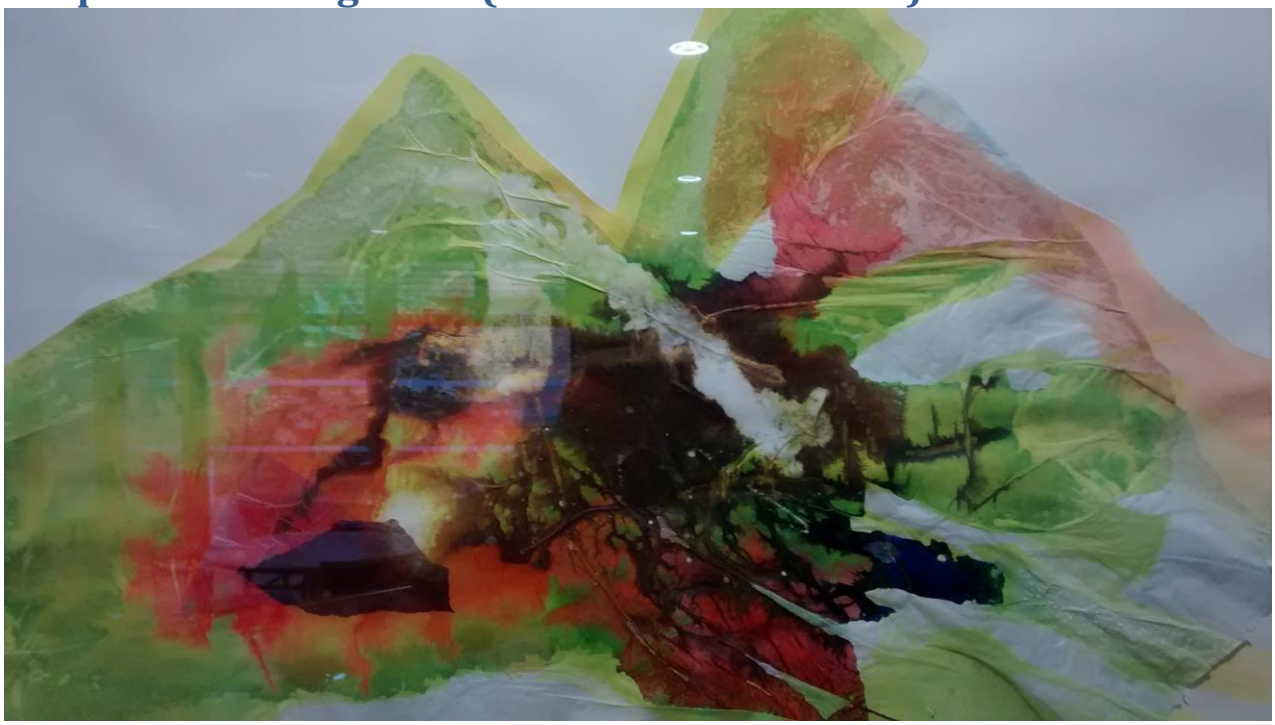
Chapter 4: Feeling Good (Public Mental Health)



Art work reproduced by kind permission of 2gether NHS Foundation Trust

Contents

Chapter 4: Feeling Good (Public Mental Health)

4.1 Introduction

Within this document, 'public mental health' is taken to mean: *a public health or population health science approach to mental health and the mental health variations exhibited by populations*[i]. As highlighted in earlier chapters, mental illness presents a significant burden of disease, accompanied by huge personal and economic cost. Contrasting this, good mental health has the potential to enable people to live "a state of complete physical, mental and social well-being" (WHO, 2002).

Whilst wellbeing as a concept may be hard to measure (See below for discussion), there is ample evidence for interventions to prevent mental illness, promote good mental health and support early intervention where required.

As discussed in chapter 2, there is a strong economic argument that, as a society, we need to work proactively to support and improve population mental health. Despite this, spending on the prevention of mental disorder and promotion of mental health represents less than 0.001% of the annual NHS mental health budget (JCPMH, 2014)[ii]. Proactive identification of wider determinants of mental ill health and intervention to address them will therefore play a key role in a system wide strategy to meet the current and future mental health needs of the people of Herefordshire.

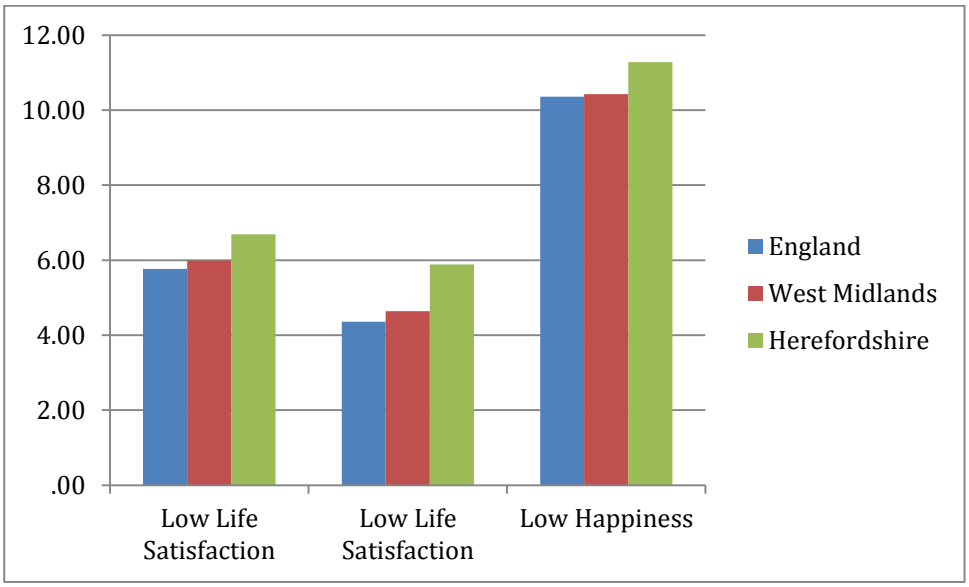
4.2. Prevalence

There is limited information to describe preventative mental health activity and well-being in the county. The ONS Annual Population Survey, and Herefordshire's Health and Wellbeing Survey (2011) offers proxy measures into people's wellbeing.

A West Midlands survey measured people's perception of satisfaction, feeling that their life is worthwhile and happiness. People surveyed were asked

- "Overall, how satisfied are you with your life nowadays?"
- "Overall, to what extent do you feel the things you do in your life are worthwhile?"
- "Overall, how happy did you feel yesterday?"

Figure 4.1: Proportion of Respondents expressing low life worth, Satisfaction and Happiness



Source: Annual Population Survey, ONS, 2012/13

Of respondents in Herefordshire, 6.7% (4.8% - 8.6%) report low levels of satisfaction with life (up from 5.2% in 11/12), 5.9% (3.6% - 8.2%) report low levels of life worth (up from 3.6% in 11/12) and 11.3% (8.9% - 13.7%) report low levels of happiness (up from 8.6% in 11/12). Although all of these indicators show an upward progression from the previous year, none differ significantly from the national averages or regional average (See Figure 4.1).

From this, we can conclude that Herefordshire is no different from other areas.

Herefordshire's Health and well-being Survey (2011) is based on a sample of the general adult population (aged 16 years and over) living in private households in Herefordshire.

- Overall around 8% of adults reported currently being treated for any form of mental illness.
- Women were nearly twice as likely to respond that they were receiving treatment for a mental illness – 10.6% compared to 5.9% of men and this figure was statistically significant.
- 6% of adults reported currently being treated for depression and 5% for anxiety.

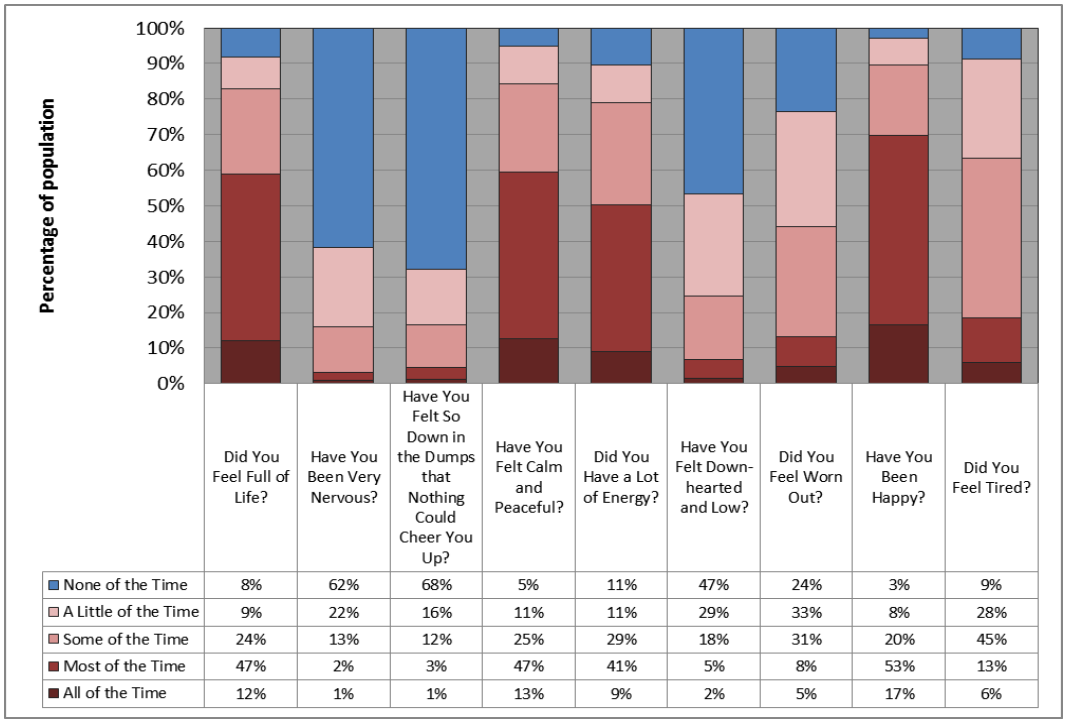
Respondents were asked a series of nine questions relating to their moods in the past four weeks;

- Over half (59%) felt 'full of life' all or most of the time but 8% did not feel 'full of life' at all.
- 50% had 'a lot of energy' all or most of the time, but 11% did not feel this way any of the time.
- 8% had not been happy any of the time; at the other end of the spectrum 70% had been happy at least most, if not all, of the time.
- 60% had felt 'calm and peaceful' most or all of the time, but 5% reported they had not felt like this any of the time.
- 3% had felt 'very nervous' all or most of the time but 62% had not felt 'very nervous' any of the time.

- 7% of individuals felt 'downhearted and low' all or most of the time. Just under half (46%) had not felt this way any of the time.
- 4% had been 'so down in the dumps that nothing could cheer you up' either all or most of the time but 68% had not experienced this mood at all.
- 13% said they felt 'worn out' all or most of the time and 19% had been 'tired' for all or most of the time.

Figure 4.2 summaries the results that the survey respondents gave to the nine questions.

Figure 4.2: Herefordshire Self-Reported Mood state in the past four weeks



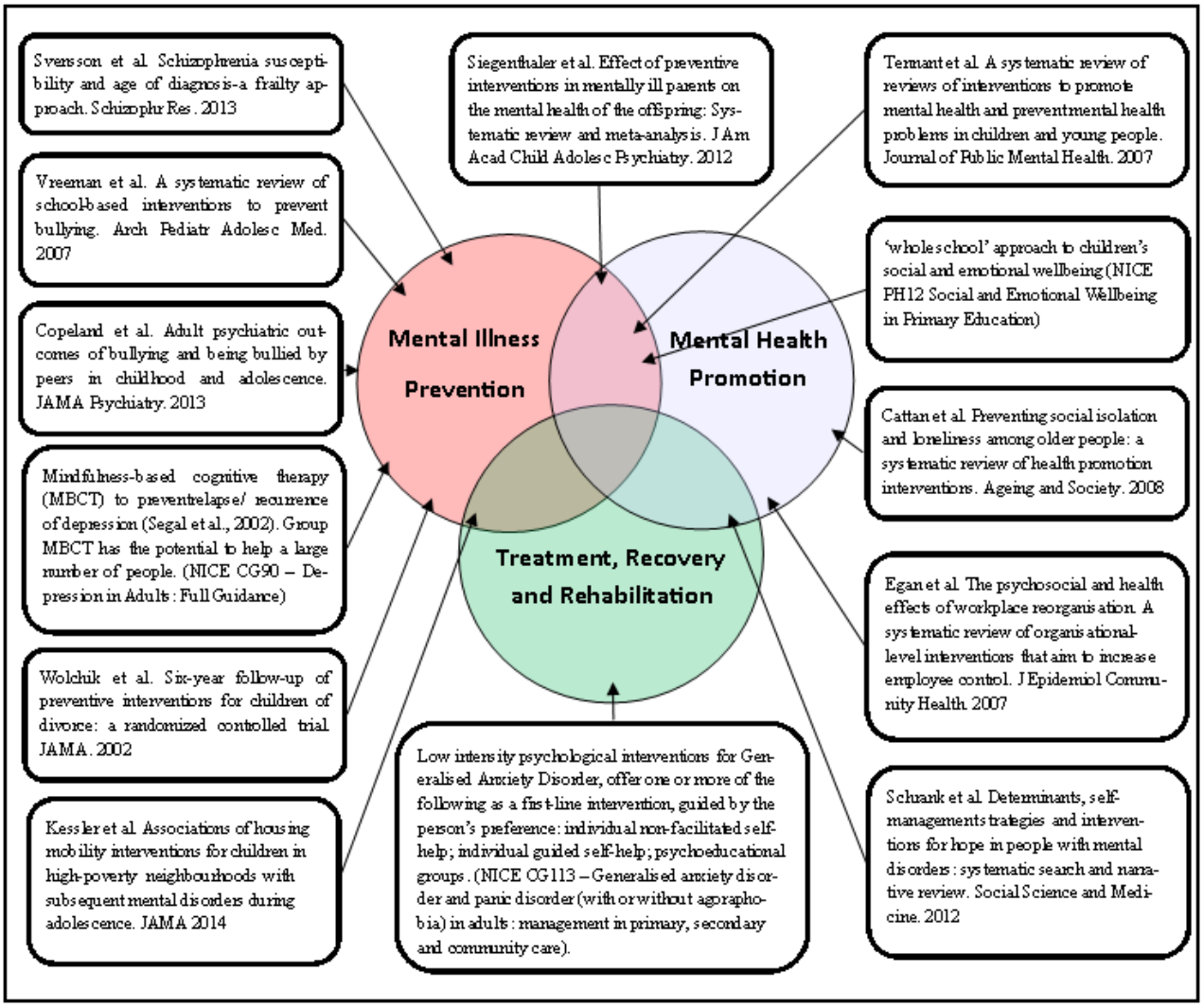
	Did You Feel Full of Life?	Have You Been Very Nervous?	Have You Felt So Down in the Dumps that Nothing Could Cheer You Up?	Have You Felt Calm and Peaceful?	Did You Have a Lot of Energy?	Have You Felt Down-hearted and Low?	Did You Feel Worn Out?	Have You Been Happy?	Did You Feel Tired?
None of the Time	8%	62%	68%	5%	11%	47%	24%	3%	9%
A Little of the Time	9%	22%	16%	11%	11%	29%	33%	8%	28%
Some of the Time	24%	13%	12%	25%	29%	18%	31%	20%	45%
Most of the Time	47%	2%	3%	47%	41%	5%	8%	53%	13%
All of the Time	12%	1%	1%	13%	9%	2%	5%	17%	6%

Source: Herefordshire's Health and Wellbeing Survey (2011)

4.3. National Evidence

England's Chief Medical Officer (CMO) published a review of the evidence for public Mental Health in September 2014[iii]. The document builds on the model of mental health improvement developed by the World Health Organisation in their Mental Health Action Plan 2013–2020, with overlapping elements of mental health promotion, mental ill-health prevention and treatment, recovery and rehabilitation (see figure 4.3 below) to inform future local research and investment strategies.

Figure 4.3: Public Mental Health: a conceptual model derived from the WHO framework and illustrated with evidence based examples (CMO, 2014)



Source: Chief Medical Officer's Report, 2014

4.3.1 Wellbeing

Five ways to wellbeing was published in 2008 by the New Economics Foundation (NEF).

Figure 4.4: Five ways to Wellbeing

However, despite its widespread use, a lack of clarity over boundaries, definitions, tools for evaluation and evidence of effectiveness render "wellbeing" a contentious concept[iv].

The CMO report found that, whilst tools such as the ONS measures of national wellbeing are developing, linkages between these and other tools is underdeveloped, definitions are inconsistent and studies and reviews demonstrating wellbeing are poorly designed.

Given these issues, the CMO recommends that;

"*Unless and until robust evidence of effectiveness is forthcoming, interventions based on the concept of 'mental well-being' should not be funded*"[v].

Rather, the NHS and Public Health England should focus on commissioning services for which there is evidence framed according to the World Health Organisation model of mental illness prevention, mental health promotion and treatment, recovery and rehabilitation.

4.3.2 Commissioning Public Mental Health

The focus on prevention, promotion and treatment is reflected in guidance for commissioners produced by the Joint Commission Panel for Mental Health[vi].

Promotion of Good Mental Health

Mental health promotion may take place across the entire life course, from supporting parents prior to the birth of a child to promoting wellbeing in later life and aim to address the determinants of health, occurring at the individual, group or structural level. Primary promotion involves promoting the health and wellbeing of the whole population. Secondary promotion involves targeted approaches to groups at higher risk of poor health and wellbeing. Tertiary promotion targets groups with established health problems to help promote their recovery and prevent recurrence.
The JCPMH identifies a number of opportunities for the promotion of good mental health. A full review of the evidence underpinning these recommendations can be found in the JCPMH document. The JCPMH has identified key areas, linked to all points along the life course where commissioned programmes would improve mental health outcomes as stated in Box 4.1.

Box 4.1 Interventions to promote Good Mental Health

Starting well:

- Promotion of parental mental and physical health
- Support after birth, breastfeeding support
- Parenting support, SureStart
- Family Nurse Partnership.

Developing well

- Pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- School-based mental health promotion programmes (reduced levels of mental disorder, improved academic performance, social and emotional skills).

Living well

- Improved housing and reduced fuel poverty
- Neighbourhood interventions including activities which facilitate cohesion
- Debt advice and enhanced financial capability
- Physical activity through active travel, walkable neighbourhoods and active leisure
- Interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and timebanks
- Positive psychology and mindfulness interventions
- Spiritual awareness, practices and beliefs.

Working well

- Work-based mental health promotion
- Work-based stress management
- Support for unemployed people.

Ageing well

- Psychosocial interventions
- Socialisation and prevention of social isolation
- Addressing hearing loss
- Interventions for 'living well'

As well as promoting wellbeing in different age groups across the life course, interventions can be targeted at particular groups:

- **Caring well** – support and psycho-education for carers
- **Recovering well** – mental promotion as a key component of recovery from mental disorder
- **Engaging well** – involvement in planning, design and delivery of interventions

Prevention of Mental Ill Health

Prevention aims to avoid, delay or decrease the impact of mental illness on individuals and populations. Prevention can occur at three levels. Primary prevention aims to *prevent ill health happening* in the first place by addressing the wider determinants of illness and using 'upstream' approaches that target the majority of the population. Secondary prevention involves the early identification of health problems and *early intervention to treat and prevent* their progression. Tertiary prevention involves working with people with established ill health to *promote recovery and prevent (or reduce the risk of) recurrence*.

It is acknowledged that contributors to the development and manifestation of mental illness, including biological, social and traumatogenic factors, operate across the lifecourse and may require intervention my multiple partners. Whilst some prevention activities may be the specific responsibility of particular commissioners, some elements regarding universal primary and secondary prevention activities, (such as supporting smoking cessation and signposting towards specialists) should be part of ALL professionals working in the system, specifically acknowledging that prevention at an early stage may produce cost savings at a stage.

The JCPMH identifies opportunities for the prevention of mental ill health. A summary of the evidence underpinning these recommendations can be found in the JCPMH document. The opportunities are listed in box 4.2.

Prevention of mental illness and dementia

- childhood conduct and emotional disorder prevention through reduced maternal smoking during pregnancy, parenting programmes, school and pre- school programmes (e.g. Family Nurse Partnership)
- maternal depression prevention through post-partum psychosocial support, home visitation, health visitor training and peer support
- depression prevention in older people through targeted interventions for groups at high risk
- Dementia prevention via access to physical activities, social engagement, cognitive exercise and antihypertensive treatment.

Prevention of health risk behaviours including smoking, alcohol and drug misuse through:

- promotion of mental health and prevention/early intervention for mental disorder prevents a large proportion of associated health risk behaviour
- integration and mainstreaming of mental health into existing programmes (including smoking, alcohol, drugs, obesity, nutrition and physical activity)
- interventions for different health risk behaviours with targeted approaches for those with mental disorder
- Interventions to prevent and intervene early with mental disorder.

Prevention of inequality

- addressing inequality can prevent mental disorder
- prevention of mental disorder and promotion of mental health
- addressing results of mental disorder such as smoking
- increasing availability of early intervention for mental disorder
- Addressing inequalities in service provision.

Prevention of stigma and discrimination:

- Mass media campaigns
- social contact between individuals subject to discrimination and members of the public
- educational programmes to increase mental health literacy

Prevention of suicide

- improved management of depression
- general practitioner education
- Population-based programmes to promote mental health.

Prevention of violence and abuse

- school based programmes to prevent abuse
- targeted interventions for children with conduct disorder and adults with personality disorder, substance dependence and/or hazardous drinking

Box 4.2: Opportunities for Prevention of Mental Health

People and organisations in Herefordshire regarded prevention of mental health problems as preferable to treating problems once they had developed. However, some felt that to funding cuts to Tier 1 and 2 support had hindered low level issues being picked up more efficiently.

[We want] staff in schools to know about mental health, wellbeing and understand when help is needed.
Young Person

There is a need for professionals to have a deeply embedded understanding of how to promote good mental health and wellbeing.
Carer

We should be investing a lot more in schools to equip young people with life skills. There should be opportunities, not necessarily through mental health services, that enable people to deal with issues in their lives. It needs to be taken upstream.
General Practitioner

We have no preventative mental health work in the county. There is no tier one and very little tier 2. We are lacking in early intervention and this has a massive knock on effect later - by the time adults present with personality disorder effective treatment is much too late even though warning signs have been present often from early school years.
General Practitioner

There is a lack of preventative work at tier 1. There has been a whole tier of professionals who have been removed who would have had those conversations prior to the problems getting serious. Early intervention work has moved to a more critical end (e.g. troubled families) so for the general population, early intervention has disappeared.
Voluntary Organisation

Early Intervention

Early intervention is associated with improved outcomes as well as economic savings. Early intervention takes a number of different forms.

- Early treatment of mental disorders particularly for children and adolescents since most mental disorders starts before adulthood. Early effective treatment of mental disorder can prevent a significant proportion of adult mental disorder. Intervention during psychosis prodrome can also prevent development of psychosis.
- Early interventions for sub- threshold disorder (a set of symptoms which are not severe enough to result in a diagnosis) to address these symptoms and promote mental health.
- Early promotion of physical health as well as prevention and early intervention for health risk behaviour and associated physical illness in those developing a mental disorder.
- Promotion of recovery through early provision of activities such as supported employment, housing support, and debt advice.
- Early recognition of mental disorder through improved detection by screening and health

professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.

- Support for victims of of proximal and historic interpersonal violence and abuse, both in terms of managing its effects and addressing the trauma directly.

Effective early intervention could negate the need for intensive work in the future as illustrated by the following comments:

Delays in getting support mean that a person's mental health has deteriorated until a lot more support is needed.
Patient/ Service User

Currently, people who are not critical and substantial fall through the gaps. A small amount of support at tier 2 may prevent people from needing more help further on down the line.
Housing Practitioner

There is a strong need for early intervention work to prevent increased activities in other services in the future.
Mental Health Practitioner

The removal of support organisations mean that we are finding people moving into crisis. People who were stable for years are now worse than ever.
Voluntary Organisation

There has been a loss of tiers 1 and 2 provision across the county. Voluntary sector and youth organisations used to pick up a lot of [low level] issues, but they have been lost.
Mental Health Practitioner

4.4. Mental Health and Stigma

Reducing mental health-related stigma and discrimination is one of the six objectives of the Government's Mental Health Strategy, No Health without Mental Health (2011).

The 2013 Mental Health (Discrimination) Act and Equalities Act (2010) have rendered many aspects of discrimination on the basis of mental (ill) health unlawful. Despite this, such discrimination can be still be felt by the individuals, preventing or delaying their access to help and impairing their recovery. Discrimination may also be enacted, directly or indirectly, limiting housing, employment, education and physical health. A 2013 study[vii] found that 87% of mental health users had experienced discrimination in the past year, 70% felt the need to conceal their illness and half reported having been shunned.

Tackling stigma and discrimination remains a key barrier in ensuring fair, prompt and equal treatment for people affected by mental health issues. And whilst economic costs of stigma regarding mental health are difficult to quantify, there is growing evidence that addressing the discrimination experienced by individuals as a result of their mental health is both effective and produces economic benefit[viii].

A number of inter-related approaches may be identified to address stigma and increase public awareness of mental health issues.

- Engaging the local population in the commissioning process
- Information about effective interventions should be given to the public, as it can help promote the uptake of such interventions.
- Raising awareness of mental disorder and wellbeing among public sector staff and the general public through community training programmes and interventions such as Mental Health First Aid.

Initiatives such as Mental Health Awareness Day (October 10th) and Time to Change play an important role in raising awareness of mental health issues. . A multifaceted programme comprising national and local-level actions to engage individuals, communities and stakeholder organisations, Time to Change (www.time-to-change.org.uk), run by Mind and Rethink Mental Illness, is the largest ever programme to reduce stigma and discrimination against people with mental illness.

Evidence from the first year of the Time to Change anti-stigma programme in England[ix] showed significant improvements in life areas in which relationships are informal, i.e. family, friends and social life. In some areas where discrimination may occur at a structural level (e.g. via regulations, laws or institutions) there were no improvements, including mental and physical healthcare and welfare benefits; in others, including those in seeking and gaining employment, early improvements have since plateaued or been lost[x]

Involving organisations across Herefordshire to 'pledge support' to Time to Change would enable local cascading of anti-discrimination messages. This would be a response to what people said about the effect of stigma- how society views mental health and mental health service users and how people felt about themselves which in turn impacts on people's willingness to engage with services.

It's important to not feel stigmatised and be able to talk about how you are feeling.
Patient/ Service User

There is still a stigma around mental health and a lot of labelling. People aren't "a Schizophrenic", they may have schizophrenia. You don't hear someone described as "a breast cancer". People have mental health problems, it shouldn't define them.
Carer

There is still significant stigma around mental health, including from patients themselves. This can lead to delays in obtaining treatment which can result in there being more of an issue at a later date
Mental Health Practitioner

There needs to be more awareness and understanding, through education in schools and workplaces.
Carer

4.5. Unemployment, Work and Mental Health

Unemployment is consistently related to higher rates of depression, anxiety and suicide, particularly when compounded by inadequate benefits[xi]. Several studies have identified increased rates of depression in the unemployed, particularly in young men[xii],[xiii].

The following outlines the profile of people out of work claiming benefits in Herefordshire.

- On average 9,120 people within Herefordshire were claiming an out-of-work benefit in 2013, equal to 8.1% of the working age population (16-64). This was a decrease from an average of 9,870 claiming in 2012. Claimants of Employment Support Allowance and Incapacity Benefit made up 61% of all claimants; double the proportion of Jobseekers (28%). The lone parent group accounted for 10% of claimants and others on income related benefits 4%.
- The number of claimants of out-of-work benefits is still slightly above what it was prior to the recession despite having seen notable decreases as the number of Jobseekers has declined post-recession. A decrease in the lone parent and ESA and incapacity benefits groups has offset the increase in jobseekers (since 2007) to some extent.
- The claimant rate for out-of-work benefits in Herefordshire (8.1% in 2013) is lower than for England (10.8%), the West Midlands (12.2%) and The Marches Local Enterprise area (9.1%).
- Long term (over 5 years) claimants of Employment and Support Allowance (ESA) and Incapacity Benefits and short term claimants (less than 6 months) of Jobseekers Allowance are the largest groups of claimants by duration, accounting for 38% and 14% of claimants respectively. It was the same groups across England who accounted for most claimants.
- Looking at the conditions of people claiming Incapacity Benefit (IB) or Severe Disablement Allowance (SDA), the most prevalent condition was a 'mental or behavioural disorder' (43% of all claimants). 12% of claimants had a 'disease of the musculoskeletal system and connective tissue', 10% a 'disease of the nervous system' and 15% had 'symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified'.
- The areas of Herefordshire that have the highest rates of claiming out-of-work benefits are in Hereford City, Leominster, Ross-on-Wye and Bromyard. Within Hereford City the areas with the highest rate of claiming are in the South of the city

Source: Facts and figures Herefordshire(2014)

Poor working conditions, including job insecurity, low support, workplace bullying and high stress/ low reward have been linked to increased sickness and premature mortality[xivxv]. Mental health is the leading reason for days of work lost due to ill health, with 13.1million days lost due to stress and anxiety in 2011 in the UK. Within Herefordshire's main statutory employers (Wye Valley Trust and Herefordshire County Council) in 2012/13, a total of 261 employees were absent from work for mental health reasons, totalling 10,585 days of work lost. This is the equivalent of 29 people off work at any one time.

However, work can also positively enrich people's mental health, increasing life satisfaction, preventing mental ill health and act as a positive environment for people recovering from mental ill health. Nice Guideline (PL22) outlines the promotion of mental health at work and there is evidence to link such activities to greater productivity at work, increased commitment and staff retention as well as effects on health and longevity[xvi]

The role of work and training was identified by local stakeholders as having an important role in maintaining and improving a person's mental health. However, respondents were keen to stress that this would not always mean paid work.

Employment and training can speed up the healing process. However, the individual with the mental health issues should dictate the introduction of employment and training.
Patient/ Service User

Within a "goldstar" mental health service, employers would be educated in knowing how to support people with mental health needs and people would be helped into employment- what to expect and how to cope with working life.
Patient/ Service User

Work, as paid or unpaid vocational activity, including things such as supported placements, is one of the best ways to support a person's mental health.
Mental Health Practitioner

The above comments reflect the value of volunteering and access to support with employment and training. These activities offer social inclusion as well as positive engagement to aid recovery.

4.6. Social Prescribing

Strategies for preventing mental ill health, promoting good mental health and providing early intervention and low-level continuing support have found form in 'social prescribing'.

The term *'social prescribing'* describes a range of mechanisms for linking patients to nonmedical sources of support in the community[xvii]. Such support may include provision of self-help books or gym membership, but may also comprise referral to support organisations undertaking such activities as guided walks for health, creative activities and low level agriculture and maintenance. Central to all approaches is a focus on reducing social exclusion and isolation.

Due to the heterogeneous nature of social prescribing, the evidence base for specific interventions is limited. There is anecdotal evidence of better social and clinical outcomes for people with long term conditions and their carers, more cost efficient and effective use of NHS and social care resources and a wider, more diverse and responsive local provider base. The JCPMH commends social prescribing as presenting potential benefits for improved mental health outcomes, improved community wellbeing and reduced social exclusion[xviii]. An evaluation by Bristol Health and Wellbeing Board[xix] indicates a minimum return on investment of 120% for social prescribing projects, with high acceptability from GPs and service users.

Overall therefore, whilst evidence for specifically commissioning 'social prescribing' is limited, as an approach it contains elements of tackling stigma and social exclusion, preventing mental ill health, promoting good mental health and providing low level support to people who require it. The diversity

of approaches also enable patient choice, avoid labelling that may result from engagement with formal mental health services and provide opportunities to combine mental and physical activities within a social environment.

Many mental health problems are associated with social isolation, either leading to worsening symptoms or preventing recovery from episodes of mental ill health. Social prescribing has been most visible within Herefordshire in the shape of two ventures, the LIFT exercise on prescription scheme run by Halo, and the Books on Prescription scheme at Herefordshire libraries, but there are many other interventions which would be covered by the definition. MIND run projects involving service users with activities such as orchard maintenance and archaeology, and this has lead to significant improvements in confidence for attendees. Orchard Origins found significant improvements on wellbeing scales in volunteers attending orchard management projects[xx]. This fits with a small but encouraging evidence base for benefits from horticulture and arts projects[xxi].

While there are a large variety of activities within Herefordshire which act to promote social cohesion, mainly within the voluntary or charity sectors, there does not exist a straightforward way for professionals, whether health, social care, other (police, clergy, etc.) to signpost patients towards these services. Provision of a web-based directory of services would help meet the duties of both Herefordshire Council and Herefordshire CCG to address wellbeing within the county.

4.7. Conclusion

Mental health is clearly about more than the simple absence of mental illness. It is linked to happiness, enjoyment of everyday experience, engagement in society and personal feelings of self-worth and safety. In a holistic sense, it is about people "being well". However, as outlined in chapter 1, measuring a person's wellbeing is difficult. There is a danger that the diversity of definitions of wellbeing render it nebulous, with interventions to support it impossible to evaluate.

Herefordshire CCG has a responsibility to invest its money where clear benefit can be demonstrated. The evidence in this chapter suggests that Herefordshire CCG should continue its focus on investing where there is a more robust evidence base on specific activities within the domains of mental illness prevention and mental health promotion. Such an approach is coherent with the evidence presented by the Chief Medical Officer and the World Health Organisation.

Many of the elements integral to mental illness prevention and mental health promotion require co-ordinated actions across the local system, such as promoting volunteering and accessing employment and housing support. In saying this Herefordshire CCG recognises that its commissioning of mental health provision sits within a wider strategic framework that integrates population approaches towards health and social care in conjunction with system partners that include the local authority, the voluntary and community organisations, other parts of the NHS and statutory sector organisations, with the need for a system wide strategy.

The recommendations are:

Well-being

- For Herefordshire Clinical Commissioning Group to adopt low prioritisation of funding for mental well-being interventions without evidence of effectiveness.

All Agencies Response

- For Herefordshire to have an all-age mental health strategy with contributions from organisations across our economy to co-ordinate mental illness prevention and mental health promotion.

Stigma

- Herefordshire CCG and its partners to make an explicit commitment to tackling mental health stigma by pledging its support for “Time to Change” and raising awareness of mental health.

Sources of Advice and Information

- Consideration of a web-based directory of services to aid practitioners, the public and communities.

References

[i] CMOs Annual Report 2014

[ii] Joint Commissioning Panel for Mental Health (2014) *Public Mental Health*

[iii]

[iv] Dodge R, Daly AP, Huyton J, Sanders LD (2012) The challenge of defining wellbeing. *International Journal of Wellbeing;2(3).*

[v] P.2

[vi] Joint Commissioning Panel on Mental Health (2013) *Guidance for Commissioning Public Mental Health Services*. JCPMH: London

[vii] Corker E, Hamilton S, Henderson C, Weeks C, Pinfold V, Rose D, et al. (2013) Experiences of discrimination among people using mental health services in England 2008-11. *British Journal of Psychiatry 3;202:s58-s63.*

[viii] Evans-Lacko S, Henderson C, Thornicroft G, McCrone P.(2013) Economic evaluation of the anti-stigma social marketing campaign in England 2009-2011. *British Journal of Psychiatry. Suppl.Apr;55:s95-s101.*

[ix] Henderson C, Williams P, Little K, Thornicroft G. (2012) The Time to Change programme against stigma and discrimination. Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010. *British Journal of Psychiatry*.

[x] Corker E, Hamilton S, Henderson C, Weeks C, Pinfold V, Rose D, et al. (2013) Experiences of discrimination among people using mental health services in England 2008-11. *British Journal of Psychiatry;202:s58-s63*

[xi] Flint E, Bartley M, Shelton N, Sacker A. (2013) Do labour market status transitions predict changes in psychological well-being? *J Epidemiol Community Health;67(9):796-802*

[xii] Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M. (2011) Effects of the 2008 recession on health: a first look at European data. *Lancet Jul 9;378(9786):124-5*

[xiii] Reeves A, Stuckler D, McKee M, Gunnell D, Chang SS, Basu S.(2012) Increase in state suicide rates in the USA during economic recession. Lancet ;380(9856):1813-4

[xiv] Butterworth P, Leach LS, McManus S, Stansfeld SA. (2013) Common mental disorders, unemployment and psychosocial job quality: is a poor job better than no job at all? *Psychol Med,43(8):1763-72.*

[xv] Lahelma E, Lallukka T, Laaksonen M, Saastamoinen P, Rahkonen O. (2012) Workplace bullying and common mental disorders: a follow-up study. *J Epidemiol Community Health;66(6):e3*

[xvi] Stansfeld SA, Shipley MJ, Head J, Fuhrer R, Kivimaki M.(2013) Work characteristics and personal social support as determinants of subjective well-being. *PLoS One;8(11):e81115*.

[xvii] Friedli, L (2009) *Social prescribing for mental health a guide to commissioning and delivery*. CSIP: London.
http://www.centreforwelfarereform.org/uploads/attachment/339/socialprescribingformentalhealth.Pdf

[xviii] JCPMH (2013) *Guidance for Commissioning Primary Care Mental Health Services*
http://www.jcpmh.info/wpcontent/uploads/jcpmhprimarycareguide.pdf

[xix] https://www.bristol.gov.uk/committee/2013/ot/ot049/1128_7.pdf

[xx] http://orchardorigins.org/2014/03/19/mental-wealth-the-wellbeing-value-of-volunteering-outdoors/

[xxi] Barley et al (2012) Primary-care based participatory rehabilitation: users' views of a horticultural and arts project *British Journal Gen Pract; DOI: 10.3399/bjgp12X625193*