



North Tyneside Social Prescribing Hub

Mental Well-being Impact Assessment (MWIA)

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THE IMPACT OF A NORTH TYNESIDE SOCIAL PRESCRIBING HUB ON MENTAL WELL-BEING

1. INTRODUCTION

Social prescribing is an innovative approach to provide a parallel pathway to conventional medical prescribing. Health and social care staff are facilitated to offer social and leisure activities to those who may benefit from participation in such activities ('taking part'). This is a population approach towards taking part, it is wholly inclusive, and activity groups are available to everybody, through to those with disabilities or in recovery from mental illness. The pathway aims to provide social inclusion and participation, increasing resilience through a sense of autonomy, choice and control for those who participate in activity. The service facilitates primary and secondary prevention of poor wellbeing.

2. AIMS OF THE MWIA ASSESSMENT

- To identify how a North Tyneside Social Prescribing Hub potentially impacts on the mental health and well-being of residents with mild to moderate stress/ anxiety / depression, social isolation
- To identify ways in which the project might maximise its positive impacts and minimise its negative impacts
- To develop indicators of mental well-being that can be used to measure, evaluate and improve the mental well being of residents with mild to moderate stress/ anxiety / depression, social isolation

3. WHAT DO WE MEAN BY MENTAL HEALTH AND WELL-BEING?

There are many definitions of well-being and mental well-being. The one that is often used, and which the MWIA endorses is:

Mental wellbeing "...is a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society."

Foresight (2009) *Foresight Mental Capital and Wellbeing Project (2008). Final Project report*. London: The Government Office for Science. (available: http://www.foresight.gov.uk/Mental%20Capital/Mental_capital_&_wellbeing_Exec_Sum.pdf , page 10)

Put simply our mental well-being is about how we think and feel.

4. METHODOLOGY

The Mental Well-being Impact Assessment (MWIA)

MWIA is an innovative and effective process to ensure proposals improve people's mental well-being as much as possible. MWIA uses a combination of methods, processes and tools to assess the potential for a policy, service, programme or project (proposals) to impact on the mental well-being of a population. It enables evidence based recommendations to be identified to strengthen the positive and mitigate against the negative impacts. It also

includes a process to develop indicators to measure improvement. It focuses on population groups who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being. It also makes the link with social determinants.

The DOH 'Making it Happen Guidance' for mental health promotion (2001) identifies four key areas that promote and protect mental well-being:

- Enhancing Control
- Increasing Resilience and Community Assets
- Facilitating Participation and promoting Inclusion

The MWIA is based on these key areas and helps participants identify things about a policy, programme or service that impact on feelings of control, resilience, participation and inclusion and therefore their mental health and well-being. In this way the toolkit enables a link to be made between policies, programmes or service and mental well-being that can be measured.

“How people feel is not an elusive or abstract concept, but a significant public health indicator; as significant as rates of smoking, obesity and physical activity” (Making it Happen, Department of Health 2001).

MWIA Workshop

The purpose of the workshop is to work with stakeholders to identify from their perspective the key potential impacts that a North Tyneside Social Prescribing Hub will have on the mental well-being of residents with mild to moderate stress/ anxiety / depression, social isolation. It will also identify actions to maximise positive impacts and minimise potential negative impacts on mental well-being

Table 1: Workshop participants

Role	No.	%
Third Sector Provider staff	9	43
Public Sector Provider Staff LA/Health	7	33
Public Health/Commissioners	3	14
Service users	2	10
Total	21	100%

5. FINDINGS FROM THE MWIA

What does mental well-being mean to the stakeholders in the project?

The participants were asked to write down words they associate with mental well-being. They were then asked to group them and link the words to come up with a definition of mental well-being.

mental well-being is....

*Feeling happy, content and fulfilled and having a sense of purpose and belonging.
Enjoying work, leisure and having positive relationships and support networks.
Absence of stress and worries and sufficient money to support needs. Able to make
a positive contribution, with hope for the future, and reaching potential.*

6. POPULATIONS MOST LIKELY TO BE AFFECTED BY THE NORTH TYNESIDE SOCIAL PRESCRIBING HUB

Public mental health aims to promote and protect the mental health of the whole population, while recognising that (as is the case for physical health) levels of vulnerability to poor mental health will vary among different population groups.

A profile of the community/ies that are living in the area that this Social Prescribing Hub is targeting suggests the following characteristics and needs:

Community Profile

North Tyneside - Population 197,300

The local Community Health Profile gives a picture of health in the area. It is designed to help local government and health services to improve people's health and reduce health inequalities. Health Profiles are produced every year by the Association of Public Health Observatories, and can be found at **www.healthprofiles.info**

Mid-2008 population estimate. Source: National Statistics website: www.statistics.gov.uk

The proposed social prescribing hub is for

- Adults +18
- People who find it difficult to engage/experience barriers to accessing activity (internal and external barriers)
- People with mild to moderate problems such as anxiety/stress/depression.
- NOT for people with good networks and activities already – affluent educated people who find their own solutions. Not for children and young people as referral will be to activities for adults.

These groups may experience barriers because of how they feel, or real barriers to access because of how things are set up.

Target Groups for the hub

- 1 in 4 at some time in life have a mental health problem
- 1 in 6 at any one point in time a mental health problem
- ½ adults experience depression
- 1 in 10 new mums experiences Post Natal Depression
- 1 in 100 population has severe MH problem
- 60% of adults in hostels have Personality Disorder
- 90% of prisoners estimated to have a MH problem and/or substance misuse problem.

- 25% of older people have symptoms of depression
- At any one time, approximately 0.4% of the population have a psychotic disorder such as schizophrenia or bipolar affective disorder.

It's important to think about the numbers and who we are targeting with this proposed social prescribing hub.

Mental Ill Health and Inequality

People with mental health problems tend to have fewer qualifications, find it harder to get work, have lower incomes, may well be homeless and are more likely to live in areas of high socio-economic deprivation. There is also a strong association between income inequality – relative poverty – and poor mental well-being and health.

Metro Map



This shows the average life expectancy for each metro stop area.

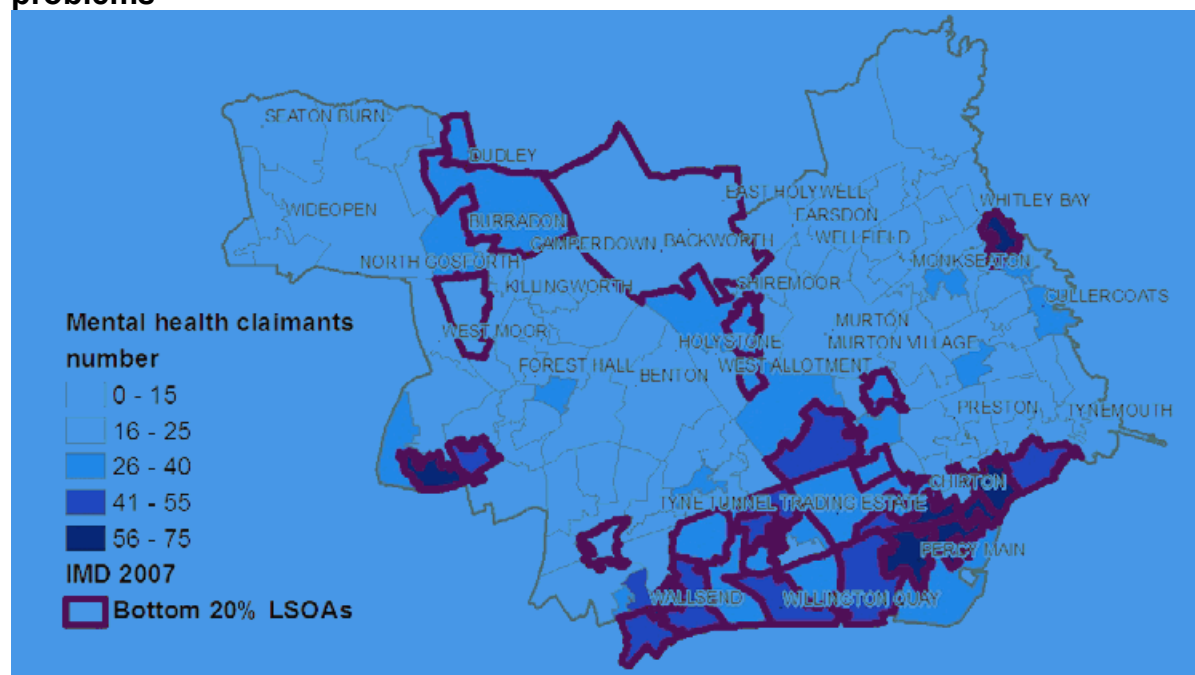
Between the most affluent (Cullercoats) and least affluent area (Riverside) the gap is greatest. A man will die 10 years younger on average in the most deprived area. The gap for women is 8 years.

North Tyneside at a glance

The health of the people in North Tyneside is generally improving, but is still worse than the England average. Levels of deprivation are higher and life expectancy is lower than the England average. There are inequalities within North Tyneside. Over the last ten years, the death rate from all causes in men and the early death rate from heart disease and stroke have continued to

improve. The early death rate from cancer has also improved but recently the improvement seems to have levelled off.

Working age claimants for Incapacity Benefit SDA for mental health problems



Numbers of people with mental illness on incapacity benefit in North Tyneside are currently above the national rate. Three thousand eight hundred and ten individuals received incapacity benefits for mental ill health in North Tyneside which is a rate of 31.4 per every 1,000 individuals of working age. This compares with a national rate of 27.7 per 1,000.

Source: (CHP - DOH / Association of Public Health Observatories 2009)

BME communities

There is significant evidence of the link between health inequalities and ethnicity (Acheson 1998), reflected in strategies over the last twenty years (National Association of Health Authorities 1988).

A joint commissioning strategy document (North Tyneside Council and NHS North of Tyne 2010) estimated that 3.9% of the population (reported as 195,000, with 120,400 people of working age, in a North Tyneside profile prepared by Government Office for the North East in 2007) are from black and minority ethnic communities, whereas a different report profiling minority ethnic communities, commissioned by North Tyneside council, calculates that this group make up 5.6% of the population, based on 2007 mid-year population estimates (Experian 2010). Analysis of the 2011 Census data will give a more accurate picture of the current population in relation to ethnic diversity.

- Different groups from EU migration, and core population

- The health of people in UK Black and minority ethnic communities is poorer than that of the majority white population by almost all health measures
- This group have three times higher admission rates
- Migrant groups and children have 2 to 8 times greater risk of psychosis
- Asylum seekers and refugees need support
- African-Caribbean people are particularly likely to be subject to Compulsory Treatment
- SE Asian women are less likely to receive timely and appropriate MH services

Dementia

There are 2583 people in North Tyneside with dementia both diagnosed and undiagnosed.

- 1221 known to GP's
- 1362 without a diagnosis

Just under half (47%) are diagnosed

Other Groups

- People with Learning Disability need mainstream access
- New Autism strategy raises the need for training and awareness
- Deaf People need accessible services
- People with Long Term Conditions & disabilities/violence/residential care/carers/criminal justice/sexuality/age religion/gender are all vulnerable.

We need to consider whether we are missing anyone out.

The stakeholder group were presented with the above information, and it was talked through with slides. The group were then asked to consider the following questions:

- Who are you most interested in
- Who will be most affected by the project
- Who could the project be most negative for
- Might this prescribing hub project increase inequality

During the discussion the group felt that some groups may have similar needs and barriers and so preferred to look at these as themes, in addition to considering particular groups. For example middle aged men and asylum seekers may not be engaged with a GP, albeit for different reasons.

In order to identify those communities that local stakeholders consider to be affected by a Social Prescribing Hub in common with the community profile, a discussion was facilitated. The findings are presented in table 2.

Socially Isolated OP. people. 3

Asylum seekers & Refugees

English not 1st language.

Anxiety disorders. Phobias

get it right 1st time.

Dementia.

Homeless people -

DVA. LGBT

People not reg. c & GP.

espec mid age men.

Table 2

Priority population group affected or targeted by your proposal
<ul style="list-style-type: none">• Isolated people – older people/LGBT (Lesbian, Gay, Bisexual, Transgender)• Anxious people – LGBT. People with phobias or in MH (Mental Health) services.• Those not engaged with GP/statutory services - middle aged men/asylum seekers• Those for whom English is not their first language or who have sensory impairment/deaf people/ asylum seekers/ BME groups• Those with physical disability• Those with dementia /cognitive impairment

7. WHAT ARE THE KEY IMPACTS OF A SOCIAL PRESCRIBING HUB ON MENTAL HEALTH AND WELL-BEING?

The MWIA toolkit provides a three factor framework for identifying and assessing protective factors for mental well-being, adapted from Making it Happen (Department of Health 2001) and incorporates the social determinants that affect mental well-being into four factors that evidence suggests promote and protect mental well-being:

- *Enhancing control*
- *Increasing resilience and community assets*
- *Facilitating participation and promoting inclusion.*

Participants were introduced to the factors and asked to think about a social prescribing hub and rate how important it was to people with mild to moderate stress/ anxiety / depression, social isolation, and the potential impact that the service could have.

The Potential Impact of the a social prescribing hub on Feelings of Control

Enhancing control - the evidence

The extent to which individuals and communities have control over their lives has a significant influence on mental health and overall health. In a major global report on inequalities in health, the Commission on Social Determinants of Health identifiedⁱ '*control over our lives*' as one of three key domains for action and empowerment:

- Material resources
- Psycho-social (control over our lives)
- Political voice (participation in decision making)

Enhancing control is also a fundamental element of health promotion practice:

“Health promotion is the process of enabling people to increase control over, and to improve their health”.ⁱⁱ

A number of dimensions of positive mental health are related to a sense of control, including:

- agency (the setting and pursuit of goals),
- mastery (ability to shape circumstances/ the environment to meet personal needs),
- autonomy (self-determination/individuality)
- self-efficacy (belief in one's own capabilities).

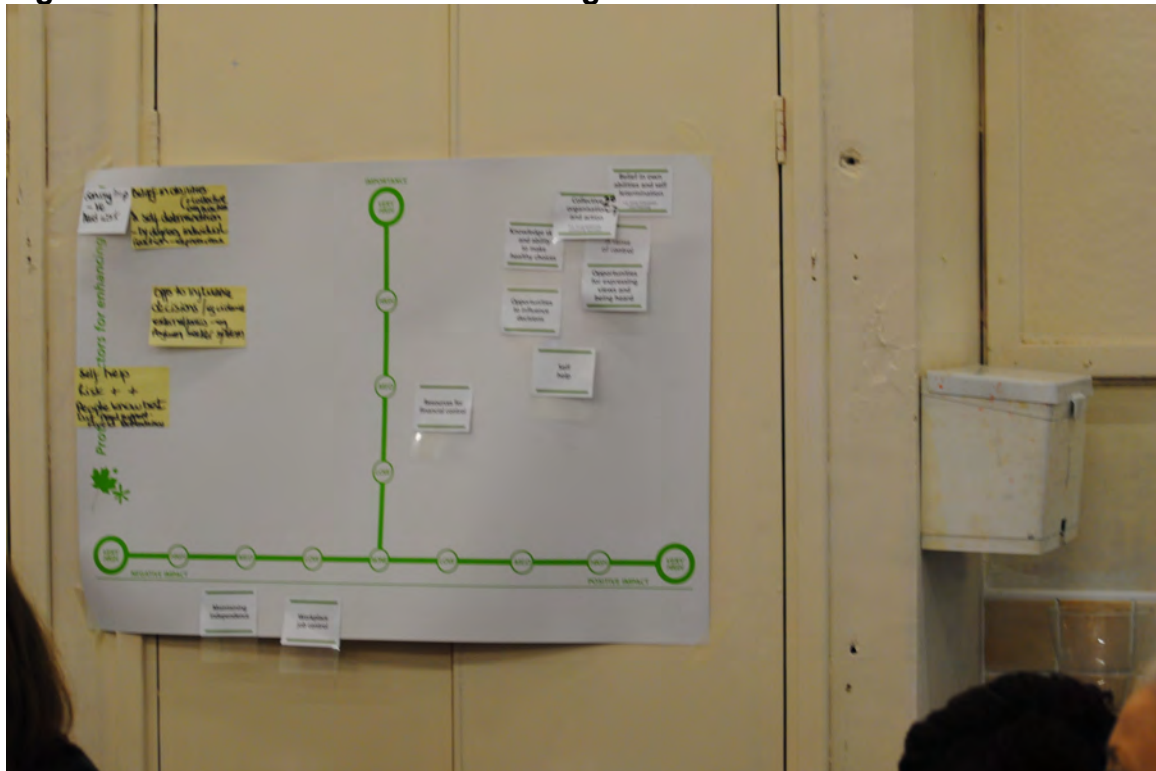
Recent research suggests that a degree of control or autonomy is a determinant of mental well-being across all cultures. Lack of control and lack of influence (believing you cannot influence the decisions that affect your life) are independent risk factors for stress. People who feel in control of their lives are more likely to feel able to take control of their health.

Some of the evidence on the relationship between control and health comes from workplace studies on levels of job control, which show that job control, effort reward balance and social support have an independent influence on health outcomes:

- Work which provides fulfilment and allows individuals control over their working lives confers considerable health benefit
- Types of job which are lacking in self-direction and control have far fewer health benefits, and people with such jobs have consistently higher rates of mortality and morbidity
- Low job control is associated with increased sickness absence, mental illness and cardiovascular heart diseaseⁱⁱⁱ as well as with markers of stress response e.g. lower levels of cortisol and blood pressure
- Evidence from Sweden shows how changing employment conditions towards less job security and control are impacting upon people's health and well-being in a high income country, influencing rates of cardiovascular disease, alcohol misuse and suicide
- Factors which diminish a sense of control, for example job insecurity, low pay and adverse workplace conditions may be more damaging than unemployment, notably where high unemployment is the norm.

Participants were then invited to work between themselves to identify which of the factors that contribute to a sense of control that they felt a social prescribing hub had the potential to have either a positive or negative impact, and the degree of importance of that impact. The results are presented in figure 1.

Figure 1 Prioritisation Grid - Increasing control



Having identified these, participants were invited to work through their top three priorities to identify in more detail the potential impacts and any recommendations that emerged.

Each factor is listed below, with a brief summary of the discussion.

The top priority results are presented in table 3

Prioritisation Grid – Protective factors for enhancing control

Resources for financial control

Medium importance, low positive impact

Some people would have financial issues and others wouldn't. A secondary impact may be increased confidence and information to deal with this, but as sessions are free, or people can choose to pay wasn't felt to be of great importance. Worry about finances can take over, people may need signposting.

Self help

Medium to high importance, high positive impact

Also potential for very high negative impact

It was felt that there is a risk that people may become dependent. Some people like to be told what to do. There's a balance between the belief that people know best what they want and how do do it and providing the appropriate level of support without creating dependency.

Opportunities to influence decisions

High importance, medium positive impact

Also potential for medium to high negative impact

Some people may have a sense of heightened helplessness if there are external forces over which they have no control and which impact upon attendance – eg. A violent partner or in the asylum system. Fear of getting things wrong Expectations may not be high for all. Some people can't articulate their views or wishes. Need to know why people drop out.

Knowledge skills and ability to make healthy choices

High to very high importance, medium positive impact.

This isn't about forcing people to hear messages but supporting them to enhance esteem and value themselves, their wellbeing and therefore their health. could be negative if people told what not to do . There's a risk of highlighting a sense of inadequacy/failure, for example for people with addictions.

A sense of control

High to very high importance, high positive impact

This will be enhanced by the hub if people are supported to navigate the system.

Opportunities for expressing views and being heard

High to very high importance, high positive impact

Taking part in appropriate activities with good facilitation will support this.

Collective organisation and action

Very high importance, very high positive impact

This was felt to be a secondary impact. If people follow on to volunteering or becoming a peer supporter, and running self led groups, this would impact on communities. Need to understand barriers to this.

People have a lot to give/offer. Some could gain more skills and so facilitate increased community capacity. Hub offers a structure and framework to enable community development.

Belief in own abilities and self determination

Very high importance, very high positive impact

Also high negative impact

If things go well for a person then a sense of meaning and purpose will be enhanced. However it was felt that not everybody is of the same ability, and some may have a sense of having to work harder to achieve. For example people with sensory or physical disabilities may see others finding things easy, and may be struggling themselves. People will have individual reactions to the situations they find themselves in. Project needs to raise self esteem, not everybody starts at the same point. This depends on abilities, low esteem can cause anxiety in new situations.

Workplace job control; also maintaining independence, weren't discussed.

Table 3

Protective Factor - Control				
Top 3 Priorities	Impact of your proposal on this protective factor			Actions identified
	Positive	Negative	Unclear	
Belief in own abilities and self determination	+	- By degrees people have individual reactions. (drop outs /expectations) Harder work for some people e.g. sensory impairment		More resources needed for some people. Specialised training/staff facilitation (to support) Physical and addressing barriers/ language. Integration/? evidence for separate groups eg. Asian women (culture/religion) research into barriers – recognise individuality and different needs for support.
Opportunities to influence decisions	+	- People in a system experience external forces – eg asylum seekers Anxiety, financial pressure, chaos can't engage		Folk in system e.g. refugees need peer support with a similar community champion ?role for hub to contextualise a persons situation (depersonalise it - not their fault) Be realistic manage expectations – be honest – things might end or stop.

<p>Knowledge skills and ability to influence healthy choices</p>	<p>+</p>	<p>Risk identified in discussion</p>	<p>Drug & alcohol dependency Creating the right environment Risk of highlighting sense of inadequacy/failure Is activity failure free for all</p>	<p>Identify negative impact if a person drops out- follow up Evaluate Ask about improved health/feelings How does it evaluate for factors. Are healthy choices being made? Follow up everybody did people get what they want Avoid pushing healthy change onto people Facilitation & signposting. Intrinsic awareness How do we know it's occurred. How to Monitor Negative Impact?</p>
<p>Collective organisation and action</p>	<p>+</p>		<p>We don't know everything that's a barrier</p>	<p>Involve people in running the org</p>

The Potential Impact of a Social Prescribing Hub on Resilience

Increasing resilience and community assets – the evidence

“Communities have never been built upon their deficiencies. Building community has always depended upon mobilising the capacities and assets of people and place.”^{iv}

“Resilience reflects the extent to which communities are able to exercise informal social controls or come together to tackle common problems. It is people's social networks, more than any physical characteristics of place, that appear to be most crucial in creating a sense of attachment to place.”^v

Resilience is broadly defined as “doing better than expected in the face of adversity”. The evidence on resilience is part of an emerging literature on salutogenesis^{vi} (Salutogenesis asks, “What are the causes and distribution of health and well-being in this group, community or country population?”. Epidemiology asks, “What are the causes and distribution of disease and early death in this group, community or population?” Health assets and capability are concerned with the determinants of health, rather than the causes of illness.

A focus on resilience and assets helps to explain the factors that protect some individuals and communities, notwithstanding adverse conditions/exposure.

A major programme of research^{vii} exploring common factors that make resilience possible and increase human capability found that these “*mostly have to do with the quality of human relationships and with the quality of public service responses to people with problems*”.

- Attachment to place, which is one characteristic of resilient communities, is closely related to strong social networks.
- For older people, high social support pre and during adversity increased likelihood of resilience by 40-60% compared with those with low social support.
- Resilience in adolescence is strongly influenced by the strength of social relationships and has powerful effects, including an increased likelihood of escape from social and economic disadvantage, a lower risk for psychological problems in adulthood and protection in the context of continuing disadvantage.
- Friends, support networks, valued social roles and positive views on neighbourhood, reduce the risk and severity of emotional and behavioural disorders among young people.

The fact that social relationships are a core feature of resilience (at all levels) highlights the importance of including social outcomes in MWIA and of a greater focus on how decisions affect “*community connections*”: the opening or closure of a local shop, swimming pool, park, post office.

Factors that influence individual and collective capacity to build and maintain relationships include transport, design of public space, work/life balance, access to green, open spaces, informal labour markets and opportunities for collective organisation and action. There is a strong correlation between

socio-economic disadvantage and poor social networks/social support. While there is robust evidence that levels of social support enhance mental health, people's mental health may influence capacity and motivation for forming and maintaining social relationships.

Public policy also influences resilience. International comparative studies show that contact with public welfare that transmits or reproduces stigma and humiliation undermines resilience in poor households and is a possible reason why poverty is more damaging to health in the UK than in Sweden, for example. This research echoes evidence from mental health service users about the negative influence of low expectations and discriminatory attitudes among professionals.

Table 2.1: Examples of Community Assets

<ul style="list-style-type: none"> • Know how • Creativity • Resourcefulness • Tradition • Intergenerational solidarity • Collective efficacy 	<ul style="list-style-type: none"> • Equity • Control • Safety • Participation • Local democracy • Social networks • Mutuality • Trust 	<ul style="list-style-type: none"> • Culture • Sport • Lifelong learning • Access to nature • Shared public spaces • Informal economy • Tolerance
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Research on resilient localities and/or communities attempts to explain why poverty or other adverse conditions are more damaging in some places than in others. Although the explanations for resilience in these studies are not conclusive, they might include a stable population (i.e. factors that strengthen neighbourhood attachment), selective migration and protective characteristics of the community e.g. collective action.

Communities with high levels of social capital, indicated by norms of trust, reciprocity and participation, have advantages for the mental health of individuals, and these characteristics have also been seen as indicators of the mental well-being or resilience of a community. Indicators of social fragmentation and conflict in communities, as well as high levels of neighbourhood problems influence outcomes independently of socio-economic status. For example, there is some evidence that informal social control (willingness to intervene in neighbourhood threatening situations, e.g. children misbehaving, cars speeding, vandalism) and strong social cohesion and trust in neighbourhoods, mitigates the effects of deprivation on mental health for children.

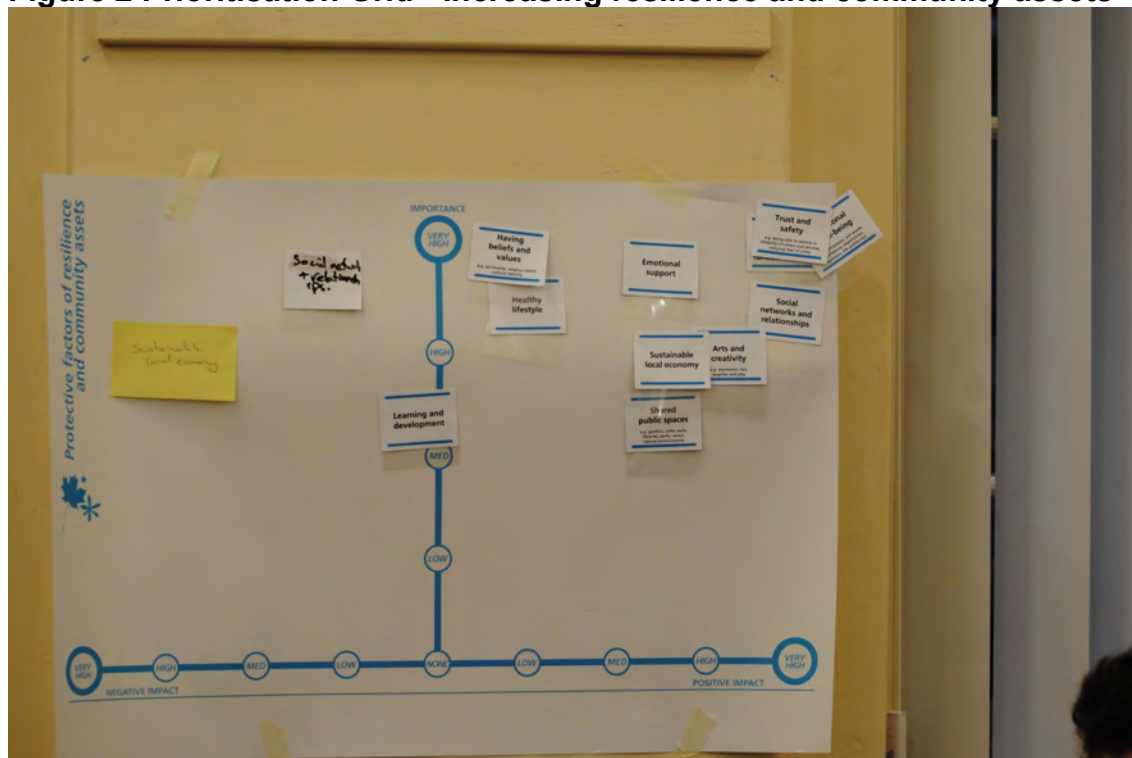
A growing body of evidence suggests that nature and access to the natural environment strengthen the resilience of individuals and communities; populations exposed to the greenest environments (parks, woodlands, open spaces) also have lowest levels of income-related inequality in health. Possible mechanisms include stress buffering, physical activity and the direct

relationship between contact with nature and reduced blood pressure (see section 2.5).

Both individual characteristics (affect, cognitive and social skills) and social context (peers, social networks, social support, and relationships) contribute centrally to resilience and may buffer the effects of material factors (low income, debt, lack of access to healthy products). However, economic adversity has a significant influence on factors that influence resilience; one hypothesis is that psycho-social resilience confers protection among equals, but is generally trumped by material advantage.

Participants were then invited to work between themselves to identify which of the factors that contribute to a sense of resilience that a Social Prescribing Hub had the potential to have either a positive or negative impact, and the degree of importance of that impact. The results are presented in figure 2.

Figure 2 Prioritisation Grid - Increasing resilience and community assets



Having identified these participants were invited to work through their top three priorities to identify in more detail the potential impacts and any recommendations that emerged.

Each factor is listed below, with a brief summary of the discussion.

The top priority results are presented in table 4.

Prioritisation Grid – Increasing Resilience and Community Assets

Art and Creativity

High importance, high to very high positive impact

This was felt by the group to be “vital to society” and that the hub would be able to inspire involvement in these activities. It was also felt that this would have impacts on other factors that were important to the client group such as social networks.

Trust and Safety

Very high importance, very high positive impact

“If the hub doesn't provide this, it is failing”

Necessity of participants feeling safe at the entry point and if they don't, they are unlikely to access facilities over time.

Ability to understand, think clearly and function socially

Very high importance, very high positive impact

Especially relevant to older people with mental health problems.

Social Networks and Relationships

High to very high importance, very high positive impact, and low negative impact

Positive impact would be as a use to meet others, not necessarily with mental health problems.

Negative impact could be that it could keep people within certain groups and disadvantage diverse socialising, focussing on the illness rather than enabling aspiration and progression.

Emotional Support

Very high importance, high positive impact

Hub enabling peer support, and promoting support into a range of services that develop further support.

Learning and Development

Medium to high importance, no impact

Learning was felt to be a job of the workshops themselves, and as such the type and amount of learning would differ, and impact could swing either way. However, it was felt that the hub would be very important in terms of “gate keeping”, that is putting people in touch with the right opportunities to move on and develop.

Emotional Wellbeing

Very high importance, high positive impact

Emotional wellbeing is considered one of the most important impacts of the project.

Healthy Lifestyle

High importance, low positive impact

The low positive impact was felt because it potentially wouldn't be sustained in the long-term. There was a potential negative impact that if projects were short (10 weeks), there could be a disruption to the weekly routine and peer group for service users after building up some regularity/ recognition.

However, it was felt that for older people an intervention of 6 weeks would “make a world of difference”.

Sustainable Local Economy

High importance, high positive impact, and high negative impact

Positive impact in supporting local businesses and reinvesting local money in local services. Negative impact if the hub was to choose one workshop over another.

Having Beliefs and Values

Very high importance, low positive impact

Positive impact of inclusion in society and participation. Sharing values with peers.

Negative impact if there was stigmatising in workshops – if workshops were poorly facilitated and had elements of segregation. Respecting beliefs and values is of more core importance than helping participants to have belief and values.

Shared Public Spaces

Medium importance, high positive impact

Positive impacts around continuation of (self) care and opening up places to reduce isolation, allowing people to feel confident to meet up afterwards.

Table 4.

Priority	Positive	Negative	Unknown	Actions Identified
Social Networks and Relationships	Peer support – empathy Understanding Like-minded Non-judgemental Breaking down barriers – exposure and integration	Dependency Fear of unknown Low tolerance Stigmatising within the group	Person/ family responsibility Is it the hub's responsibility to engage with person/ family/ wide circle Conflict of client expectations and support networks expectations	Set expectations with participant and their support network – where does responsibility start and stop Inclusive groups irrespective of need Be clear about the offer at point of entry Ensure quality

				of groups – measured through client feedback
Trust and Safety	Feel safe and able to engage Recognise people Confidence More likely to engage in community More likely to engage with services Reduced isolation	Poor experience could result in disengagement and worse health Client could disappoint their support network by dropping out Increased dependence	How is this delivered to meet a range of needs	Good communication Adopt an attitude of “the door is always open” Review and reinforce a comparison of baseline and exit data and use stats to add context.

The Potential Impact of a Social Prescribing Hub on participation and Inclusion

Facilitating participation and promoting social inclusion – the evidence

Facilitating participation

Participation is the extent to which people are involved and engaged in activities outside their immediate household, and includes cultural and leisure activities, as well as volunteering, membership of clubs and groups, as well as participation in local decision-making, collective action, voting and other forms of civic engagement. Some aspects of participation may overlap with social support/social networks; however network rich individuals and communities do not necessarily participate in civic affairs. The percentage of people who feel they can influence decisions in their locality is an indicator for the cross-sector outcome “to build cohesive, empowered and active communities”.

For individuals, social participation and social support are associated with reduced risk of common mental health problems and better self reported health. Measures of social integration are highly correlated with risk of coronary heart disease. Voting abstention, possibly an indicator of low social capital, has negative lifetime health effects, over and above low socio-economic position.

Social isolation is an important risk factor for both deteriorating mental health and suicide. Similarly for recovery, social participation increases the likelihood, while low contact with friends and low social support decreases the likelihood of a recovery by up to 25%. Many cross sectional studies show a correlation between well-being, social ties and pro-social behaviour e.g. participation, civic engagement, volunteering. One longitudinal study found that well-being (positive affect) predicted participation in volunteering but volunteering also increased positive affect.

Participation in education and employment both have strong positive effects on mental well-being. Having a secondary qualification reduces the risk of adult depression by 5 to 7 percentage points; an effect that remains after work and family characteristics are controlled for. Other studies have found that women with low literacy skills were five times more likely than those with average or good literacy skills to be depressed. Research drawn from an analysis of BHPS data suggests a significant relationship between literacy and social engagement, which in turn may impact on mental well-being. Community participation is higher among men and women with higher literacy skills, while non-readers and those with poor basic skills are:

- less likely to vote or have an interest in politics
- less likely to participate in their local community
- less likely to belong to a membership organisation.

“To be literate is to gain a voice and to participate meaningfully and assertively in decisions that affect one’s life”.

Where we have comparisons, the effects of initial schooling on health are generally greater than the effects of subsequent adult learning. However, adult learning remains an important influence in positive outcomes in health and well-being amongst adults. There is some (limited) evidence that the health benefits of adult learning may be greater for those with less education than for others. Quantitative analyses of data from the 1958 National Child Development Study (NCDS) provide evidence for an association between participation in learning and self efficacy, particularly for adults who had low levels of achievement at school.

There is very robust evidence that participation in employment, notably good quality employment, is good for mental health and, even more unequivocally, that unemployment is bad for mental health.^{viii}

Promoting social inclusion

“...a lack or denial of access to the kinds of social relations, social customs and activities in which the great majority of people in British society engage. In current usage, social exclusion is often regarded as a 'process' rather than a 'state' and this helps in being constructively precise in deciding its relationship to poverty.” ix

Social inclusion is the extent to which people are able to access opportunities, for example employment, education, leisure, credit. It is often measured in terms of factors that exclude certain groups, e.g. poverty, disability, physical ill-health, unemployment, old age, poor mental health. People with mental health problems are among the most socially excluded on a wide range of indicators. For individuals, feeling useful, feeling close to other people and feeling interested in other people are key attributes that contribute to positive mental well-being. Social exclusion on any grounds is both a cause and consequence of mental health problems. Like participation, social inclusion plays a significant role both in preventing mental health problems and improving outcomes.

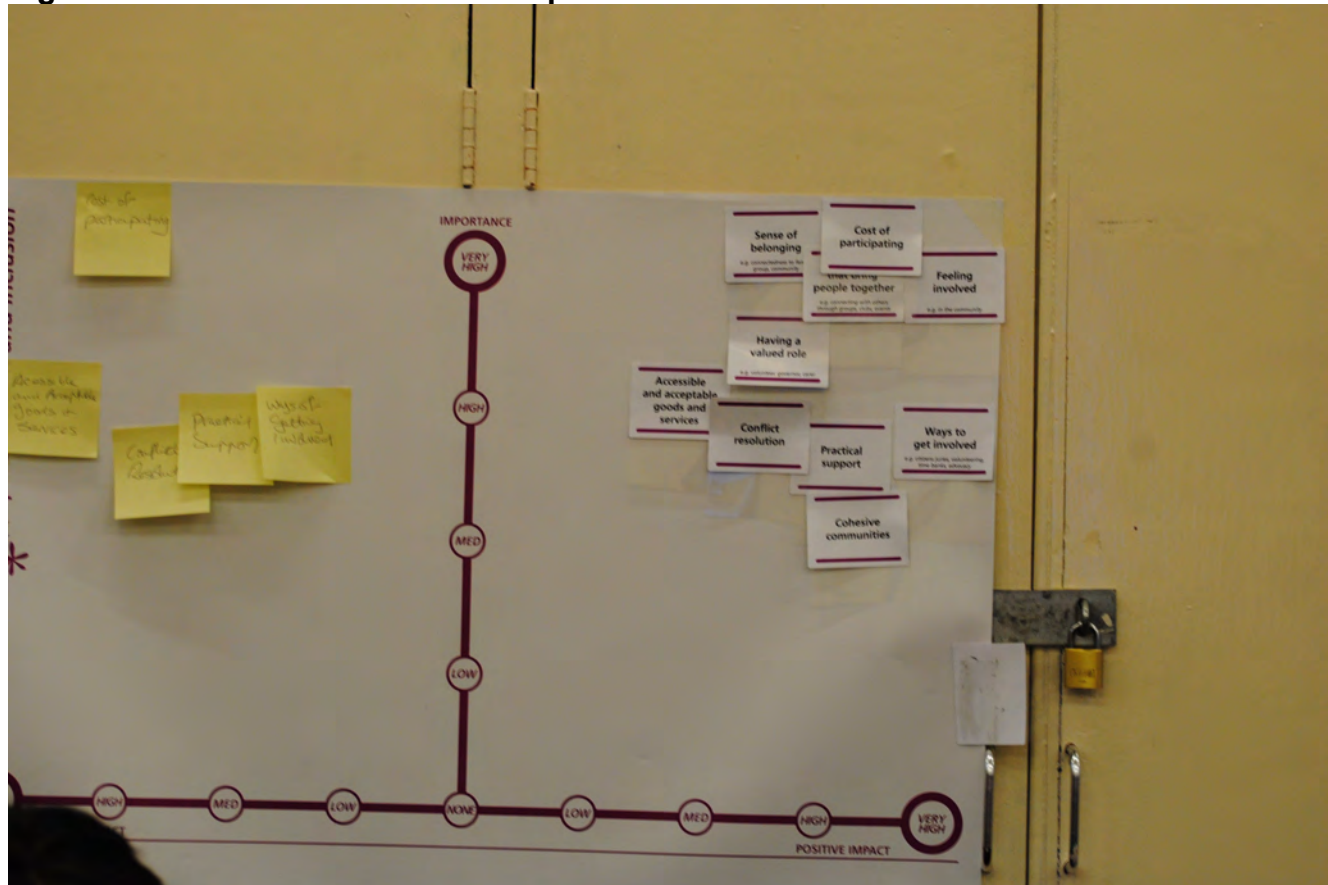
Factors influencing social inclusion include anti discrimination legislation and policies designed to reduce inequalities. There is a strong correlation between socioeconomic deprivation and levels of social integration. One study demonstrated a strong correlation between socio-economic disadvantage and social integration, using the following measures:

- availability of a confidant partnership
- close ties
- social participation

Participants were then invited to work between themselves to identify which of the factors that contribute to facilitating participation and reducing social isolation they felt a Social Prescribing Hub had the potential to have either a positive or negative impact, and the degree of importance of that impact. The results are presented in figure 3.



Figure 3 Prioritisation Grid – Participation and inclusion



Having identified these participants were invited to work through their top three priorities to identify in more detail the potential impacts and any recommendations that emerged.

Each factor is listed below, with a brief summary of the discussion.

The top priority results are presented in table 5.

Prioritisation Grid – Increasing Resilience and Community Assets

Sense of belonging

Very high importance, medium to high positive impact

This was felt by the group to be important for people who would be using the hub.

The hub would have a medium to high impact for the people -some more than others depending on how well the person fitted in. As TPW occurs in a number of different locations and this will promote a sense of belonging. It was noted that some people would not mind travelling if the activity was important to them. Potential drawbacks include negative group dynamics and now all groups are welcoming to every one.

Activities that bring people together

Very high importance, high positive impact

It is all about sharing and the hub should have a very high impact as it supports this. However this impact may be hampered to a degree, if for one reason or another, a person fail to realise a sense of belonging with what they are referred to

Feeling involved

Very high importance, very high positive impact

It has to be - the hub will connect people with what is going on in the community and this will very important for people who will be using the hub

Accessible and acceptable goods and services

High importance, medium positive impact and potentially very high negative impact

It has to be accessible to people and there are issues around accessibility such as transport or sensory needs. The negative side can be very negative is one has a bad experience- inappropriate advice can set one back instead of improving things. Activities need to be available at the right times to suit people and this is not always easy to deliver. Some people may end up having a negative experience if they are not sent on the right pathway and this can be detrimental. Vulnerable people coming through need sensitive and skilled approaches and if this is lacking a lot of things can go wrong.

Having a valued role

High to very high importance, medium to high positive impact and very high negative impact

This is a very important component for people who would be using the hub. The hub could potentially have a medium to high positive impact by creating the opportunities for people to experience a valued role. A sense of achievement is vital. However people with particular vulnerabilities could experience very negative impacts if they fail to gain a valued role. There is also the potential negative impact of being judged as not valuable in your own right. One could get stuck

Practical support

Medium to high importance, high positive impact, medium negative impact

It will depend on how dependent you are. Practical support is not there some people will struggle – physical, sensory, language, psychological barriers. Service needs to be bespoke and personalised. There is a need to be aware of the potential for dependency

Ways to get involved

Medium to high importance, very high positive impact, low to medium negative impact

The hub will encourage a range of ways of getting involved and the positive benefits of getting involved are well recognised. The negative impact relates to ways in which involvement could be curtailed by poor or inappropriate advertising

Cost of participation

Very importance, high positive impact, high to very high negative impact

It was felt that affordability would be a very important issue for hub users. The hub was seen as affordable and offering value for money. If people's resources are limited then accessibility is significantly compromised

Conflict resolution

Medium to high importance, medium positive impact, and medium to high negative impact

People need to feel at ease. The hub is likely to be good at this however if conflict fails to be resolved people may walk away and be unlikely to engage again. Groups find their own way of dealing with conflict and you may be referred to one where you don't gel. Vulnerable people may not have the negotiation skills and may need support and this would need to be picked up

Cohesive communities

Medium importance, high to very high positive impact

People are more likely to need the support of the hub if they are from non-cohesive communities. The hub will bring people together and help foster understanding and sharing. Question posed - do cohesive communities exist?

Table 5

Top two priorities for protective factor participation and inclusion to priorities

Priority	Positive	Negative	Unknown	Actions Identified
Sense of belonging	<p>Bring people of similar interest together</p> <p>Building relationships</p> <p>Connection with others</p> <p>Making friendships</p> <p>Sense of achievement</p> <p>Having a purpose</p>	<p>Isolating for people who don't fit in Led by what's available rather than need</p> <p>Unsuitable locations/times</p> <p>If peoples hopes are not achieved</p> <p>Move on without appropriate follow-up support</p>	It is not always clear what people want and need	<p>Make expectations and achievement of these clear</p> <p>Ensure baseline and evaluation in place</p> <p>Have a wide range of options for referring people to and know what available</p> <p>Appropriate training for staff</p> <p>Range of venues to suit different audiences</p> <p>Ensure move on is supported by signposting</p> <p>Have an exit strategy and make timescales explicit to people</p>
Activities that bring people together	Opportunity to choose activity that majority of people will find	Conflict – people who don't get on and conflict of values		Need risk assessment skills, policies, procedures

	<p>interesting</p> <p>Rolling programmes of events available</p> <p>Help people develop, learn and experience new things</p> <p>Help people to express themselves</p> <p>Learning from each other</p>	<p>Different expectations</p> <p>Comparing oneself with others</p> <p>Unable to achieve</p> <p>Barriers e.g. anxiety and shyness</p> <p>Risk when bringing vulnerable people together</p>		<p>Listen to service users and do consultations</p> <p>Check out skills and competence of providers and their risk policies. Pitch selling at right level for your audience</p> <p>Staff have the necessary skills and confidence Training in awareness raising, conflict resolution, people skills and group facilitation</p>
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Summary

The stakeholders identified 14 key determinants of mental well-being that were both of high importance and had a high impact.

MWIA Area	Increasing Control	Resilience	Participation and inclusion
Key Determinants	A sense of control	Activities that bring people together	Art and Creativity
	Opportunities for expressing views and being heard	Feeling involved	Trust and Safety
	Collective organisation and action	Cost of participation	Ability to understand, think clearly and function socially
	Belief in own abilities and self determination		Social Networks and Relationships
			Emotional Support
			Emotional Wellbeing
			Sustainable Local Economy

A focus on these for a Social Prescribing Hub will help promote the mental well-being of residents with mild to moderate anxiety and/or depression.

8. REVIEWING THE LITERATURE EVIDENCE BASE

The MWIA toolkit assessment criteria for the protective factors (discussed in section 6) are based on a review of the published literature that research suggests are helpful in promoting and protecting mental well-being. In order to build on this evidence base a short additional literature review was undertaken to identify, what if any, published research studies there may be suggesting that a Social Prescribing Hub may have an impact on mental well-being. This is intended to provide further evidence to substantiate or challenge the findings from the MWIA workshop.

A glass half full: How and asset approach can improve community health and well being, April 2010, Improvement and Development Agency's (IDeA) Healthy Communities Programme

Page 6 key messages-The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half-empty....One of the key challenges for places and organisations that are using an asset approach is to develop a basis for commissioning that supports community development and community building – not just how activities are commissioned but what activities are commissioned.

Our health, our care, our say (Department of Health 2006) sets out the government agenda for shifting resources towards prevention of ill health, increasing the range of interventions available to people, and promoting partnership between statutory health, social and third sector services. It supports *Choosing health*, the public health White Paper (Department of Health 2004), which prioritises the improvement of mental wellbeing.

The *Commissioning framework for health and well-being* (Department of Health 2007a) builds on *Our health, our care, our say* and promises to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home, and to tackle inequalities.

The framework advocates involving the local community in providing services that meet its needs, extending beyond merely treating people when they are ill to also keeping them healthy and independent; and it has a particular focus on partnership working.

Social prescribing for mental health – a guide to commissioning and delivery, CSIP Lynne Friedl Nov 2009

Page 5: Social prescribing has been quite widely used for people with mild to moderate mental health problems, and has shown a range of positive outcomes, including emotional, cognitive and social benefits. Social prescribing may also be a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Bates 2002; Gask et al. 2000).

Broadly, social prescribing is one route to providing psychosocial and/or practical support for:

- vulnerable and at risk groups, for example low-income single mothers, recently bereaved elderly people, people with chronic physical illness, and newly arrived communities;
- people with mild to moderate depression and anxiety;
- people with long-term and enduring mental health problems; and
- frequent attenders in primary care.

(Frasure-Smith 2000; Greene 2000; Harris et al. 1999)

Social prescribing may be particularly appropriate for isolated or marginalised groups, and for groups whose needs may be best met from within the voluntary and community sector (VCS). Some women and lesbian, gay, bisexual and transsexual people may find support from the VCS more accessible (Hutchison et al. 2003). Some black and minority ethnic (BME) communities have also expressed a strong preference for support provided within the BME voluntary sector (Mental Health Act Commission 2001; Department of Health 2003). In these cases, social prescribing via a referral facilitator or link worker can facilitate understanding between primary care providers and BME communities (Gillam and Levenson 1999).

Page 7 Short- and medium-term outcomes include:

- increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of positive steps for mental health;
- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services;
- increased levels of social contact and social support among marginalised and isolated groups;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression, in line with National Institute for Health and Clinical

Excellence (NICE) guidelines (NICE 2004);

- reduced waiting lists for counsellors and psychological services; and
- reduced levels of frequent attendance (defined as more than 12 visits to GP per year).

Page 8 The key activities that social prescribing involves – arts and creativity, learning, training and volunteering, access to the natural environment, sports and leisure – are consistent with wider goals for localities to:

- improve health, wellbeing and quality of life;
- reduce inequalities; and
- regenerate deprived communities.
-

Social prescribing can contribute to:

- increasing participation among those most deprived and marginalised;
- reducing social exclusion;
- helping people to actively manage their own health; and
- promoting employability.

9. APPRAISING THE EVIDENCE

In the community profile we identified target vulnerable groups who would benefit most from inclusion. Rather than target discrete groups we agreed that it would be better to focus on areas of need e.g. people not registered with GP. A list of the of the needs to address is detailed in section 3, table 2. The stakeholder group agreed that those groups which are most in need are the ones we are targeting with this project.

The benefits of participation for these vulnerable groups is well defined in the literature review as set out in section 7. There is strong evidence that participation improves well being, and that a social prescribing mechanism will remove barriers to participation for these vulnerable groups.

It is clear from the community profile, the literature review, and the stakeholder workshop (see APPENDIX THREE for collated table of issues/ actions/ comments), that social prescribing for participation improves well being. There are key issues to pay attention to in delivering a social prescribing hub:

Tension between integration and supporting specialised needs

Some people feel it is important that groups are able to meet particular needs, but others put more emphasis on maintaining diversity.

Manage client expectations

several discussions highlighted the importance of making sure that clients knew what to expect, so that they were not let down later on, and continued to feel empowered during and after the project.

Potential for negative impact if drop out.

if a person tries something and it does not work out then there are lots of other options for them, ' the door is always open' and the fear of failure needs to be acknowledged and mitigated as far as possible.

Tension between facilitation/ signposting and overt 'health change' messages

The projects are funded with NHS money, so the aim is to improve health. However the project will do badly if the health messages are overt and intrusive. Risk of exacerbating the participants sense of being unhealthy. Participation should be the vehicle for increasing health, so improving well being will have other positive effects.

Continuing to involve participants in key decisions about the project

Listening to the participants voice should be key to the development of the programme. Opportunities to feedback about sessions as well as comment on accessibility issues, should be created.

Maintaining the quality of groups through feedback/ monitoring/ evaluations

Using the feedback from participants the quality of the sessions should be continuously improved as challenges to delivery are addressed as they arise.

Staff training to help people feel included.

The skills and competencies of staff will need to be developed to address the needs of participants.

Risk assessments of groups/ activities

This will be important so that people are not out in danger and standards are maintained.

With reflection on the evidence base there are further issues which have emerged:

Moving people on is a challenge for many groups and activities.

There is a danger of dependency if groups prefer to hold on to existing members indefinitely. Groups and activities will need help, to commit to moving people through the social prescription process. It will be acceptable for people to become long term members, once the social prescribing intervention is completed.

Provider expectations will need to be acknowledged and managed.

Some groups will be on the social prescribing list, and some will not. There will be a need for transparency in this process.

10. DEVELOPING INDICATORS OF WELL-BEING

“What gets counted, counts.” Therefore being able to measure progress and impact of the social prescribing hub on the determinants of mental well-being identified by the stakeholders through the MWIA is an important step. Building on the initial ideas from stakeholder about “how you know” that certain impacts have happened 8 indicators have been developed.

Factor	Determinant	How do you know?	Data collection	Frequency
Increasing Control	Belief in own abilities and self determination	Manage client expectations Potential for negative impact if drop out.	WEMWBS	In evaluations at beginning and end of each block
	Opportunities to influence decisions	Continuing to involve participants in key decisions about the project	Ask if people feel able to influence the programme	
	Knowledge skills and ability to influence healthy choices	Tension between facilitation/ signposting and overt 'health change' messages	Ask if people have made any lifestyle changes	
Resilience	Collective organisation and action	Continuing to involve participants in key decisions about the project	Ask if people feel able to influence the programme	In evaluations at beginning and end of each block
	Social Networks and Relationships	Manage client expectations. Tension between inclusivity vs. need.	Ask if people felt they had been treated with dignity and respect	
	Trust and safety	Maintain		

		<p>quality of groups through feedback/ monitoring.</p> <p>Good communication Adopt an attitude of “the door is always open”</p>		
Participation/ Inclusion	<p>Sense of belonging</p> <p>Activities that bring people together</p>	<p>Manage client expectations. Staff training to help people feel included. Exit strategy explicit</p> <p>Risk assessments of groups/ activities</p> <p>Client feedback</p> <p>Staff training</p>	<p>Ask people if they felt a sense of belonging to the group/ activity</p> <p>Count number of sessions attended</p>	<p>In evaluations at beginning and end of each block, and registers</p>

See appendix 2 for further information.

11. RECOMMENDATIONS

This is based on

1. APPENDIX THREE – MWIA stakeholder workshop 8/3/11 Important issues identified ACTIONS FOR PROJECT
2. Section 8 appraisal of the evidence

1. Integration versus specialised groups:

More resources may be needed for some people. Specialised training/staff facilitation to address barriers physical/ language.

e.g. Asian women (culture/religion) or refugees may need peer support with a similar community champion

Potential role for hub to contextualise a persons situation (depersonalise it - not their fault)

Inclusive groups irrespective of need

2. Managing client expectations:

Be realistic manage expectations – be honest – things might end or stop.

Identify negative impact if a person drops out- follow up

Involve people in running the org

Set expectations with participant and their support network

Be clear about the offer at point of entry

Good communication

Adopt an attitude of “the door is always open”

Ensure move on is supported by signposting

Have an exit strategy and make timescales explicit to people

3. Achieving improved health and well being outcomes:

How does it evaluate for improved health/feelings factors. Are healthy choices being made?

Avoid pushing healthy change onto people - Facilitation & signposting.

Ensure quality of groups – measured through client feedback

Review and reinforce a comparison of baseline and exit data and use stats to add context.

Have a wide range of options for referring people to and know what available

Range of venues to suit different audiences

Work with groups to help them to understand how people can be moved through the social prescribing process.

4. Appropriate training for staff

Need risk assessment skills, policies, procedures

Listen to service users and do consultations

Check out skills and competence of providers and their risk policies.

Pitch selling at right level for your audience

Staff have the necessary skills and confidence: Training in awareness raising, conflict resolution, people skills and group facilitation

There will be a need for transparency about why a group is 'starred' for social prescribing and what the criteria are for this.



12. APPENDIX ONE

Evaluation of the Stakeholder MWIA workshop

Participants were invited to complete an evaluation form. The results suggest the workshop was successful in:

- Helping increase understanding of mental well-being, social prescription, the proposed hub activities and their fit in the local infrastructure.
- Comments from the question: How do you think the MWIA will contribute to your local project? have been collated into the wordle below. Larger words appeared more often. [www.wordle.net]



Additional comments included:

- “Increased awareness of resource available and remit”
- “very well facilitated”
- “This is not my area of expertise, but I am looking forward to understanding more and developing programmes and services within my area of remit that have a more holistic approach to wellbeing.”

Although a large proportion of organisations which represent service users' views were present, there were only 2 service users involved in the workshop (and a further 2 of the 3rd sector providers were also service users, but chose to attend as providers), so potentially there may not be enough of that constituents views or perspectives in the process. It is worth noting that a significant amount of qualitative, narrative and quantitative evaluation has been gathered from participants during local pilot delivery stages of the programme and will be incorporated into the future developments of Taking Part Workshops and the social prescription hub.

14. APPENDIX THREE

MWIA stakeholder workshop 8/3/11
Important issues identified;

Issues	Actions for Project	Comments
Belief in own abilities and self determination	<ol style="list-style-type: none"> 1. More resources needed for some people. 2. Specialised training/staff facilitation (to support 3. Addressing barriers physical/ language. 4. Integration vs. separate groups e.g. Asian women (culture/religion) 	Tension between integration and supporting specialised needs
Opportunities to influence decisions	<ol style="list-style-type: none"> 1. Folk in system e.g. refugees need peer support with a similar community champion 2. ?role for hub to contextualise a persons situation (depersonalise it - not their fault) 3. Be realistic manage expectations – be honest – things might end or stop. 	Manage client expectations.
Knowledge skills and ability to influence healthy choices	<ol style="list-style-type: none"> 1. Identify negative impact if a person drops out- follow up 2. How does it evaluate for improved health/feelings factors. Are healthy choices being made? 3. Avoid pushing healthy change onto people 4. Facilitation & signposting. 	Neg. impact if drop out. Tension between facilitation/ signposting and overt 'health change' messages
Collective organisation and action	Involve people in running the org	Continue to involve participants in key decisions
Social Networks and Relationships	<ol style="list-style-type: none"> 1. Set expectations with participant and their support network 2. Inclusive groups irrespective of need 3. Be clear about the offer at point of entry 4. Ensure quality of groups – measured through client feedback 	<p>Manage client expectations.</p> <p>Tension between inclusivity vs. need.</p> <p>Maintain quality of groups through feedback/ monitoring.</p>

Trust and safety	<ol style="list-style-type: none"> 1. Good communication 2. Adopt an attitude of “the door is always open” 3. Review and reinforce a comparison of baseline and exit data and use stats to add context. 	
Sense of belonging	<ol style="list-style-type: none"> 1. Make expectations and achievement of these clear 2. Ensure baseline and evaluation in place 3. Have a wide range of options for referring people to and know what available 4. Appropriate training for staff 5. Range of venues to suit different audiences 6. Ensure move on is supported by signposting 7. Have an exit strategy and make timescales explicit to people 	<p>Manage client expectations. Evaluations Staff training to help people feel included.</p> <p>Exit strategy explicit</p>
Activities that bring people together	<ol style="list-style-type: none"> 1. Need risk assessment skills, policies, procedures 2. Listen to service users and do consultations 3. Check out skills and competence of providers and their risk policies. 4. Pitch selling at right level for your audience 5. Staff have the necessary skills and confidence: Training in awareness raising, conflict resolution, people skills and group facilitation 	<p>Risk assessments of groups/ activities</p> <p>Client feedback</p> <p>Staff training</p>

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