-being. The Department of Health (2017) stated that secondary school staff would get mental health "first aid" training through a £200,000 funding to help teachers understand and identify mental health issues in children. The programme is delivered by the social enterprise Mental Health First Aid, and staff will receive practical advice on how to deal with issues such as depression and anxiety, suicide and psychosis, self-harm, and eating disorders.

One in ten school-aged children will have a mental health condition at any time, with half of all mental health conditions beginning before the age of 14, making early intervention and support vital.

Promoting positive well-being for children is vital. The Children's Society (2017) research has shown that external factors play a major role in determining children and young people's life satisfaction and life chances. The society has identified six priorities that promote positive well-being:

1. the right conditions to learn and develop;
2. a positive view of themselves and an identity that is respected;
3. having enough of what matters;
4. positive relationships with family and friends;
5. a safe and suitable home environment and local area; and
6. opportunity to take part in positive activities to thrive.

They further advocate that addressing these will help make the UK the best place in the world for children to grow up, and give every child the best possible chance of having a good childhood and a positive outlook for their adult lives.

NICE has also made substantial recommendations for the promotion of social and emotional well-being for children and young people, in particular for vulnerable children aged under five years and all children in primary and secondary education. The right for children having the best start in life is repeated again and again in policy documentation such as Fair Society, Healthy Lives (Marmot *et al.*, 2010) and objectives outlined in the public health outcomes framework for England, 2013-2016 (Department of Health, 2013).

I am delighted to see this edition having two papers that emphasise the importance of children and young people's emotional and mental health and well-being. Sharon Neufeld's "Child and adolescent mental health services: longitudinal data" sheds light on current policy for psychological interventions in the community" and Lucy Mark's "Overview of challenges to implementation of good practice in perinatal mental health promotion in universal primary care and community services".

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Child and adolescent mental health services: longitudinal data sheds light on current policy for psychological interventions in the community

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Abstract

Purpose – *The purpose of this paper is to expand upon policy implications of a recent study assessing adolescent mental health service contact and subsequent depression.*

Design/methodology/approach – *Review of related evidence from academic and grey literature.*

Findings – *Studies assessing the role of mental health services in reducing mental disorder during adolescence are sparse, and even prevalence figures for adolescent mental disorders are out-of-date. Adolescent mental health service contact rates are shown to fall concurrent with budgetary decreases. School-based counselling is highlighted as an important source of help that may be at risk of being cut. Increased training of General Practitioners and school counsellors is needed to improve efficiency in specialist Child and Adolescent Mental Health Services (CAMHS).*

Practical implications – *Longitudinal studies of young people's mental health should include mental health service usage and its relationship with subsequent mental health outcomes.*

Social implications – *Funding cuts to CAMHS must be avoided, school-based counselling must be protected, and service referrers should be better trained.*

Originality/value – *This paper highlights the need for increased CAMHS data, sustained funding, and improved training for this vital service.*

Keywords *Policy, Depression, Child and adolescent mental health services, Community interventions*

Paper type *Viewpoint*

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Young people's mental health problems account for many adulthood adversities, including greater likelihood of mental disorder (Jones, 2013), decreased income, decreased probability of being employed or maintaining a stable cohabiting relationship (Goodman *et al.*, 2011), and greater contact with the criminal justice system (Knapp *et al.*, 2016). Increasing the effectiveness and numbers treated by Child and Adolescent Mental Health Services (CAMHS) would therefore yield personal, economic, and societal benefits over the lifespan. Recently, a paper was published supporting the association of treatment-as-usual mental health service contact with improved mental health by late adolescence (Neufeld *et al.*, 2017). While the baseline mental health service data were collected a decade ago (2005/2006), such data are rare and provide insights relevant to current CAMHS. Some policy implications for CAMHS arise from this study, pertaining to the evidence base, funding, continuity of services, and training of referrers.

Studies assessing the role of mental health services in reducing mental disorder during adolescence are sparse, an oversight that must be addressed. The literature review conducted by Neufeld *et al.* (2017) found only six studies internationally which assessed the relationship of adolescent mental health services and subsequent mental health; none were as rigorous in simultaneously addressing non-randomisation of service usage, attrition, and clinical relevance as Neufeld *et al.* (2017). Longitudinal studies of young people's mental health should without question include mental health service usage and its relationship with subsequent mental health outcomes.

Policy would be more greatly informed if larger samples (e.g. national surveys) assessed a variety of psychosocial and perhaps physiological outcomes by individual diagnoses and/or treatment sectors. In the UK, such data are sorely lacking. Even up-to-date prevalence figures for mental disorders are glaringly absent: the most recent survey was last carried out in 2004 (Green *et al.*, 2005). Whilst a new survey will be carried out in 2017 (HM Government, 2017), the lag in collecting information that so vitally instructs service provision and planning for young people is concerning. For comparison, the Adult Psychiatric Morbidity Survey has been conducted twice as often – every seven years (McManus *et al.*, 2016). National surveys on young people's mental health must keep pace with those performed in adults, and they must rigorously assess the impact of service contact.

The data from the Neufeld *et al.* (2017) study were obtained prior to funding cuts to CAMHS, and taken together with other evidence, can make the case for how deleterious such austerity is to mental health service access for young people. From 2005/2006, Neufeld *et al.* (2017) found that 38 per cent of 14-year olds with a mental disorder had made contact with mental health services in the past year; however, in 2014/2015 only 25 per cent of all children and young people with a mental disorder had made such service contact (NHS England, 2015). During this time, between 2008/2009 and 2012/2013, CAMHS funding dropped by 5.4 per cent in real terms (Lamb, 2015) so that in 2012/2013, only 6 per cent of NHS' total mental health budget was spent on CAMHS (McShane *et al.*, 2015). Services from data in 2005/2006 that Neufeld *et al.* (2017) showed were related to an improvement in subsequent depression in young people have been overstretched due to austerity. For example, the number of young people attending A&E due to a psychiatric condition had more than doubled in 2014/2015 compared with 2010/2011 (Frith, 2017), indicating a breakdown in access to primary mental health services. In contrast, funding for adult mental health services was less impacted during this period, with NHS funds falling for the first time in a decade in 2011/2012 by 1 per cent in real terms (The Kings Fund, 2015). Encouragingly, among adults with mental disorder, service contact rose from 24 per cent in 2007 to 37 per cent in 2014 (McManus *et al.*, 2016), indicating that more stable funding can facilitate service access. It is heartening that the NHS aims to increase rates of young people's mental health service contact back up to 35 per cent by 2020/2021 (NHS England, 2015). However, society must acknowledge the suffering in our young people that has not been alleviated due to austerity measures, and resolve to ever-increase connection of young people with mental health services which are effective.

Data from the Neufeld *et al.* (2017) paper indicate the importance of school-based counselling, yet this source of help for young people must be protected. Neufeld *et al.* found that for those with a mental disorder, after specialist CAMHS, the next most used service was school counselling, and for those without a mental disorder, school counselling was the most highly used service. The current government has promised to provide funding for mental health first aid training for teachers in secondary schools (HM Government, 2017), enabling them to better identify those with mental health issues and connect them to support services (Mental Health First Aid England, 2016). However, this is against a backdrop of freezing school budgets until 2020/2021, the very budgets which typically fund school-based counselling (Frith, 2016). Increased identification of young people's mental health problems is commendable; at the same time leaving key services at risk of being cut is highly counterproductive, potentially increasing pressure on more specialist CAMHS. In total, 90 per cent of the cost of young people's mental health problems falls on the education system (Frith, 2017). The fact that young people who do not meet diagnostic criteria are referred back from specialist CAMHS to counselling in schools and General Practitioner (GPs) surgeries (Frith, 2016) underscores the importance of such services in preventing more serious problems. Funding for school-based counselling must be ring-fenced, whether it be funded through the education sector or NHS, to ensure young people have adequate service access prior to specialist CAMHS.

Service referrers, such as those in primary care or schools, need to be better trained in identifying the presenting features of mental disorders, to help prioritise specialist CAMHS for more serious cases. Neufeld *et al.* (2017) showed that improvements related to mental health service contact were only seen in those who had a clear need for services, as defined by the presence of a mental disorder. The findings imply that those meeting a diagnostic threshold of mental disorder may be more responsive to treatment, and that prioritising more serious cases could make the system

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Mental Wellbeing Impact Assessment (MWIA) in the workplace

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Abstract

Purpose – *The Mental Wellbeing Impact Assessment (MWIA) is an evidence-based tool that guides decision makers, such as policy makers and service managers, about the potential impacts of a new programme or policy change. It was initially used in urban regeneration but has subsequently been used in housing, children's centres and education. The purpose of this paper is to report, for the first time, on the strengths and weaknesses of using the MWIA in the workplace.*

Design/methodology/approach – *Feedback was collected from staff who participated in stakeholder workshops as part of the MWIA process at two different public sector organisations.*

Findings – *The MWIA can be used as an effective workplace assessment tool and is valuable as both a diagnostic tool and as an intervention in its own right. The MWIA generates tailored action plans focused on addressing the organisation or team-specific issues. The weaknesses of the MWIA in the workplace are mainly focused around management cooperation and commitment to the process which should be screened for prior to engaging in the full stakeholder workshop.*

Originality/value – *This is the first report of MWIA's use in the workplace but suggests that it is a useful tool which can be used to support workplace wellbeing, especially in relation to a policy or organisational change. Further studies should be carried out to fully understand the impact of the MWIA in the workplace.*

Keywords *Wellbeing, Impact assessment, Workplace, MWIA*

Paper type *Case study*

Introduction

Mental Wellbeing Impact Assessment (MWIA) was developed over a ten-year period by the South London and Maudsley NHS Foundation Trust and partners (MWIA National Collaborative). It has been used both nationally and internationally (West and Scott-Samuel, 2010). MWIA is an evidence-based diagnostic tool that aims to orientate decision makers such as policy makers and service managers towards considering the impact of policies, programmes and services on the mental wellbeing of the target group. MWIA is a stepwise process that begins with a desk-based screening tool and culminates in a workshop that engages multiple stakeholders and results in co-produced action plans. The action plans aim to develop the positive impacts on wellbeing and mitigate against any negative impacts.

MWIA was developed based on the health impact assessment methodology (European Centre for Health Policy, 1999), an evidence review about mental wellbeing influences that includes a social model of health and takes an assets-based approach. Initially, it was used in urban regeneration but has since been used in housing, children's centres and education. In addition, over the past three years, we have been exploring, and finding success, in its application in workplace wellbeing.

The economic benefits associated with improved workplace wellbeing, in addition to the benefits to the individual, make it an increasingly attractive area to employers. Employees who are physically and psychologically healthy are more productive, better at decision making, have reduced absenteeism and reduced healthcare costs, have increased resilience, engage more and are better at coping with uncertainty and change (Boorman, 1999; Hillier *et al.*, 2005; National Institute of Clinical Excellence (NICE), 2009).

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The authors would like to thank all the participants in the MWIA workshops who took the time to give us feedback about the process and share their experiences.

Employers have previously approached wellbeing in a reactive rather than proactive manner. It has however been shown that interventions focussed on worker wellbeing can have a significant effect on commercial outcomes, and an effective human capital management is starting to be seen as indicative of companies' long-term prospects (Litchfield *et al.*, 2016). For example, it has been estimated that every pound spent on prevention and early intervention can result in ten pounds of savings for businesses, which are currently estimated to spend £554 per person on employee absences (Chartered Institute of Personnel and Development, 2015).

Major factors that directly affect the employee's wellbeing and productivity include an organisational change and stress, in addition to relationships with employers, working arrangements, relationships at work and an employee's work design and work demands (Hillier *et al.*, 2005; Campaign for Social Science, 2013; Litchfield *et al.*, 2016). Current workplace mental wellbeing interventions therefore range from approaches that focus on the individual's ability to cope, endure stress and proactively manage a healthy work-life balance (resilience) to organisational and wider system-level approaches that consider structural and cultural aspects of organisational culture such as the access to work-based support, engagement and mental health awareness (Gravelling *et al.*, 2008; Public Health England, 2014).

Stress management interventions, which focus on stress awareness and the development of techniques to minimise the impact of stressors, form a large part of workplace wellbeing programmes (Seymour and Grove, 2005; Public Health England, 2014). In addition, manager training has been shown to benefit the mental wellbeing of those who they oversee (Tsutsumi, 2011) and Mental Health First Aid training for managers has also been shown to be effective in improving the mental wellbeing of those who partake in it (Kitchener and Jorm, 2004). At the structural level, interventions such as flexible working hours, work-based support schemes, line manager training in mental wellbeing and increased staff participation can improve the workplace wellbeing (Gravelling *et al.*, 2008).

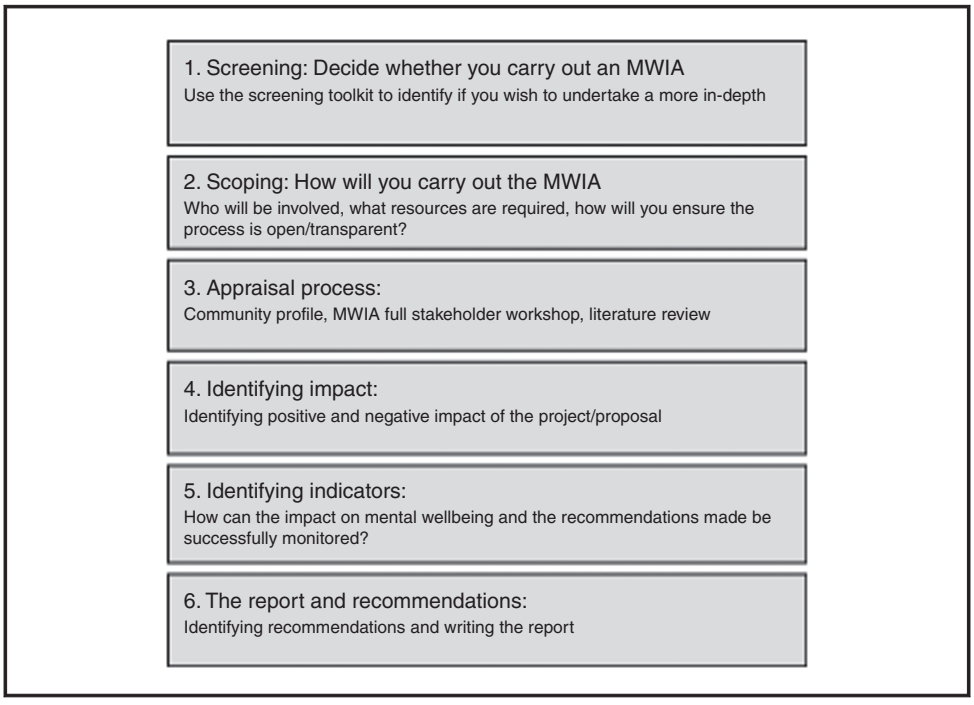
MWIA is a unique approach that operates across the continuum of the above described interventions. It uses a reflective practice to identify underlying issues and the interventions that would be most appropriate for each specific set of circumstances. In this respect, it is both a diagnostic tool and an intervention in its own right.

An MWIA begins with a "screening" phase (Figure 1). In the screening phase, the proposal or issue is explored with a small number of people who represent different viewpoints such as frontline staff as well as management. Typically, the manager or human resources lead responsible for the proposal is present for the screening. This initial discussion provides the context and begins to unpack the potential impact on the wellbeing of a proposal or issue, and can lead to an action plan in response to any potential adverse impacts identified. The screening considers the same issues that will be discussed more completely as part of the full stakeholder workshop and can be found in the MWIA toolkit (Cooke *et al.*, 2011).

The "screening" informs the "scoping" phase, which determines whether further investigation in the form of a full MWIA is necessary, given the possible impacts identified. In addition, the scoping identifies: the resources and time required to undertake the project; if those participating would have a safe space to have this engagement; and whether the findings from the MWIA would be taken on board by the organisations concerned. This requires in-depth conversations with the management of the workplaces in question and an honest appraisal of their commitment to supporting the outcomes of a full stakeholder workshop.

If a full MWIA is indicated, then a stakeholder workshop will be conducted in which the toolkit is used (Figure 1) to stimulate a discussion amongst those who are being affected by a proposal or issue. The toolkit asks the participants to consider how different factors, which are known to be associated with mental wellbeing, are being or will be impacted on. The toolkit asks the participants to consider both positive and negative impacts on these factors (Knapp *et al.*, 2011). Actions to minimise the negative impacts and maximise the positive are then discussed and indicators are developed to assess the outcome of these actions. A short literature review is conducted after the workshop to analyse the suggestions in the context of best practice as well as examining demographic data (community profiling) of the affected population.

Figure 1 Stages of the MWIA process as applied in the workplace



Methods

Two case studies are presented to help illustrate areas where the MWIA has worked well in workplaces and how it could be improved. These organisations underwent an MWIA between 2013 and 2014.

The first organisation was an academic health sciences collaboration centre composed of member organisations from different backgrounds such as clinical services (including NHS trusts), academic research and human resources. The organisation underwent the MWIA process as a result of funding awarded to improve the workplace mental wellbeing of staff. The seven teams that underwent the initial screening were from a range of different services and therefore faced a diverse range of issues. The experiences of staff undergoing the MWIA process was collected from the final report produced after the workshop and from the interactions with facilitators (TC, AC, SK).

The second organisation was a local authority. Similar to case study one, the local authority was composed of teams operating within different areas of the organisation and also included human resources personnel. A total of seven teams were also included in an initial screening process and six went on to complete a full MWIA workshop. During the screening phase, it was recognised that the environment within the seventh team would not enable an effective full stakeholder workshop and generate workable action plans due to issues around the relationships between the team members and management. The experience of the participants who underwent the workshops was collected by a telephone interview one year after the workshop was held (see the Appendix).

Interviewers had experience in facilitating a full MWIA stakeholder workshop and had been trained to deliver the MWIA screening (CB) or were involved in the original development of the MWIA (AC). Both interviewers were contracted to work on MWIAs by Maudsley International (MI) at the time of interviewing. In total, four participants were contacted by e-mail from different teams within the local authority to share their experiences anonymously. All four participants gave a full telephone interview and were aware that the interviewers worked for MI. The four team members were selected as they took part in both the initial screening and the full

stakeholder workshops. The participants and researchers were both alone when the telephone interviews were being conducted. Written notes were taken during the interviews which lasted between 30 and 45 minutes.

The responses from participants in both case studies were compared and issues that were common to both were identified.

Results

The evidence from the case studies suggests that the MWIA is a useful tool for teams to assess and discuss the issues around wellbeing. It also enables the joined development of solutions that may require organisational-level change, and therefore commitment from the higher levels of management. MWIA's external facilitation aids coordination, but also provides a safe space for the participants to freely voice their concerns that may affect their workplace wellbeing.

The MWIA screening toolkit can be used as a standalone assessment

As the screening involves a small group of people, it will not capture the full range of issues impacting, or potentially impacting, on teams. However, it may start to guide managers towards thinking about these challenges and it can often generate enough information to inform the development of actions in response to the findings it generates. For example, one of the teams within the health sciences centre felt that, based on the issues raised in the screening, there were issues related to the team's environment that made it difficult to provide a safe space for the employees to discuss issues as part of a full stakeholder workshop. The screening acted as a stimulus to bring about a change in the management of this team and was therefore useful in its own right.

Additionally, employees from the local authority underwent training in delivery of the screening toolkit, following the full stakeholder workshop, so that it could be delivered to groups of employees from large teams (bigger than ten) who could not all be included in a full workshop, due to resource constraints. Unlike the full MWIA that tends to be delivered to groups of ten or smaller, the MWIA screening toolkit has the potential to be used in large teams (Cooke and Stansfield, 2009). This is important, given that the smaller number of individuals included in a full stakeholder workshop may not represent the diverse views held in larger teams.

In both case studies, it was noted that the screening alone increased the understanding and awareness of mental wellbeing, even if the participants did not undergo the full MWIA process.

MWIA requires the management to be committed to and engaged with the process

One of the teams in the local authority that underwent a full stakeholder workshop was restructured shortly after the process was completed. A year later, the actions proposed following the MWIA process had not been implemented due to uncertainty and continued disruption to the team. The upcoming restructuring should have been identified as a barrier to completing the full stakeholder workshop.

Engagement with senior management during the implementation of the actions identified by the MWIA was highlighted as important for successful outcomes in both case studies. One of the teams in the local authority highlighted the benefit of receiving management feedback on suggestions – even when nothing could be done about the issue. The explanation helped increase employees' sense of control and improved wellbeing. This team went on to introduce a regular line manager newsletter, which reported the outcomes of anonymous employee suggestions in the previous month. Furthermore, in the health sciences centre, the repeated clarification of progress with implementation of the actions identified in the MWIA demonstrated that it was not another "tick-box" exercise, as some employees had initially assumed, but was able to generate a real change. In the local authority, some employees were initially sceptical of the process and the likely benefit, especially given the time commitment it required from the employees. Previously, similar work had been started but never completed within the organisation.

In addition, management support can be important if issues related to organisational culture are raised by the MWIA stakeholder workshop. Within the NHS Trust team, it was felt that their current working conditions were inconsistent with the values of the Trust and the values the individuals themselves held, which had motivated them to train in their respective careers. At the team level, the action suggested was for the line manager to acknowledge that the team were facing difficulties and to give more praise to the team members for the good work they were doing in difficult working conditions. At the organisational level, cultural change would be needed to address the inconsistencies between daily practices and trust values, which requires support from the highest levels of management.

MWIA generates solutions that give responsibility back to teams

Although the MWIA can generate issues requiring an organisational-level change, many of the actions identified place emphasis on the team and what the team and individuals can do to improve their own wellbeing. For example, in one of the teams within the local authority, it was suggested that staff were not being recognised for their good work. The team therefore decided to set up a display on the wall, and every time they received some good feedback, it was added to the wall to help improve the team morale. This action helped to motivate the members of the team and encouraged them to be more engaged, although it was not costly and did not require a management input. In the health sciences centre, it was felt strongly that there was an unhealthy work-life balance and this was impacting negatively on the home-life of members of staff. It was suggested that one of the ways of helping staff cope would be to establish peer-to-peer relationships within teams that could provide valuable support.

MWIA provides external facilitation

In both case studies, external facilitators delivered the MWIA, which was regarded as very important to the success of the process. It allowed a group-led approach with the stakeholders providing "the content and direction" and the facilitators "just adding structure". Ensuring managers were not present allowed an open forum for discussion, which meant that the issues could be fully explored in a safe environment. This was important in one of the teams in the health sciences centre, due to sensitivities between team members and management. Conversely, in the local authority, the manager who commissioned the work was present at the full stakeholder workshop. The manager was moved between different teams during the day and it was highlighted that this was important for allowing employees to speak freely. However, the manager also felt that it was useful to be able to listen to those she managed and the issues they faced. The participants felt that the external facilitation provided an opportunity to speak honestly and openly in a safe environment. It was mentioned that during times of organisational change or difficulty, individuals can feel reluctant to express fears and share those with others, especially if there are concerns about job security. This was the case for one team in the local authority and the external facilitation was felt to be particularly important.

MWIA may initially raise issues that lead to more stress

The nature of the MWIA process means it can often bring up some very personal issues and this may initially cause a higher strain on mental wellbeing before they resolve. For example, in the local authority, there was an individual who decided, shortly after the MWIA full stakeholder workshop, that they would leave the organisation. It was felt that the MWIA process helped the individual reach that decision as it became clear that the issues most important to them were outside the control of the organisation. It was felt that MWIA had helped to make it a positive decision for the individual, and the manager felt that it was a positive decision as well.

MWIA as an intervention in its own right

Participants felt that the MWIA workshop gave them the opportunity to have their voice heard by senior management and that they were allowed to express concerns. In addition, it helped

team members appreciate issues that others within the team were facing, such as age, circumstances in their personal life and career aspirations and ambitions. The sharing of perspectives helped team members to understand what motivates others and was beneficial for contextualising the behaviour and interactions between team members. In both the NHS Trust and local authority, stakeholders felt that it was beneficial to learn that others felt the same way and shared similar concerns.

MWIA as a diagnostic tool

In both case studies, the actions suggested by the groups differed depending on the specific challenges the organisations were facing. For example, teams within both organisations had issues with the physical space of the workplace; in the local authority, it related to a recent move to a new space, whilst in the NHS Trust, it related to the physical layout. The actions the teams identified were therefore tailored to the specific problems rather than just applying a blanket solution to issues.

Discussion

The findings from the case studies support the use of the MWIA as both an intervention in its own right and a diagnostic tool. The process of sharing and exploring concerns can help improve mental wellbeing as it allows an individual to define the issues really impacting them (The Mental Health Foundation, 2016). The MWIA stakeholder workshop provides a forum for team members to do this and can therefore be of benefit even in teams unable to implement the recommended actions. The other role of the MWIA, as a diagnostic tool, is perhaps one of its most useful aspects. It helps to identify actions in response to the discussed issues, which are likely to make the greatest difference as they are generated based on the employee experience rather than being instituted in a top-down manner. Both organisations could have rolled out stress management training to employees, although this would not have addressed the most salient issues. There is no "one-size fits all" for mental wellbeing and it depends on the organisational culture and values. The MWIA can be used to "diagnose" the real problems affecting staff so the organisations' time and efforts to improve mental wellbeing can be used more effectively.

In addition, the process can help to highlight the issues that may be impacting different members of the team and can raise the awareness of mental wellbeing in general. Increasing the awareness of good mental wellbeing can help lead to an early detection of mental health problems, which, in turn, leads to earlier intervention and better outcomes (NICE, 2009).

A challenge with the MWIA process is ensuring that the actions are implemented. When an organisation or team is unable to implement the actions suggested, it can cause individuals to feel more helpless, as they feel ignored. This can lead to a decreased sense of control and poorer mental wellbeing at work (Public Health England, 2014). Therefore, the MWIA should only be used in circumstances where there is an organisational support; the scoping phase can also be used for developing an understanding of whether an organisation is in a position to support a full MWIA workshop. In the case of the local authority, a more in-depth scoping phase would hopefully have identified the upcoming restructuring that had been planned for one of the teams, and therefore highlighted why this may have made them unsuitable for a full stakeholder workshop.

Paradoxically, MWIA also provides an opportunity to increase employees' sense of control and wellbeing through the implementation of actions. Frequently, the actions proposed can be carried out by the employees without the need for a manager input. This can help provide a sense of control and empowerment as the individual, or individuals, become responsible for driving the change.

The case studies also demonstrate the challenging and complex nature of some of the issues raised by MWIA. It is important to explore this with management and make them fully aware of this possible outcome during the screening and scoping phase. This allows them to prepare for how they might navigate any potential issues.

Finally, it is important that quantitative methods for assessing the impact of MWIA are developed. During the MWIA workshop, participants are encouraged to decide on indicators for each of their proposed actions that will act as the measures of their success. Possible measures suggested in the local authority included number of sick days taken, staff retention and promotion, and number of staff suggestions submitted. However, it is important that quantitative measure can be applied across different organisations to allow the comparison of the impact of MWIA. The local authority suggested using the Warwick-Edinburgh Mental Wellbeing Assessment Scale (Tennant *et al.*, 2007) to assess mental wellbeing before and after the workshop. A difficulty with this is that mental wellbeing may still decrease after the workshop, as a result of the change that necessitated the workshop in the first place, and it is not possible to know what mental wellbeing would have been like without the MWIA.

The experiences in these two cases studies suggest that the MWIA can be used as an effective assessment tool for workplace wellbeing. In both case studies, the MWIA toolkit was applied in full but highlighted how the screening alone can add value. In addition, the MWIA can be used to identify issues most important to the employees and therefore allow tailored solutions, which could save the organisations' time and money over providing generic, "off-the shelf" mental wellbeing interventions.

The weaknesses of the MWIA are mainly related to the implementation of actions and depend on management cooperation. It may therefore be necessary to develop the engagement process so that organisations have a thorough understanding of what they are committing to. Finally, the assessment of the impact of the MWIA needs to be developed further. Although this is considered within the process, with participants trying to develop indicators for each of the actions they propose, it would be useful to be able to assess any overall global changes in mental wellbeing as a result of undertaking the MWIA.

It is important to note that results derived from case studies cannot be generalised, and are specific to the one particular case. In addition, bias and, in particular, observer bias and the "halo" effect may have impacted the results. More work is therefore needed to develop robust evaluation methodologies for the impact of the MWIA. The use of the MWIA in the workplace is in its infancy but these case studies suggest that it has the potential to provide an effective means of improving a workplace mental wellbeing (King, 2014).

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Appendix

1. Has an action plan been completed?
2. Have any of the actions been implemented successfully? If so, how many and which ones?
3. Do you foresee any difficulties in implementing any of the actions? If so, please describe.
4. What difference did the MWIA make in understanding the wellbeing issues of your team/issue?
5. How would you have tackled the issue your service/team was experiencing without MWIA?
6. Do you think you would have found the same answers without MWIA? Why do you think this is?
7. Do you think you may use MWIA in the future and why?
8. What other impact assessment or team/service planning tools do you use? Do you think MWIA can be used with these/instead of these/be integrated?
9. Did MWIA provide a way of clarifying and being transparent around decisions? Can you give an example.
10. What worked really well?
11. What did you like least/most about the process?
12. Were there any objections to the process before or after?
13. Did the MWIA raise any difficult issues?
14. Did you/participants feel is was a safe space to talk openly?
15. How were the difficult issues dealt with during and after?

16. Were there any unexpected consequences.
17. Were you able to get appropriate support for all the issues that needed to be addressed?
18. Did you feel you/your team/your organisation has enough recourses (money/time/skills and experience) to implement the required changes?
19. Was there any stigma attached to the use of MWIA?
20. Have there been further opportunities after the MWIA to talk more/work more on mental wellbeing?
21. Any strategic changes connected to working with mental wellbeing? For example, policy, new boards or staff forums, new partnerships?

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Shame and blame and its influence on male gay (*chaay rak chaay*) quality of life in Bangkok Thailand: a health promotion community nursing perspective

Praditporn Pongtriang, Anthony Paul O'Brien and Jane Maguire

Abstract

Purpose – *The purpose of this paper is to explore gay male informant experiences of discrimination and stigma in Bangkok from a health promotion community nursing perspective.*

Design/methodology/approach – *Semi-structured in-depth interviews were conducted with 30 informants and included field work observations at eight entertainment venues. Data analysis utilised an inductive thematic approach.*

Findings – *Key themes that emerged from the data were related to communication, particularly the use of smart phone applications; lack of privacy in health services; sexual exploitation by entertainment venues; and concerns about coming out safely to protect self-esteem and mental health.*

Originality/value – *Development of key mental health promotion messages based on a greater understanding and knowledge of discrimination and stigma may help to reduce negative behaviour and stigmatisation towards Thai gay men in Bangkok.*

Keywords *HIV, Health promotion, Mental health, Discrimination, Stigma, Gay male*

Paper type *Research paper*

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Introduction

Stigma and discrimination are problematic for gay men and factors related to mental illness, disability, race, religion, prostitution and drug addiction contribute to this occurring (Frye *et al.*, 2015). In Bangkok, Thailand, non-acceptance of men who have sex with men (MSM) and who may be at higher risk of contracting human immunodeficiency virus (HIV) adds to the likelihood that stigma and discrimination will be experienced. It is also evident for the Bangkok gay community that despite an initial decline in infection rates in MSM the prevalence of HIV is increasing (Bureau of Epidemiology, 2015). This paper provides a community nursing health promotion response towards understanding the issues about HIV for gay men living in Bangkok. Managing the HIV infection rate in Thailand is a serious issue for everyone, but for gay men this is even more challenging (UNAIDS, 2012). This is particularly the case when the incidence of unprotected sexual intercourse is reported to be higher in MSM and this factor contributes to greater social and cultural isolation for them (Holt *et al.*, 2011; Phillips *et al.*, 2011; Heath *et al.*, 2012; Prestage *et al.*, 2012; Sirivongrangson *et al.*, 2012). In a Buddhist country such as Thailand, where mainstream sexual practices are firmly anchored in heterosexuality and where HIV incidence is increasing overall, gay men appear to be experiencing another layer of unwanted social attention not experienced by the heterosexual community.

Discrimination and stigma effectively limit Thai gay men from full participation in the pluralist mainstream. The concept of "stigma" has long been associated with the notion of misalignment and marginalisation of individuals who are different from mainstream accepted groups and persuasions.

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Stigma and discrimination associated with HIV/AIDS has been identified as a precursor to major depression and suicidality. Depression is significantly associated with internalised shame and perceived stigma which contributes to further social isolation and poor self-esteem (Land and Linsk, 2013).

As early as the 1960s (Goffman, 1968) homosexuality was described as a "spoiled identity", seen in the eyes of society as an attribute that significantly reduced the person who possessed it. Goffman related the spoiled identity concept to mental illnesses, physical deformities and socially deviant behaviours such as homosexuality. Goffman (1968) argued that the stigmatised individual was a person with "an undesirable difference". Applying this view, Goffman suggested that stigma is constructed by society on the basis of perceived "difference" or "deviance" and then applied through socially sanctioned roles. Thus, for the gay men in the ethnographic study reported here, participant social identity is already spoiled, even before they begin to tell their story.

Methods

Informants attended the Thai Red Cross Niranam clinic as scheduled for their routine care. Informants were asked to identify themselves as either "Gay male (ชายรักชาย)/Rak ruaam phet (รักร่วมเพศ) (Homosexual)" "gay" (เกย์) (Gay male) "King (คิง)/Rook (รุก)" (Top) "Queen (ควีน)/Rub (รับ)" (Bottom) "Both (โบ๊ท)/ Quing (ค วิง)" (Versatile) "Bai (ไบ)/ Suea bi (เสือ ไบ)" (Bisexual) or "kathoey (กะเทย)/tut (ตุ๊ด)" (Queer); and at least 18 years of age; and Thai speaking. Written consent was obtained from all informants after the study aims and processes were explained by the researcher. Interviews took place at the Thai Red Cross Research Centre. Non-participant observation was undertaken in public shopping centres, bars and other entertainment venues.

Interviews were digitally recorded and transcribed into Thai, then translated and transcribed from Thai into English. Participant observation was recorded in field notes and the researcher's personal diary. All data were aggregated and transcripts de-identified interviewees by code. Data analysis utilised inductive content analysis (Vaismoradi *et al.*, 2013) and followed the six steps as described by Creswell (2013) which involve, data organisation, reading, memoing, describing the data into codes and themes, classifying the data, interpreting the data and representing and visualising data. NVivo 10 was utilised to organise the data into codes and themes.

This study was approved by Human Research Ethics Committee at The University of Newcastle, Australia (H-2014-0071) and Chulalongkorn University, Thailand Human Research Ethics Committees (12-57).

Results profile of participants

Demographic characteristics

In total, 31 male informants volunteered to be interviewed. One informant had a poor-quality audio recording and these data were excluded. The demographic data of the informants are provided in Table I. Informants were aged between 18 and 59 years. Most informants identified as "Both" (โบ๊ท/versatile). The majority of informants were of Buddhist religion. At least 50 per cent of informants worked for wages, over half of the male informants had a regular partner and 18 informants had completed a bachelor's degree in education.

Findings

Social construction of stigma and discrimination towards gay MSM in Bangkok

Family conflict. The study presented describes informant's experiences of discrimination and stigma living in Bangkok. There were numerous informant examples of exposure to discrimination and stigma in everyday life and how it impacts on their daily perceptions and behaviours. Thai family acceptance and background in this study was a key influence on gay social, cultural and spiritual acceptance. Many families reject sons who identify as gay men, especially those with feminine expression (Preston and D'Augelli, 2013). This conflict can result in the son moving away

Table I Demographic characteristics of the informants in the in-depth interview process

Characteristic	*Frequency*
Age (years)	
18-22	8
23-27	7
28-32	7
33-37	5
38-42	2
43-47	0
48-52	0
53-56	0
57-60	1
Gay identity	
Gay male	1
Gay	2
King/Rook	0
Queen/Rub	9
Both	16
Bai/Sau bai	0
Kathoey/toot	1
Phu- ying- pra- phet -sorng	1
Religion	
Buddhist	28
Christian	1
Muslim	0
Other	1
Status	
Having partner	16
No partner	14
Employment status	
Employed for wages	15
A student	8
Self-employed	5
Out of work and looking for work	1
Out of work but not currently looking for work	0
A homemaker	0
Unable to work	1
Education	
High school	8
College	3
Bachelor	18
Postgraduate	1

Note: $n = 30$

and losing the family support which further places their mental health at risk. Family status may also be affected when others in the community learn a child is gay, causing further distance between gay men and their families (Ojanen, 2009).

The following participant discussed his feelings about family conflict:

> My family has Chinese background, so they were furious and punished me. They claimed Chinese family does not have Kathoey (queer) members. When I went out, walking the catwalk, or something, then they would punish and ground me. I was the oldest boy in the family, so they were completely against me […]. At the time I dressed as a woman […] I would be the one who was punished, as they hated me so much back then (25, 1).

Living with social pressure – "being branded". Social pressure towards gay men in the community was evident from the informants' stories of growing up as a gay man in Thailand. Behavioural expressions of gay men can have an effect on the mainstream heterosexual community around them. Many gay men experience difficulty in their working lives and the impact of being gay has also been

reported to affect their career (Matzner, 2015; Pongtriang *et al.*, 2015). Research data indicate that the community in which a gay person is part of, including educational institutes, his workplace and other community facilities, impacts directly on their behaviour and mental health (Courtenay-Quirk *et al.*, 2006). Evidence also supports the role of stigma having an impact and a negative effect on self-esteem and emotional equilibrium (Courtenay-Quirk *et al.*, 2006; Felix, 2014). Although Thai society is much more open to same-sex behaviours in the current day, there is still limited acceptance of certain behaviours, including affection between same-sex couples in public areas.

The following informant reflects on the effects of social and familial pressure:

> My mom and my grandparents are all civil servants. If I became an HIV patient, how can my family face the public criticism and how can my family live under such humiliation? This is what I have always been most afraid of. If I was diagnosed with a cancer, they would only say "Oh, he has this type of cancer because of poor health". My family is pretty well-known. They would have to face all the gossiping around them (10, 2).

Many gay men have to hide their HIV status and isolate themselves from the community in order to eliminate troubling situations in their lives (Preston and D'Augelli, 2013; Smit *et al.*, 2012).

One HIV positive informant discussed his future plans:

> Now I am in Bangkok. I thought I was going to go home, but I changed my mind, because I think my family won't accept me. The society still brands me. So I stay and live a normal life in Bangkok, because I have friends who understand me. I've been talking to my friends about buying a house then turned it to massage parlour. Living our normal life (12, 12).

The informant, living with HIV, reflects on the lack of acceptability of being a gay man within both his family and Thai society in general, and that this influenced him to run away from home. Bangkok is a good place to live a normal life, he said. He has other friends who accept his gay life and this makes it much more comfortable and provides to him the freedom to plan for his future. Dealing with stigma is perhaps one reason why Thai gay men are reluctant to access mainstream health services, to avoid the further angst of discrimination, but when stigma has been associated with depression and other poor mental health outcomes avoiding health services can be a problem for homosexual men (Ha *et al.*, 2015).

Lack of acceptance by the healthcare system

The social pressure of living with HIV and or being gay appears to be a barrier to gay men seeking appropriate health services (Riisher *et al.*, 2013). Nevertheless, the healthcare system is a key component to supporting these men in the reduction of the incidence of HIV, but also in providing general support, health advice and care. In this research study informants suggested that the healthcare system can actually discriminate against and stigmatise gay men.

This informant discusses people's perception around gay men using health services:

> I went to the hospital with my friend's mother and she was ill, so we took her to the hospital. "There was a gay couple, who walk passed her and she said Just look at those 2 people. They must be here for HIV+ test. Even though she didn't know the actual reason why they were there in the first place". It seems people believe if you are certain thing then you would have certain disease. If you are (gay) and you come to the hospital with someone and that means you would certainly be HIV positive (13, 7).

Such opinions further indicate that discrimination and stigma are apparent towards Thai gay men accessing healthcare services. Uncomfortable feelings experienced by gay men about their acceptance and identity are further compounded by negative social reactions and attitudes (Table II).

Self-consciousness and self-acceptance

Being accepting and accepting self. Self-esteem plays a significant role in *chaay rak chaay*'s everyday life by decreasing discrimination and stigma.

This informant reflected on his perception about accepting himself as being gay:

> I'm happy about who I am, for the time being. Going out as I still have strength to go out. But when I'm older then I would probably go to temple or stay home (Laugh) having dogs and cats (Laugh). See how it goes (13, 9).

Table II Cultural explanation for social exclusion and isolation of gay informants

Theme	*Representative quotes*
Family conflict	[…] my father pretended to be asleep as he could not accept it, but he just did not lash out or anything[…] my parents did not understand me in some of the things. So I ran away from home twice, but I did not go far and I also did not go for long period of time, so they were worried and were sensitive about my feeling. They probably felt bad, but if they did anything bad to me then I might run away from home again (24, 1)
Living with social pressure	When I go out with my boyfriend, we might hold hands and I could see that people would take notice as if it is such undesirable behaviour. "Look at that couple"! I do not understand why we would have to be branded, as we have no rights to hold hands, even though we did not do anything ridiculous. We were just like any other lovers walking around department store. I don't understand why we would be confined to certain areas (17, 9)
	I was at one place with my mother and this woman walked to where we were sitting, and pointed at me then said "look at this "kathoey quaay" (effeminate bear). They do it with other men. So "disgusting". So I thought what was wrong with people like us. In the past, when straight guys saw gay guys around them, they would have said "We are so scared of being done anally". We just wanna say that it is not the case (24, 2)
Lack of acceptance by the healthcare system	One thing is that they still prevent us from giving blood donation. I don't understand why they don't allow men like us […] I mean a man having sexual relationship with another man to donate blood since they have all the tools and equipment to run the test before they allow blood donation anyways although it's true that it is mostly common among Gay Group based on research results (6, 6)

Gay men should feel confident and secure with their choices like any other member of society, and although being gay is not conforming to traditional Buddhist cultural meaning, it is purely a same-sex preference, it is also not wrong to be gay (Greene and Britton, 2013). Discrimination and stigma can affect everyday lives negatively, but also can lead to greater acceptance and support that assists informants to have stronger self-esteem (Greene and Britton, 2013; Gómez *et al.*, 2005). Being part of a group of men who are gay and like-minded is a supporting factor when society at large discriminates against the minority.

This informant describes how he undertook the rigorous training to become a monk in an attempt to counteract his feelings of unworthiness and prove his added worth:

> I have 3 brothers. I was the first one to be ordained as a Monk, once I graduated. I felt I was inferior compared to others, so I tried to do this. To make them see that I could be ordained even though I am this way (homosexual). Though there are obstacles, but I think I can do it (20, 2).

Acceptance and support of an individuals' gay status is important in raising and sustaining the self-esteem of gay men and this participant also sought additional verification through engaging in a cultural and religious attainment held in high social regard. He felt greater self-confidence and methods such as this can lead to a greater ability to be true to one's self. Positive self-esteem and group support also decrease the effects of stigmatisation and negativity on a gay male's perception of himself (Hubach *et al.*, 2015). This is potentially significant in reducing the incidence of mental health problems in the gay population in Bangkok, but perhaps also Thailand (Courtenay-Quirk *et al.*, 2006). Health promotion strategies to reduce the incidence of HIV infection could focus upon building self-esteem in Thai gay men, teaching skills of empowerment and mindfulness so they feel stronger as a minority group and individually to be part of mainstream society. Raising self-esteem and self-acceptance of gay men by healthcare providers, as well as Thai society would help to promote acceptance of the homosexual community.

Identity concealment – an uncomfortable life. Concealed gay status can be found in the Bangkok gay community, even though same-sex issues are likely to be more acceptable in today's modern Thai society (Tangmunkongvorakul *et al.*, 2010). Disclosing gay status might be difficult for *chaay rak chaay* who live with the strictness of family and straight customs keeping them from coming out. Informants found that to conceal gay status for them resulted in an uncomfortable life. The following excerpts speak to *chaay rak chaay*'s feelings about the limitations on their life and on their same-sex behaviours.

The informant discussed social norms related to same-sex behaviour:

> Some people might hide their sexuality, and then others will try to guess and notice your behaviour. It's truly unhappy. Just admit it and people will know how to treat you (20, 1).

Many informants did not disclose their gay status and their normal feminine behaviours were disguised and suppressed by masculine actions whilst out in public. Being a homosexual man is not accepted by his family, so masculine behaviours had to be displayed in front of others to conceal his real identity.

One HIV positive gay male expressed that it was difficult living with HIV:

> So I am quite worried that when I pick up the medicines, I would find someone I know. I was concerned about my privacy. I am afraid that people I know might find out (17, 6).

In some studies, disclosure of HIV status has been found to be less likely in gay men and this can result in a complicated life where the shame of not disclosing contributes to further isolation and emotional disquiet (Smit *et al.*, 2012; Courtenay-Quirk *et al.*, 2006). The informants in the study reported here openly disclosed that they faced lifestyle restrictions on their freedom.

Coping with social pressure. The majority of gay men who participated in this study experienced emotional and social conflict, pressure to be like others not part of their minority and other life problems. The informants told the researcher that all of these situations required numerous coping strategies to confront and resolve their conflict associated with not being accepted. Some informants believed their negative feelings would be fixed over time and that the experience would make them stronger, with the strength gained from being resilient helping them to deal with other life challenges. They also supported and made recommendations to assist close friends who were troubled by emotional distress. Informants employed numerous strategies to cope with negative feelings which were of great assistance to them. Personal self-coping is one effective strategy that was seen to manage a problem:

> When it turned out to be HIV+, I just tried to cheer myself up and did not blame myself. I already had bad mentality and didn't want to feel any worse, so I cheered myself up and not to think too much (14, 7).

The next informant reflected on his perception of positive thinking:

> Thai society is more open. What else needs to be open? The world may explode. (Laugh) You have this much and you want more. If you have it all, then can you accept it? It's okay. I just live a happy life with no stress (18, 13).

Being positive and maintaining resilience in the face of discrimination and stigma might assist these informants to solve problematic life issues and to avoid contracting HIV through negative lifestyle behaviours. Strong coping strategies are important in assisting gay men to solve everyday life problems (Dewaele *et al.*, 2014). Various approaches were employed by informants to resolve the challenge of being a gay man in Thai society. A health promotion strategy could place a heightened importance on the individual life situations of gay men. An individual consultation might also be beneficial in exploring and guiding them to address their individual difficulties more personally and in turn reduce the possibility of mental health issues developing. Being more self-aware as to the effect of discrimination and stigma causing them to be socially isolated might also assist these informants to build their self-esteem and focus on healthier coping strategies (Table III).

Discussion

Thailand, as a predominantly Buddhist country, is home to a range of sexual identities pertaining to gender and because of this all sexual variations must be included in the dissemination of information regarding HIV infection. The serious concern for MSM regardless of their assumed sexuality, or location in the country, is the increasing risk of contracting HIV. Of particular interest there is a current societal perception that homosexual behaviour is directly related to HIV infections in the Thai heterosexual population. This perception has served to generate socio-cultural and religious bias and blame towards MSM. A psychological burden of blame has been shown to further impact on the mental health of gay men living with HIV/AIDS (Ojanen, 2009; Darawuttimaprakorn, 2012; Mutchler, 2004). Thai community nurses with mental health promotion interests who focus on some of the issues of identity, self-esteem, familial support, early intervention; and reducing stigma and discrimination can be of great benefit to the gay community at risk, but also to those men already living with HIV.

Table III Self-perception-related stigma

Theme	*Representative quotes*
Being accepted and accepting self	It does not depend on your family. It is more about yourself. If you are confident about what you do that it is the right thing. It does not have anything to do with custom or culture. You do the right thing and it is only your sexual preference, correct? (18, 3)
	At this point no. I like it this way. I can accept myself. Comparing to the past when I didn't have breasts or haven't had gender reassignment operation. When I have a boyfriend, I feel that I have someone who loves me for who I am. So I am okay with this (23, 2)
Identity concealment – an uncomfortable life	I used to be very serious about people finding out that I was gay. I don't think my family would have liked me being effeminate gay guy, so I tried to be more masculine and not be too open (21, 1)
	I just live a normal life. I am from provincial town, so I have to hide it a little[…] (Laugh). I was afraid that others will look at me in the bad way, so I escaped to Bangkok. I felt more freedom (12, 1)
Coping with social pressure	Actually, I felt much better […] I think that I get to live my life to this day because it is takes time. Time passes by day, by month and by year and it makes me stronger. Sometimes I took younger friends to get tested and they could not handle it. So I told them it takes time as I had the same feeling too. Time will tell. In the past, I listen to soft music. It is relaxing, or I might just walk around in the park looking at trees. I like fields. Sometimes I just got on the free train and just went around looking at fields, green trees. It was fun (12, 9)

Unfortunately, it appears from this small study that social and sexual discrimination and stigma is still common towards the Bangkok gay male fraternity (Darawuttimaprakorn, 2012). Some of this discrimination appears to be related to HIV infection and fear of AIDS but is also due to the fact that MSM and being gay is not the norm for heterosexual Buddhist Thailand. Such negative attitudes towards gay men in this study contribute to them feeling ashamed and blamed for what is a much larger public health and social problem. The effeminate behaviours of some men also expose them to the negative attitudes of others who are unaccepting of gay sexuality. Family background was found to be one of the significant factors influencing the stigmatisation of gay men in this study, limiting their everyday lives by marginalising them from family and mainstream social involvement. Having a non-accepting family is also known to have a deleterious effect on mental health and emotional resilience (Felix, 2014).

To highlight the extent of isolation and subsequent stigma some of the informants chose not to disclose their gay status in order to retain their equanimity in their workplace (Matzner, 2015). HIV positive gay men reported having to hide their HIV status and isolate themselves from the Thai community to eliminate further troubling situations in their lives (Preston and D'Augelli, 2013; Smit *et al.*, 2012).

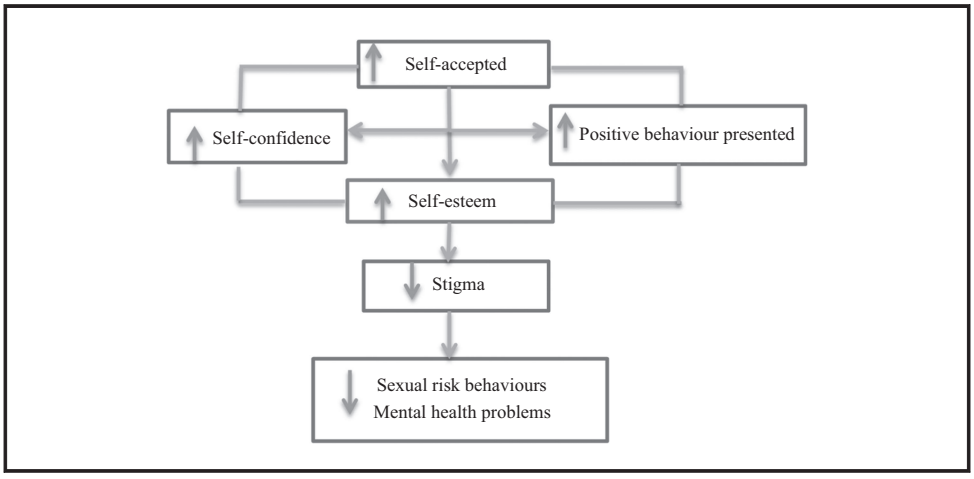
Stigma is also known to be partly responsible for a lack of condom use, because gay men feel uncomfortable when asking for condoms, experiencing embarrassment and actively avoiding negative attitudes from others (Hubach *et al.*, 2015). It is, therefore important to work towards a modification of this subcultural viewpoint about the perception of being shamed when buying condoms. This ethnography found that gay informants who accepted themselves as being gay had stronger self-esteem and were able to be gay in a positive way. For example, they were comfortable to express their individual sexuality and were not anxious about a gay identity. Such an attitude was reported to lead to greater social acceptance and emotional stability. Strong self-esteem in gay men serves to eliminate stigma and may reduce sexually risky behaviours for some (Courtenay-Quirk *et al.*, 2006; Felix, 2014; Udall-Weiner, 2009).

A recent study signposts that self-esteem is also relational to HIV disclosure in HIV positive gay men (Moskowitz and Seal, 2011). The relationship of self-esteem to sexual risky behaviour in the findings of this study is illustrated in Figure 1.

Conclusion

The findings of this study whilst qualitative and not generalisable highlight a number of important discrimination and stigma foci related to the study informants living in Bangkok. A key feature of the collective informant experiences is the notion of their identity being spoiled in the eyes of others who do not accept their sexuality. It does seem as if the development of solutions which

Figure 1 The relationship of self-esteem to sexual risk behaviours



inform public opinion and policy to change negative views about Thai gay men is warranted. Perhaps one mental health promotion approach worth exploring is to tax the entertainment industry where male sexuality is exploited and use this funding to promote humanitarian, mental health and health promotion to support Thai men living with HIV/AIDS. A negative perception towards same-sex relationships can be found in Bangkok and more broadly in Thai society and gay men experience social and cultural limitations because of this lack of acceptance. Further emic exploration of the socio-cultural perceptions about MSM in Thailand will assist to inform acceptable approaches to HIV prevention, mental health promotion, mental health nursing and public health innovations.

Stigma and discrimination should be further addressed in public HIV prevention programmes and health education, to eliminate shame and blame towards the male gay community. For community nurses providing healthcare and mental health support to gay men, respectfully engaging family support (with client permission) may assist to keep the family structure intact and to become more accepting. Perhaps helping to break the news to families in an informed and compassionate manner is another support function for community nurses and their *chaay rak chaay* clients.

Limitations

This study was conducted with informants residing in the Bangkok gay community and reflects the experiences of men in this geographical region which may have distinct social and cultural variation and cannot be generalised to gay men living in other regions in Thailand. Findings, however, can provide deep insights and a better understanding of this Bangkok-based group that can be used to design additional studies. In addition, these findings are tentatively related to real life issues for gay men across the country.

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Public involvement in public health research

Julian Ashton

Abstract

Purpose – *The purpose of this paper is to examine the progress in public and patient involvement (PPI) in public health research, and identify the relevant problems and solutions.*

Design/methodology/approach – *To explore the advantages and drawbacks of PPI in health research, drawing on studies which have looked at the barriers to effective PPI, as well as the benefits to all parties.*

Findings – *Guidelines have emerged from recent research for the process of PPI throughout a project; however different schemes for PPI will apply, depending on the context.*

Research limitations/implications – *There are not many well-researched studies into PPI in this area. A frequent limitation in research projects is that there is not sufficient provision for PPI. The implication is that more time and funding should be made available for well-planned PPI.*

Practical implications – *Researchers need to find more ways for involvement, as well as optimising current methods.*

Social implications – *The growth of PPI has opened up channels of communication and developed new roles for people in research, who would not otherwise be involved.*

Originality/value – *The paper draws together a range of studies in an original way, as well as using some unpublished material. It is an area of current interest.*

Keywords *Review, Implementation, Public, PPI, Community-wide*

Paper type *Viewpoint*

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Given its name, it might be expected that public health research would lend itself to public involvement, but in practice that does not appear to be the case. The man in the street has generally been the subject of and participant in public health research, and often the audience for the results. 12 years ago, public and patient involvement (PPI) became a requirement for research projects that are part of the UK Clinical Research Network portfolio. The need to develop PPI led to the establishment of INVOLVE (2014), a national advisory body, by the National Institute for Health Research (NIHR), continuing to take a lead on PPI throughout NIHR. As public involvement grows, its definition has been refined. The extent of involvement in the UK is estimated by the NIHR (2015, pp. 20-21). This document also briefly describes positive and negative aspects (NIHR, 2015, pp. 33-34).

Where public involvement has been programmed into research, there have been problems in some areas, but evidence of both the positive and negative impacts has grown slowly in recent years (Brett *et al.*, 2014; Boote *et al.*, 2002; Oliver, 1995). In a systematic review (Brett *et al.*, 2014), the challenges to good PPI were examined: "because of problems of colliding worlds, where priorities, motivations and ways of working differ and science gets congested, causing conflict and power struggles between researchers and service-users". This is not the usual picture, and it should be noted that similar conflicts can arise where the public members are professionals. The same review describes involvement: "a unique perspective of the lived experience of the condition under investigation is what brings added value". However, if the experience is expected to be specific to the relevant condition, this underestimates the ability of the "expert patient" to relate to experience of other conditions, which may not be closely related. Each patient's experience is unique, so being able to relate to others with the same condition has similarities with relating to people with other conditions.

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A distinction is drawn between public involvement at one point in the course of a study, and integration with the project. For some years, funding from bodies such as NIHR has been conditional on planning for PPI to be part of the work at various stages. The systematic review, Brett *et al.* (2014) found that, "the better the training, planning and procedures that are put in place, the clearer the definition of roles, the more positive the attitude towards PPI and the greater the trust and respect that parties (users, researchers, clinicians, funders, policy makers) have with each other".

As a positive example of PPI in research, The Watcombe Study (Somerville *et al.*, 2002; Barton *et al.*, 2007) was a randomised controlled trial (RCT) of the effects of improved housing conditions on the health and well-being of residents. The project came about following a community development worker being assigned to the Watcombe area of Torquay in 1994, which was in turn response to the concerns of primary health-care workers. The community development worker helped residents survey their homes for dampness and record respiratory symptoms. The results prompted Torbay Council to initiate a major improvement programme on housing in Watcombe, and to work with the Health Authority and University of Plymouth for the main research project (the results did not show improvements for all groups: for asthma, adults showed a significant reduction in symptoms, but not children, and there was no change in arthritis or rheumatism). This was one of the first large-scale RCTs in the UK on a community-wide intervention.

Integration of PPI in a project is sometimes enabled by the appointment of a service-user researcher, for example at the University of Lancaster Centre for the Study of Bipolar Disorder. The role includes developing opportunities for service users to take part in, and/or be involved in research. In recent years, Rita Long, the Post-holder has co-authored four publications (Jones *et al.*, 2015; Lobban *et al.*, 2015, p. 201; NIHR PAREDES Psychoeducation Study Group, 2016). A service-user researcher works with researchers on a comparable level; however the inclusion of a service-user researcher does not necessarily mean that PPI is well integrated in a particular project.

The workings of PPI are clearly shown in the evidence of the RAPPORT study (Wilson *et al.*, 2015). This study set out to examine different approaches to PPI, and how they might affect the processes of research. Information was derived from 182 UK studies in key health subject areas. In total, 22 case studies were then given a realist in-depth evaluation, including four public health studies. The background to the study (Howe *et al.*, 2016, pp. 2-3) specifies six factors which need to be present for positive PPI, summarised as follows:

1. shared understanding of the purpose of PPI between researchers and PPI representatives;
2. co-ordination of PPI by one individual;
3. PPI representatives having a strong link with the study population;
4. engagement of the whole research team with PPI input.
5. relationships established and maintained over time; and
6. evaluation of PPI, proactively and systematically.

It was reported that "the majority of researchers and PPI representatives felt that PPI is worthwhile" and that "case studies with the most embedded PPI were likely to demonstrate the greatest number of PPI-related outcomes. These studies were also likely to demonstrate outcomes from the moral perspective, such as increased self-worth for lay representatives".

Following the RAPPORT study, the IMPRESS study (Researching the implementation and evaluation of PPI in CLAHRC East of England Research) looked at the embeddedness of PPI in a regional, multidisciplinary, applied health research programme. In total, 16 relevant projects completed questionnaires, and 10 were followed up with in-depth interviews. Lead Researcher, Julia Keenan, reflects on the background to the study (IMPRESS, 2016a).

"Innovations don't always translate into the real world very well; when we try to implement something like PPI within organisations or research institutions, there are sometimes problems with communication, and whether they fit with the existing values and routine practices".

Some conclusions reinforced the points mentioned from the RAPPORT study, and barriers to successful PPI were delineated, including lack of awareness of PPI groups and lack of recognition of researchers' time and energy for PPI. It was emphasised that work needs to be done within a project, nurturing relationships between researchers and PPI groups.

Fiona Poland (IMPRESS 2016b) addresses action points arising from the IMPRESS study, which round up the subject. Some salient points are:

- the need for more training, education, advice and discussion around PPI;
- support for PPI initiation before and maintenance between projects; greater transparency and sharing of project reports with PPI representatives; and
- mobilising PPI for translating research into practice.

Developments in understanding PPI indicate that there will be larger numbers getting involved in research. Wider involvement could, where appropriate, include seeking the opinions of a broader range of the public than usual on selected research questions, by means of online questionnaires; some projects have done this using the Delphi system (Iqbal and Pipon-Young, 2009).

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Book review

Military Veteran Psychological Health and Social Care

Edited by Jamie Hacker Hughes
Routledge
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Keywords Social care, Veterans, Psychological health, Mental health policy

This book covers a key area of UK mental health policy that is in need of development: veterans' health and social care needs. A recent issue of the *Journal of Public Mental Health* demonstrated widespread interest in the mental health of veterans (Green, 2017). Professor Hacker Hughes has extensive, personal experience with both the UK Military and with NATO (so this book contains some interesting international material, especially a Dutch perspective on their National Veterans Healthcare System). The back cover mentions a number of potential types of reader and the Preface ten more types. Here, I can only respond on behalf of three types of reader: commissioners of services, academic researchers and family carers.

Routledge have published what Air Vice-Marshal Lock rightly calls "a mass of contemporary knowledge". That mass is presented in 13 chapters with 26 authors. The risk with publishing such a multi-author book is an inconsistent literary style and difficulty synthesising information from different chapters. For example, three chapters deal with the services in specific geographical areas (Scotland, Wales and North West England), but it is impossible for readers to compare data from these three chapters directly. The Introduction does an excellent epidemiological job of setting the scene, explaining why veterans compose "a population with unique qualities and specific needs". However, if the order of the next ten chapters was shuffled randomly, I doubt if a reader would notice any change in this book's disconnected literary flow or development of ideas. General the Lord Dannatt thinks that the book will have value for "the general reader", but I cannot imagine who reads it from cover to cover, just for reading pleasure or intellectual stimulation. My guess is that the commissioning editors at Routledge did not maintain consistent dialogue with the 26 contributors during the evolution of this mass of contemporary knowledge?

Military Veteran Psychological Health and Social Care contains much rare and valuable material. For a commissioner, the chapter on the Scottish perspective is outstanding. This places services for veterans within the wider systems of care and gives a clear voice to service users. There is a balanced picture of social and health needs, and a sense of building relationships across people and organisations. In public health training that competence is called "collaboration for health". Commissioners typically have responsibilities for a range of service users over time, so it is valuable to see evidence of their trajectories within the health system (e.g. Rona *et al.*, 2017). The chapter on the Veterans and Reserves Mental Health Programme for British Forces (VRMHP) provides food for thought on future research. There can be many strands to the life story of one ex-service person, and their mental condition may change over time, after their service ended. A reservist's experience of care involving both an NHS general practitioner and the specialist VRMHP suggests future research on the integration of care, and links with community support at critical times. Another chapter which gives a voice to service users deals with veterans' children. This includes a key lesson for schools:

> Schools should make every effort to *really* understand the culture and context in which these children have lived when part of the service community and how this may impact on children going forwards.

The final chapter gives an international perspective on transition. For readers who dip in and out of this book as a reference text, or who use it in coursework within a postgraduate degree, this chapter offers some balance: a veteran is not just some liability, but also bring assets to civil society:

> Veterans are most noted for their ability to work in a fast-paced, changing environment; as well as their leadership, teamwork, flexibility, dependability, integrity and loyalty.

Probably the last, comparable, book to *Military Veteran Psychological Health and Social Care* on the health of UK veterans was published in 2009 (by the Kings Centre for Military Health Research). This new book provides a valuable update. It also contains some nuggets of real gold.

Woody Caan
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