

Kent Mental Wellbeing Programme Evaluation: Concept Mapping Report

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April 2015



Funded by

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Executive Summary

This report summarises the findings from the first phase of an ongoing evaluation of Kent County Council Public Health's Mental Wellbeing Programme by The McPin Foundation, which began in late 2013 / early 2014.

This first phase of the evaluation took place from December 2014 – March 2015, and involved mapping the models and concepts for each of the eight wellbeing interventions that constitute the programme, which are as follows: Library Wellbeing Hubs; Primary Care Link Workers; Kent Sheds; Six Ways to Wellbeing Campaign; Creative Arts Partnerships; Happier@Work Workplace Wellbeing Pilot; Mental Health First Aid; and MindFull's Pilot in Schools. This phase is to be followed by a comprehensive evaluation of the reach and impact of each of the interventions, which will be reported on in March 2016.

The aim of the concept mapping work has been to achieve a detailed understanding of each intervention, as well as to document progress to date, including any challenges to implementation that may have been encountered. Through the creation of these maps, we have established the assumptions on which the projects are based and the 'active ingredients' of the intervention which can inform future design and implementation, as well as improvements within the programme itself. The maps also inform the detail of an evaluation by making links between activities and outcomes explicit, and allowing us to test these through the data collected.

The data for the concept maps was gathered via semi-structured interviews with between two and four project leads and key stakeholders in each project – those with a primary role in designing, commissioning and / or delivering the projects. The interview data, alongside a range of other sources such as provider bids, monitoring and reporting returns and reviews of the relevant literature, was analysed in depth to develop the maps. These maps provide a visual overview of the links between the intended design, set up and implementation with the anticipated outcomes for each intervention and can also be used as a standalone output.

Background & Methodology

This report summarises the findings from the first phase of an ongoing evaluation of Kent County Council Public Health's Mental Wellbeing Programme. The wellbeing programme in Kent is one of the first of its kind among local authorities to focus primarily on prevention. It is unusual in terms of both the level of investment in preventative interventions, but also the scope and depth of its evaluation of the projects that have been commissioned. The Mental Wellbeing Programme began in late 2013 / early 2014, with the eight projects beginning and ending at different times – some are still being set up, whilst others completed delivery before the evaluation was commissioned.

This first phase of the evaluation has involved mapping the models and concepts for each of the eight wellbeing interventions that constitute the programme, which are as follows:

Library Wellbeing Hubs: Dedicated wellbeing zones established in eight libraries across Kent, providing space to meet with wellbeing-related organisations as well books, resources and internet access to promote mental health literacy and wellbeing.

Primary Care Link Workers: A county-wide service providing individually tailored, one-to-one and time-limited support to individuals with mental health or related needs; giving targeted, practical help and sign-posting to other organisations that encourage healthy behaviours and wellbeing.

Kent Sheds: The provision of grants and support for groups – particularly, though not exclusively, targeting men and ex-service personnel – to engage in the Six Ways to Wellbeing and related activities in an informal, community-based setting.

Six Ways to Wellbeing Campaign: A public-facing campaign aimed at promoting awareness of, and engagement in, the Six Ways to Wellbeing – Be Active; Connect; Keep Learning; Give; Take Notice; and Care for the Planet – delivered through the Live It Well website, social media, local media and communications (including via the Creative Arts Partnerships), and seminars.

Creative Arts Partnerships: Sessions for young people to explore the Six Ways to Wellbeing through engagement in creative arts, including performance, film, music, dance, poetry and sculpture, along with public events and festivals aimed at raising awareness of the Six Ways to Wellbeing among the wider community.

Happier@Work Workplace Wellbeing Pilot: A pilot aimed at implementing changes in the workplace to support wellbeing for teams within Kent County Council, by skilling staff to carry out a Mental Wellbeing Impact Assessment of their work environment and develop an Action Plan to bring about change.

Mental Health First Aid: Provision of training aimed at a wide range of individuals and organisations through the nationally recognised Mental Health First Aid courses, including a two-day session aimed at adult mental health, a two-day session focused on mental health in young people, and a half-day taster session.

MindFull Pilot in Schools: A young people’s wellbeing pilot including web-based counselling, mental health awareness training, and training peer mentors to offer support within three Kent secondary schools.

The evaluation commenced in late November 2014, and is scheduled to run until August 2016. The first four months of the evaluation have focused on engagement with the individual interventions to achieve a detailed understanding of the aims and models employed by each, as well as to document progress to date, including any challenges to implementation that may have been encountered. This first phase has also enabled the research team to establish good working relationships with the programme leads, and identify how KPI data is currently being collected as well as next steps for McPin’s data collection strategy.

For each of the interventions, semi-structured interviews were conducted with between two and four project leads and key stakeholders in each project – those with a primary role in designing, commissioning and / or delivering the projects. The interviews explored:

- The organisation or individual’s background and expertise
- Their understanding of how the programme leads to improved wellbeing, and how this is being measured
- A detailed description of the models used and the programme design, including how key decisions were reached
- Any challenges or barriers encountered, and any solutions or changes in design and implementation made to address these
- The interviewee’s own perspective on the effectiveness of the programme for improving wellbeing
- Any recommendations for improvements or revisions to the original design

The interview data, alongside a range of other sources such as provider bids, monitoring and reporting returns and reviews of the relevant literature, were used to develop a series of concept maps. These maps provide a visual overview of the links between the intended design, set up and implementation with the anticipated outcomes for each intervention. The aim of producing these maps is to establish the assumptions on which the projects are based and the ‘active ingredients’ of a programme which can inform future design and implementation, as well as improvements within the programme itself. The maps also inform the detail of an evaluation by making links between activities and outcomes explicit, and allowing us to test these through the data collected.

It is important to note that in some instances, it has been difficult to distinguish in the interviews between what was intended at the beginning from what happened in practice, as most of the projects had commenced, or even completed, delivery when the evaluation was commissioned. Supporting documents, such as original bids for commissions, have been crucial in helping us make these distinctions.

Library Wellbeing Hubs

Background

For some time, it has been acknowledged that public libraries have an important though frequently understated role in providing easily accessible and safe spaces for a wide range of vulnerable groups. Brewster (2014) goes so far as to argue that public libraries should be viewed as a 'therapeutic landscape' that exhibits the link between practical engagement with a public space, and subsequent improvements in mental health. The idea for the Kent County Council Library Wellbeing Hubs intervention – dedicated spaces within select libraries that include specialised book collections, but also provide a venue for third party organisations to work from – stemmed in part from a needs assessment that showed that there was a need for easily accessible, non-judgmental places to meet and access support and reliable information to improve health and quality of life, particularly within areas of high deprivation.

"Public Health realised that libraries are wellbeing zones anyway, they're a great asset to the community because they're on the high street, they're non-judgmental, they're safe, neutral, trusted environments that people can go into."

Library Wellbeing Hubs Project Lead

The Public Library Health Offer – a national strategy expressing public library contribution to the health and wellbeing of local communities – is one of the four universal Society of Chief Librarians Offers (the other three being Reading, Digital and Information). At a local authority level, KCC had been working for some time to strengthen the link between libraries and mental health, and a formal partnership between the relevant Libraries and Public Health teams, working collaboratively to achieve similar outcomes, was a natural progression in making this vision a reality. The Library Wellbeing Hubs project is being managed by the Libraries team.

A review of the literature suggests that the relationship between reading and improved mental health is widely recognised and long established. For example, Ball (1954) asserts that "the assumption that stimulation received through reading may affect an individual's emotion, attitudes and subsequent behaviour is as old as the art of reading itself" (p. 145). More recently, this approach to improving wellbeing through engagement with literature forms has been termed 'bibliotherapy'. This is defined by one commentator as the use of any text to "improve physical or emotional wellbeing through reading, discussing and facilitating a greater understanding" (Brewster, 2009, p. 400). It is generally agreed that there are two distinct branches of bibliotherapy. The first, self-help bibliotherapy, involves the use of non-fiction self-help books, often recommended by medical practitioners, to provide practical help to improve mental wellbeing. The second, creative bibliotherapy, involves engaging with fictional and poetry to work to promote better mental health (Brewster, 2009). There is a wealth of evidence that supports the delivery of bibliotherapy for a host of mental disorders (Chamberlain, Heaps & Robert, 2008).

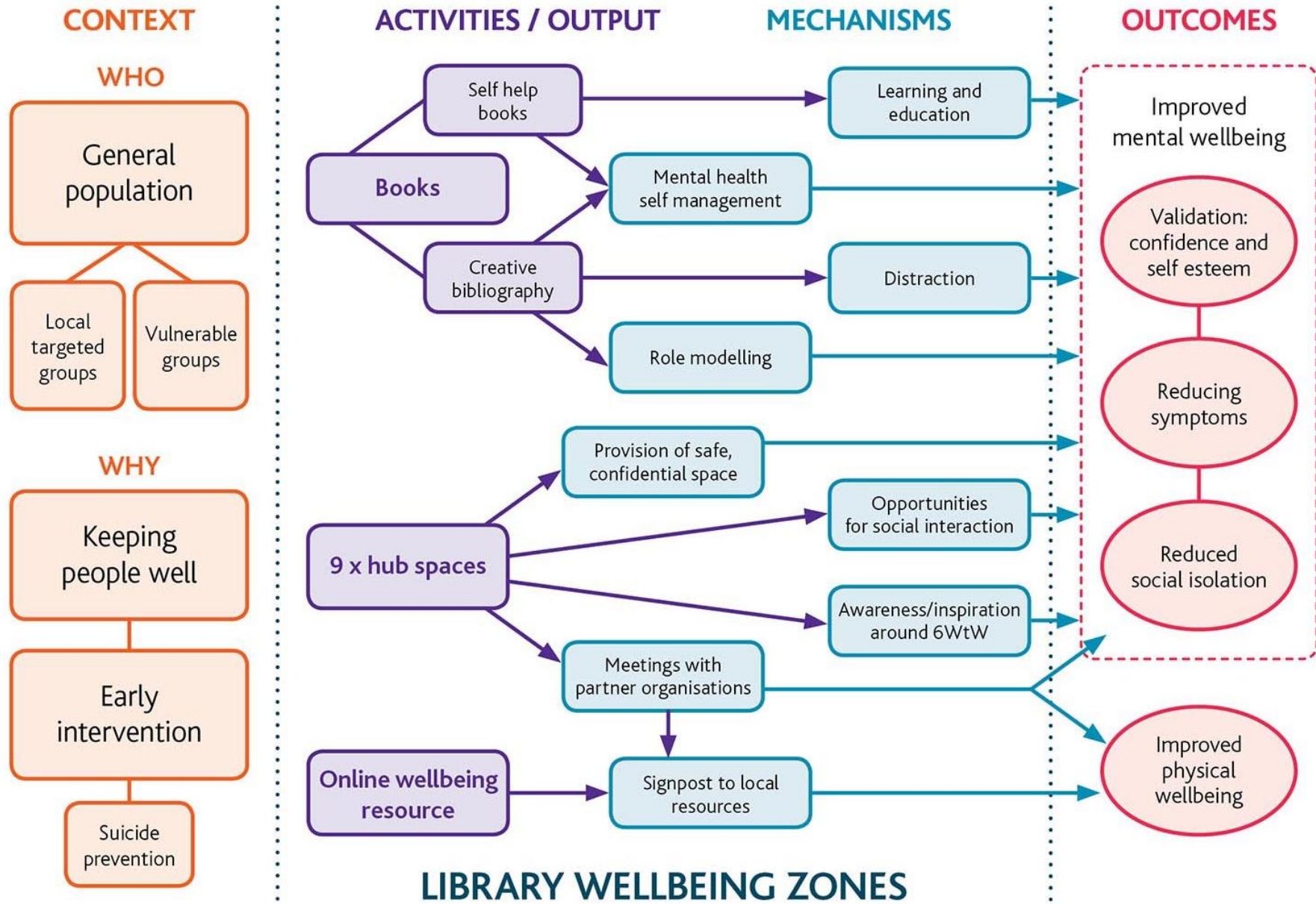
It is highly plausible, then, that Kent libraries may provide a useful platform to publicise the Six Ways to Wellbeing messages, raising awareness and inspiring behaviour change. Prior to the launch of the hubs in April 2015, a number of libraries across the county were already delivering wellbeing

activities such as specialised book collections around mental wellbeing and spaces for partner organisations to offer health interventions. These were, in a sense, a precursor to the Wellbeing Hubs intervention, the idea being that having a dedicated physical 'hub' should make it easier for library users to locate wellbeing books and information, and for partner organisations to benefit from the physical space provided by libraries. Wellbeing zones have been described by Public Health as "designated areas in libraries offering a one stop shop for health and wellbeing information", and, in addition to the books, each zone is to contain advice and information, stock and promotional items, and furniture that supports the Six Ways to Wellbeing campaign. In addition to this, the libraries are to promote and offer access to the hub space to local partner organisations and agencies with a health and wellbeing or social focus.

It is important to frame the Kent Library Wellbeing Hubs initiative within the context of the current economic climate. In the interests of self-preservation, it is becoming increasingly vital for libraries to be able to demonstrate the positive benefits a physical library space can offer above and beyond the mere provision of information. There is a sense that increasing unresponsiveness to libraries in the community is threatening government spending and investment in public libraries. One aspect of this is that libraries are increasingly becoming perceived as unnecessary in a technological environment where vast amounts of information are readily available to access and download remotely. Thus, the rationale often cited for providing spaces that are not exclusively used for housing books, but also for other activities, is that they encourage and inspire community engagement with libraries and ultimately books (Begg, 2009).

Set against this backdrop, it becomes clear that it will be crucial for the wellbeing hubs to demonstrate their effectiveness in order to become sustainable aspect of Kent's public libraries. The issue of sustainability has been carefully considered by the intervention leads, who have emphasised that the individual libraries should have 'ownership' of the zones in order to increase the likelihood of these hubs being long-lasting. This is part of the rationale for expecting the hub libraries take individual responsibility for maintaining the hubs once they are set up, with a designated member of staff to take on this role alongside their other duties.





Discussion

Concept

The library wellbeing hubs are aimed at the general population in line with the rationale of providing an easily accessible space open to all members of the public. In this regard, the programme can be seen as having ‘keeping people well’ as its core motivation. It is important to note, however, that the locations for the hubs were selected based on a higher prevalence of health inequalities in those areas, meaning that there is also an additional focus on local groups who are more likely to be vulnerable. The local rooting of the hubs is also reflected in the role of the partner organisations, who are to be managed by the libraries at a local level and are likely to seek to respond to the needs of specific local communities.

There are three main components to the hubs that aim to promote individual wellbeing: five book collections that seek to improve wellbeing in a range of ways, the provision of a wellbeing hub space that offers information and advice – both directly through leaflets etc. and through the work of partner organisations – and the additional component of an online wellbeing resource. The five book collections that will be housed in the wellbeing zones include two ‘Read Yourself Well Books on Prescription’ collections, two ‘Mood Boosting’ collections and one ‘Six Ways to Wellbeing’ collection. Whilst the Read Yourself Well and Six Ways to Wellbeing collections consist of non-fiction self-help books, the Mood Boosting books are a list of fictional works compiled by people with mild to moderate mental health problems who recommend reading these books to improve wellbeing. The library wellbeing hubs therefore encompass both the self-help bibliotherapy as well as creative bibliotherapy aspects discussed above.

"You need to couple self-help with the message that simply reading can make you feel good."

Library Wellbeing Hubs Project Lead

It is important to note that there is a difference between the two sets of self-help collections. Whilst the Read Yourself Well collections focus on improving specific mental health problems such as depression or anxiety, the Six Ways to Wellbeing collection is more generally focussed on lifestyle changes such as increasing happiness. These therefore adopt slightly different approaches to improving wellbeing, with the former focussing more on early intervention and the latter more broadly on keeping people well.

Each of the collections relies on different mechanisms by which to improve the reader's wellbeing. The mechanisms used by self-help books are relatively straightforward: they help the reader to improve their mental health self-management and also provide an opportunity for learning and education. The latter is particularly true of the Six Ways to Wellbeing collection, which is not focussed on specific mental health problems but instead encourages the education of the reader about how to promote wellbeing in general. Whilst creative bibliotherapy may also assist the reader in improving their mental health self-management, this type of bibliotherapy relies more on alternative mechanisms, namely distraction, role-modelling or identification with characters.

One project lead explained that even a small amount of creative reading per day can reduce stress levels vastly - this is because the reading process itself serves to distract the reader from other problems they may be focussed on. Shrodes (1949) asserts that there are a variety of objectives of creative bibliotherapy that relate to a role-modelling mechanism. Creative bibliotherapy can help people realise that they are not the first to have a particular problem and that there is more than one solution to a problem. It can also help the reader become more aware of the basic motivations of others involved in a situation, provide the reader with the facts needed to solve a problem and encourage the reader to approach a situation realistically.

"Because obviously if you've got an anxiety or a depression, one way to get out of that is to have some creative reading, because research has shown that six minutes of reading a day reduces stress levels by 68%."

Library Wellbeing Hubs Project Lead

The presence of a physical hub space also leads to several different mechanisms that improve wellbeing. The provision of a safe, non-judgmental space coupled with increased opportunities for social interaction may help keep people well, whilst the use of the hub space by partner organisations is more likely to facilitate early intervention around specific problems. The hub space also aims to increase awareness of the Six Ways to Wellbeing through its branding and promotional materials. The library hubs themselves, however, do not necessarily aim to encourage engagement with the Six Ways to Wellbeing *per se*, but instead aim to generate interest and signpost to the Live It Well website where there is more detail and opportunities to learn more, such as by booking onto a seminar. It is following this further engagement that people will be more likely to have the knowledge and resources to consciously practice the Six Ways in their everyday lives.

The outcomes of the library wellbeing hubs can be seen to fall into two categories: improved physical wellbeing which stems specifically from meetings with partner organisations and signposting to local resources, and the overarching improved mental wellbeing that encompasses outcomes such as reduced social isolation, reduced mental health symptoms and improved confidence and self-esteem.

Promoting Wellbeing

The library hubs embody the Six Ways to Wellbeing in a number of ways. As one project lead explained, users are encouraged to 'be active', either through small tasks such as walking to the library, or through bigger schemes that they may be signposted to either from partner organisations or the online wellbeing component. Perhaps most significantly, hub users necessarily 'keep learning', not only through engagement with the collections in the hub, but also through engaging with new activities or sources of advice in the shape of the partner organisations. Hub users may also be encouraged to 'give' their time, either through volunteering in the library or being signposted to other voluntary organisations. On a smaller scale, the wellbeing hubs may even just remind hub users that they should 'give' more time to family or friends as a way of improving their wellbeing. In relation to this point, hub users are likely to have increased opportunities to 'connect' with others, either in the hub space itself or through the signposting of users to organisations that they may wish

to join. Hub users will be encouraged to take notice of their local environment by coming across books in the library that educate on the local history or community. The hubs also promote care for the environment inasmuch as the concept of borrowing books from a library is an environmentally-friendly one. We can see, then, that the Six Ways to Wellbeing underpins a Library Wellbeing Hubs project in a range of ways.

Challenges to implementation

Although in its infancy, this project has already come up against several practical challenges to implementing the wellbeing hubs. First, it is important to point out that only eight hubs are being set up, despite there being an initial target of nine. This is because it transpired that there were space issues in the ninth library. It was mentioned that the issue of space had been a problem in a number of the libraries, as space within libraries is often limited and in demand. This could be a potential challenge to the sustainability of the hubs in the longer-term.

More generally, it appears that the very practical, material components of setting up the library hubs have posed the biggest challenges to date, and have meant that the process has taken slightly longer than expected.

"It has taken longer than what one anticipates, because to start with you think, ooh, that's a great idea, but then when you start peeling the layers you realise there's a lot more involved in it than just buying some furniture and plonking some books in and putting a bit of branding there. I mean, it sounds quite straightforward but it's not."

Library Wellbeing Hubs Project Lead

A related diversion from the original concept has been that the online kiosk element of the hubs has been put on hold, and the money invested elsewhere.

"At the moment we haven't done anything with the kiosks or anything like that. There was [funding] but we aren't actually looking at the funding for kiosks at the moment, we're just seeing how this goes. Because the kiosks are a separate issue and that would be quite complicated. You've got to work with IT and things like that, that would open up a can of worms and that would be a separate project."

Library Wellbeing Hubs Project Lead

There have been several other practical barriers to successfully and quickly installing the wellbeing hubs. This has included finding the right expertise for furniture provision, the time it takes to ensure that the branding and promotional strategies are in place, and managing staff relationships within the individual libraries in relation to setting everything up. Project leads highlighted that getting the branding right was very important, in order to avoid an amateur look. They also had to ensure that they followed SLAM's branding guidelines (see Six Ways to Wellbeing Campaign section of this report). Above all, there is a feeling that the hubs should not have a clinical feel to them, and should take advantage of the fact that libraries are primarily viewed as *social* spaces in order to promote health and wellbeing in a non-health setting. This will be crucial to the library hubs' success in

reaching vulnerable groups that may otherwise not be reached by formal health services – and there is a commitment to ensuring that the hubs do not resemble health centres or other clinical services. As well as the branding, project leads felt it was important to call the hubs 'wellbeing zones' rather than 'health and wellbeing zones' which has more clinical connotations.

"Because if you want to go into somewhere and want to meet somebody you've got to go through that door. But if you're going into a library, borrowing a book, using a computer, something like that, you feel more relaxed and calm, and they see somebody and think, oh, I'll go over and have a chat with them. It doesn't seem so clinical."

Library Wellbeing Hubs Project Lead

Finally, although the library hubs are just in the process of being launched at the time of report-writing, there are a number of potential problems that could impact on their success in the future. One key issue is around sustainability and whether the physical space in the library can be protected in the long-term (see above). A key challenge here is that the libraries have not been given any funding to maintain the hubs, and so library buy-in will be crucial to preserving the hubs. A related point that is currently unresolved is whether some partner organisations – depending on the nature of their work – might need to be charged for their use of the space, and how that could impact on the hub's future.

Finally, a potential challenge to the effective use of the hub space lies in the tension between it being intended to be a safe, confidential space in which people can discuss potentially highly sensitive matters, and it simultaneously being well-integrated into the broader library space. Indeed, as we understand it, the hubs are not physically separated from the rest of the library, which makes sense in terms of promoting the wellbeing message, but could be problematic in terms of confidentiality.

"I mean the only thing we can't provide, we can't provide confidential places. But if they do want a confidential conversation then they can make an appointment. Because at least they've met that person, that they can then, they feel more comfortable then."

Library Wellbeing Hubs Project Lead

Implications for the evaluation

As mentioned above, it will be important for each of the library hubs to identify a member of staff responsible for ongoing maintenance and promotion once set-up has been completed. These individuals have yet to be confirmed, which has two main implications for the evaluation. Firstly, it has meant that we have had to hold off making direct contact with the libraries – although given that the hubs are only just being launched, this is unlikely to be problematic. However, it will be important to establish these relationships sooner rather than later so that data collection (staff interviews, survey distributed to hub users etc.) can progress. Secondly, the issue of staff turnover – one of the reasons why staff have not yet been assigned to the hubs – feeds into questions about the sustainability of the hubs in the long term.

Regarding data collection, it has become clear that an electronic survey sent out to users of the hubs is not likely to be viable due to data management, IT and other technical issues. We are therefore proposing to distribute paper surveys – which will require the individual libraries to be very proactive in supporting with distribution. At present, we believe that the best way of administering the survey to a hub user will be upon the return of a borrowed wellbeing book, although paper copies can also be made available within the hub space. The survey will primarily focus on how borrowing a wellbeing book or using the hub space may impact on their wellbeing on the future, rather than approaching wellbeing changes retrospectively, which would be beyond the scope of the survey. It will therefore be important to bear in mind the link between behavioural *intention* and actual behaviour change, which may not be possible to measure directly (see also Six Ways to Wellbeing Campaign section of this report).

Finally, it will be important to consider the issue of reach – as it cannot be assumed that the populations that use the wellbeing hubs are reflective of those who use the library in general, nor of the general population in the area served by the library. We therefore propose to work with the KCC Evaluation and Monitoring team to link data on books borrowed with postcode classification of individuals by socio-economic and other demographic factors.



Primary Care Link Workers

Background

The Kent county-wide Primary Care Link Workers project came about as a result of a partnership between Kent County Council Public Health, KCC Families and Social Care, and Kent's Clinical Commissioning Groups. The overarching aim of the initiative was to provide a Primary Care based service that would enable GPs to direct people with mild to moderate mental health problems towards mainstream activities in everyday community settings that would benefit their wellbeing, thereby reducing demand on the formal health services infrastructure in the longer-term. This would be facilitated by the Link Worker, to whom the initial referral would be made, and who would offer support and signposting in this regard.

Part of the impetus for the commission was the success of a similar Link Worker project that had already been piloted in Thanet between 2009 and 2013, and the contract was awarded to Porchlight, the same organisation that had delivered this pilot. Porchlight are a Kent homelessness charity, based in Canterbury but active across the county, with a long history of supporting people who are homeless or experiencing associated issues such as problems with mental health, benefits, housing or personal finance and debt.

It is instructive to frame the Kent Link Workers project within broader understandings of what has come to be called 'social prescribing', as well as existing models of link working. The idea that primary mental health care should be integrated into the community and connect individuals with a range of agencies and organisations has been endorsed by the Joint Commissioning Panel for Mental Health, who suggest that a stepped model of care should be founded on the concept of social prescribing, or 'community referral'.

Social prescribing has been defined as 'a mechanism for linking patients with non-medical sources of support within the community'. (Friedli & Watson, 2004, p.3). Such 'prescriptions' tend to be issued by Primary Care practitioners, under headings such as 'exercise on prescription', 'arts on prescription' or 'prescription for learning'. Individuals may be referred to a range of activities or services, including creative and arts activities, exercise and sports, skills development, volunteering, and employment or benefits advice. It has been suggested that social prescribing may be especially effective for certain populations. For instance, Rogers and Pilgrim (1997) suggest that the broader, more holistic framework of social prescribing, with its emphasis on personal experiences, relationships and social conditions, may be more intuitive to and therefore appropriate for those with lay understandings of mental health and wellbeing than more medicalised models. Others have suggested that social prescribing may be more beneficial than standard Primary Care services for LGBT communities (Hutchinson et al., 2003) and BME communities (Mental Health Act Commission, 2001; Department of Health, 2004) due to the increased stigma and discrimination experienced by these populations which can be a significant barrier to access and engagement with the latter.

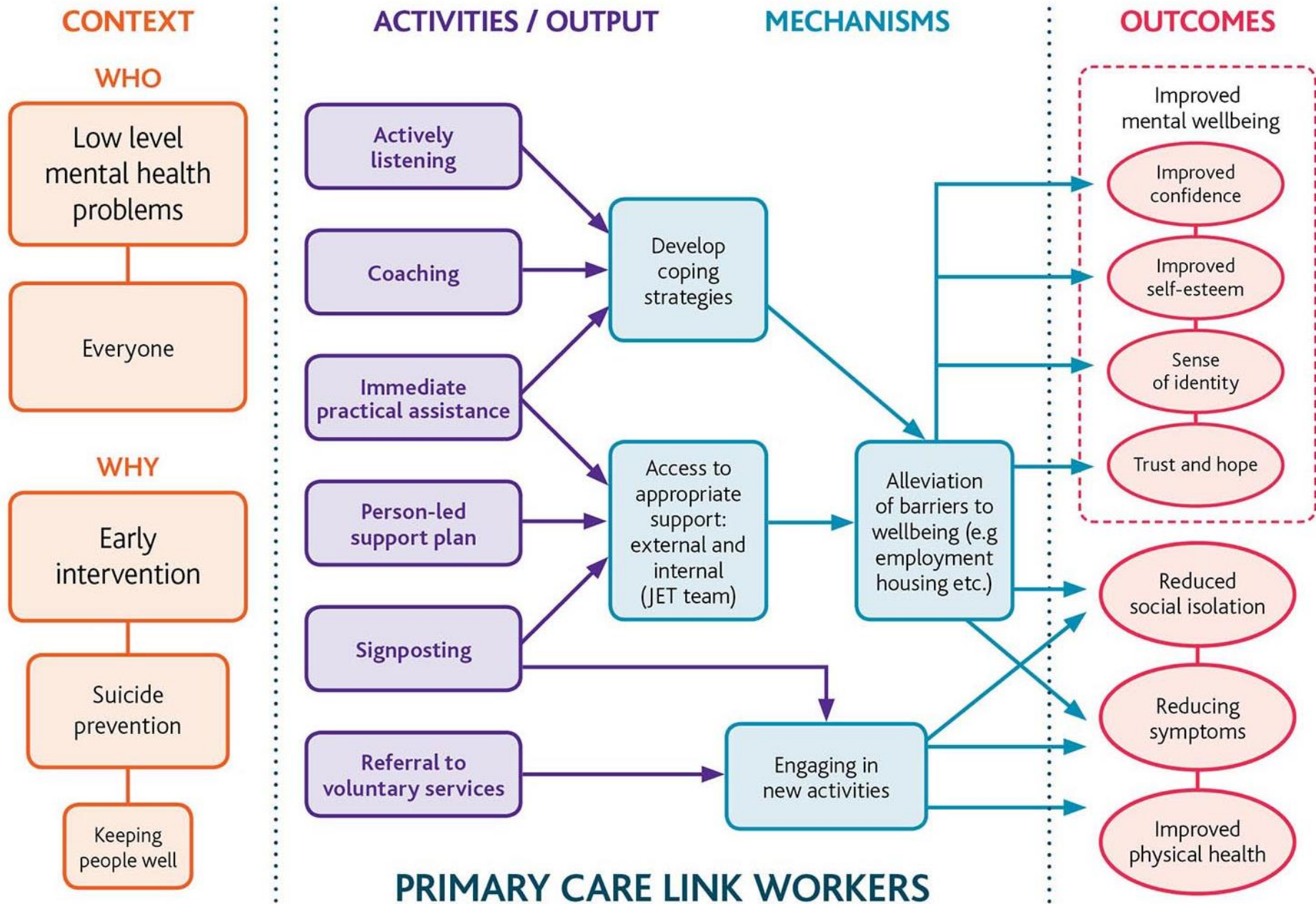
Friedli and Watson (2004) argue that social prescribing generates benefits in three broad areas: improved mental health outcomes, improved community wellbeing, and reduced social isolation. More specifically, social prescribing is linked to a range of outcomes, including increased awareness of skills, activities and behaviours that improve and protect mental wellbeing; 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; reduced waiting lists for counsellors and psychological services; and reduced levels of frequent GP attendance (defined as more than 12 visits to the GP per year) (Friedli & Watson, 2004).

It has been suggested that one way to promote the use of social prescription is through link workers acting as intermediaries, as GPs may not always have the time or knowledge to directly issue prescriptions to the activities or services outlined above. This is the model on which the Porchlight Link Workers project is based. According to one study, a link worker's role may encompass a range of responsibilities and tasks: the empowerment of clients and their carers, individually tailoring service provision based on an assessment of need, promoting inter-agency collaboration at all levels, and providing continuity of care and a named care manager for each client (Appleton et al., 1997). Other responsibilities, as outlined by Halliday and Asthana (2004), include providing a contact point for the patient, including the provision of information, signposting and emotional support, coordinating the services provided, and monitoring and reviewing the care plan and ensuring its effectiveness. One well-known precedent of a link workers model that exemplifies these principles is the interventions delivered by the Revolving Doors Agency, a charity that works with young people in the criminal justice system with mental health problems (see Solomon, 2005).

To date, studies that explore the outcomes of integrating link workers within a primary mental health care team are few in number and somewhat inconclusive. There is some evidence to suggest that such an addition leads to positive outcomes such as improved WEMWBS scores (Morton, Ferguson & Baty, 2014) and a reduction in relapse rates (Byng et al., 2004). A Revolving Doors Agency pilot suggested that there were positive outcomes for mental health, with 68% showing an improvement in mental health after working with the link workers over the long term (Solomon, 2005). They also found that 56% had improved their housing situation, with fewer people remaining homeless and more staying with relatives or in supported housing. The study also found that one in three had improved their management of drug misuse after engagement with the team. Hunter, Playle and Cahill's (2008) qualitative study also provides evidence of the benefits of having a mental health link worker, but another study (Bindman et al., 2001) found that the introduction of a link worker had no impact on rates of admission to formal services or subsequent in-patient costs.

As noted above, the Porchlight service hinges on the figure of the link worker, who acts as an intermediary between the GP, who makes the initial referral, and the community based activities and services that have the potential to improve wellbeing and constitute the 'social prescription' itself. We shall see, however, that the Porchlight model diverges from the conventional link worker / social prescription model in a number of ways – both in terms of the nature of the support offered, but also the time frame within which the link workers are expected to operate.



Discussion

Concept

As discussed above, the rationale for Porchlight's service is best understood in terms of social prescribing - addressing the social determinants of mental health in a community setting – with a view to helping individuals who are experiencing lower-level mental health problems and saving costs by preventing them from requiring longer-term more expensive services. The mechanism through which this takes place is via a link worker, who acts as an intermediary between the GP and a range of community activities and services. The service was designed to be accessible to people living across all CCG areas in Kent, although certain priority surgeries that were expected to be significant sources of referrals were identified by Public Health and were the focus of targeted engagement during the set-up period.

“Anxiety and depression is the classic one; being medicated month on month for that when actually the problem is debt, and it's the debt that needs to be sorted out to alleviate that and therefore not need the medications.”

Porchlight Project Lead

There are two key elements to the Link Worker service. The first – which corresponds more to other models of link working discussed in the literature (see above) – consists of tailored, one-to-one support to help individuals engage in a range of social activities in a community setting. Our understanding is that this aspect of the work was central to the service specification developed by the commissioners. The other element of the service consists of more immediate, practical support provided by the link worker directly to the person – resembling the role of a support worker. Our understanding is that this aspect of the work was emphasised more by Porchlight in their response to the tender, probably because of Porchlight's experience and expertise around working with people who had housing, benefits or other financial issues that needed an immediate, practical resolution. It is important to note, however, that Porchlight's service is quite different to conventional support work, as the support is explicitly intended to be time-limited – with a target eight week maximum intervention – in order to avoid long-term dependency. This is approached flexibly, however, and service users have the option of contacting their link worker after the intervention formally ends. It is also important to note that part of the service may involve internal referral to other Porchlight services, notable the Jobs, Education and Training team, who offer employment and education support.

The intended outcomes of Porchlight's offer centre on reducing the symptoms of a mental health problem before it becomes more severe. However, the service also seeks to actively promote mental wellbeing by increasing confidence and self-esteem, inspiring hope and aspiration, and strengthening a sense of identity. At a community level, the social prescribing element of the intervention is expected to reduce social isolation and promote social inclusion. Porchlight actively promotes service user involvement, and invites service users who have completed an intervention to take part in a feedback forum, with a view to improving the service.

Accessibility

In our conversations with the project leads, the theme of accessibility emerged as central to the way the project has unfolded in practice. Although the service was intended primarily as a model for early intervention for people with mild to moderate mental health problems, in practice, it has been keen to promote itself as a service that can be accessed by anyone – there are no particular criteria that must be met.¹

“[Other mental health services] are very restricted into which clusters they can work with and with what criteria; whether someone needs a diagnosis, whether someone has previously accessed services. And one of the good things about GP Link is that it’s just very easy to get into, it’s very accessible. So all someone needs to say is, ‘I need some help’”.

Porchlight Project Lead

This does not mean that the service has diverged from the original concept; rather, it points to broader questions around definitions of mental health and wellbeing, and the importance of recognising that these are best understood in terms of a *spectrum*, rather than a *dichotomy* between those who have and do not have, a mental health problem. The project leads have been conscious of this challenge of whether or not to frame the service as a mental health service. On the one hand, it is felt that it is important not to turn people off from accessing the service due to negative associations with terms like ‘mental health’ – but on the other, the team has a strong commitment to challenging this kind of stigma and changing attitudes around mental health. Porchlight has found that using words like ‘anxiety’ when promoting the service has been helpful, as it is broad enough that it is easy to relate to, but also conveys the idea that someone is struggling to cope and doesn’t know where to seek help.

Housing and benefits focus

Another defining feature of the project as it has been implemented in practice is that it the majority of the problems the link workers offer support with relate to very practical challenges around housing, benefits or other financial matters. As discussed above, this focus was, to some extent, anticipated at the outset, and is partly due to the background and expertise of the contracted provider. Most importantly, however, it is also driven by the needs of the people who access the service – and it was clear at the start that this would be the case.

“The service users have dictated what we do with them...So a huge amount of work has been done around housing and benefits and economic activity – getting people into work etc.”

Porchlight Project Lead

It is important to note that this diverges slightly from the original model, as there is less scope for a more holistic, community focused ‘social prescribing’ approach encompassing a range of life

¹ The only exception to this is when somebody is very unwell and is, or should be, being treated by specialist (Secondary Care) mental health services.

domains when someone needs assistance filling out a particular benefits claim form, which is a typical example of what the link workers have been helping people with. However, it is well-aligned with the intention for this to be a time-limited intervention, as many of these very practical problems are 'short and sharp' and can be resolved within days, or sometimes hours. There is a potential further challenge here, however, as the link worker support is intended to help the person develop the skills they need to manage independently in the future, and it is not clear that 'quick-fix' solutions will secure this independence and resilience. It is important to note, however, that in some instances, what appears to be a simple problem is actually much more complex, and longer-term support could be needed. In these cases, the link worker can exceed the maximum eight week target and offer ongoing support.

There is a sense that some of the other stated outcomes, mostly around engaging in new activities at a community level, are harder to achieve in the short time-frame allocated to the link worker support. The project team felt that these outcomes were very relevant, but were longer-term goals, or consequences of the intervention for many of the people who go through the service.

“You’ve only got eight weeks, so you’re not exactly going to be developing a long-term personal trust with those people. You’ve got to be able to get in there quickly, build the relationship, get some results quickly...and that’s alien to the way a lot of support work has gone.”

Porchlight Project Lead

Service promotion, referral and social prescription

One of the main practical challenges encountered by Porchlight has involved promoting the service amongst the designated GP surgeries. During programme set-up, the link workers were tasked with visiting GP surgeries, seeking their buy-in and willingness to refer appropriate cases. However, the link workers found that GPs are highly suspicious of any kind of promotional activity, and frequently mistook the link workers for drugs reps trying to sell to them.

Although the project is still ongoing, one observation to date has been that the GP surgeries have not proved to be the major source of referrals as had been expected. Instead, referrals are coming from a wide range of sources, including GPs who had not been actively targeted by the link workers, a range of other agencies and organisations, and via self-referral, which can take place online, over the phone, or face-to-face at drop in sessions. One project lead commented that although they have been surprised by the high number of self-referrals, it could also be that GPs are telling people to self-refer, or that people are hearing about the service from leaflets or posters in GP surgeries. There is also some anecdotal evidence that the service is being promoted in a peer-to-peer way within the local community, with some service users taking an active role in service promotion.

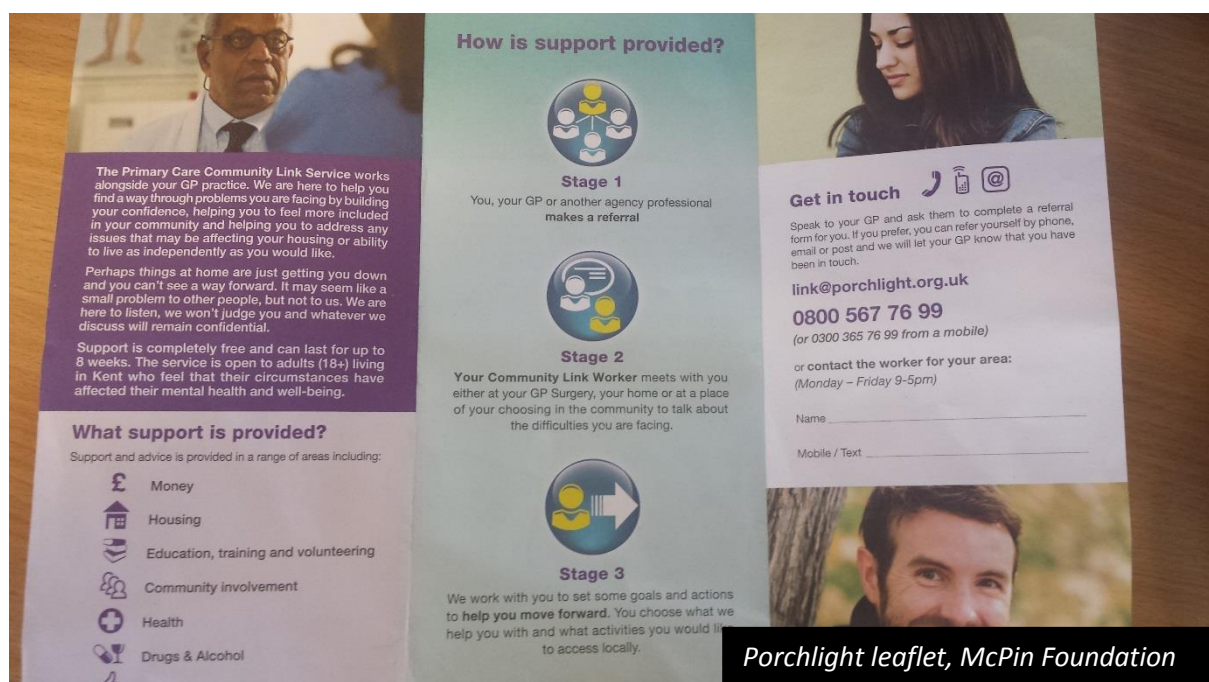
Although the Porchlight team has been positively surprised that referrals are coming from diverse sources, and are keen to work in a joined-up way with a range of agencies and organisations, this development raises some interesting questions about the nature of a service that was ultimately intended to be Primary Care based. There is an underlying view that GP referrals should still be the central way in which the service is accessed, given the large numbers of people who go to their GPs on a regular basis and are issued medical prescriptions that do not seem to help in the long run.

Implications for the evaluation

Porchlight has been collecting comprehensive KPI data on numbers reached in each area and demographics. When someone exits the service, link workers are required to submit a worker outcome form, and service users encouraged to complete a feedback form. Porchlight have been using the Recovery Star before and after the intervention, and recently started using the WEMWBS tool in a similar way. We have been supporting with the process of setting Porchlight up to administer WEMWBS, and understand there to be a number of concerns about its use. This includes over-burdening link workers and service users by giving them yet another form to fill out before support can be offered, concerns around whether the tool can measure the impact of very short, targeted interventions, and concerns around the feasibility of re-contacting people for follow-up research. This last point in particular has implications for the evaluation, and also applies to the other follow-up work (interviews, survey) that we intend to do. Porchlight felt that we were perhaps too optimistic in our targets, especially regarding follow-up WEMWBS at three and six months, based on their knowledge of their client group. They also said that we might encounter a challenge in accessing people who were referred to the service and chose not to engage, as this usually happened when attempts to make contact failed (due to address change etc.).



It is also important to note that we have established that collecting data around GP attendance will be difficult to do within project timings and budgets, as Porchlight do not have agreements in place with the surgeries that would facilitate easy access to this data.



The Primary Care Community Link Service works alongside your GP practice. We are here to help you find a way through problems you are facing by building your confidence, helping you to feel more included in your community and helping you to address any issues that may be affecting your housing or ability to live as independently as you would like.

Perhaps things at home are just getting you down and you can't see a way forward. It may seem like a small problem to other people, but not to us. We are here to listen, we won't judge you and whatever we discuss will remain confidential.

Support is completely free and can last for up to 8 weeks. The service is open to adults (18+) living in Kent who feel that their circumstances have affected their mental health and well-being.

What support is provided?
Support and advice is provided in a range of areas including:

- £ Money
- Housing
- Education, training and volunteering
- Community involvement
- Health
- Drugs & Alcohol
- Confidence

How is support provided?

Stage 1
You, your GP or another agency professional makes a referral

Stage 2
Your Community Link Worker meets with you either at your GP Surgery, your home or at a place of your choosing in the community to talk about the difficulties you are facing.

Stage 3
We work with you to set some goals and actions to help you move forward. You choose what we help you with and what activities you would like to access locally.

Get in touch 📞 📧 📱

Speak to your GP and ask them to complete a referral form for you. If you prefer, you can refer yourself by phone, email or post and we will let your GP know that you have been in touch.

link@porchlight.org.uk
0800 567 76 99
(or 0300 365 76 99 from a mobile)

or contact the worker for your area:
(Monday – Friday 9-5pm)

Name _____
Mobile / Text _____

Porchlight leaflet, McPin Foundation

Kent Sheds

Background

The Sheds movement originated in Australia, where there are currently 690 sheds and over 90,000 shed members – frequently referred to as ‘Shedders’ (AMSA, 2015). According to the Australian Men’s Sheds Association (2015) a shed can be defined as:

“a community-based, non-profit, non-commercial organisation that is accessible to all men and whose primary activity is the provision of a safe and friendly environment where men are able to work on meaningful projects at their own pace in their own time in the company of other men. A major objective is to advance the wellbeing and health of their male members.” (AMSA, 2015)

The movement has recently spread to other parts of the world, however, with over 80 Sheds now up and running in the UK, and many others in planning (UK Men’s Sheds Association, 2015). The Kent Sheds project sits under this umbrella, and, similarly to the roll-out of Mental Health First Aid (see relevant section of this report), is an example of Kent County Council’s pioneering and ambitious approach to improving the mental wellbeing of its population by delivering established interventions, with 14 Sheds funded to date.

As indicated above, the rationale behind the Sheds movement is that men – especially those who are middle-aged (40-60 years) may be less likely to benefit from conventional approaches to improving mental wellbeing via formal learning environments and counselling approaches such as talking therapy. Instead, they are more likely to thrive in informal spaces, in the company of their peers, and through engaging in practical activities. A wealth of research supports the thesis that the sheds model leads to improved mental health and wellbeing outcomes for men (Ballinger, Talbot & Verrinder, 2009; Brown, Golding & Foley, 2008; Cordier & Wilson, 2013; Morgan, Hayes, Williamson & Ford, 2007; Ormsby, Stanley & Jaworski, 2010). The key outcomes include feeling a sense of purpose, being part of something and having a sense of belonging, learning new skills in a supportive environment and feeling like they can give back to the community (Ballinger, 2007, Ballinger; Talbot and Verrinder, 2009).

However, there are also a number of studies that challenge this positive picture. Most worrying perhaps, some commentators have critiqued the concept of a ‘men’s shed’ as being highly gendered, relying on, and perhaps leading to, the stereotyping of men as ‘bloke-ish’ and only able to engage in ‘manly’ activities (Hayes and Williamson, 2007; Moylan et al., 2015). Hayes and Williamson (2007) also suggest that sheds have the potential to be exploited by those who wish to impose certain political agendas on others.

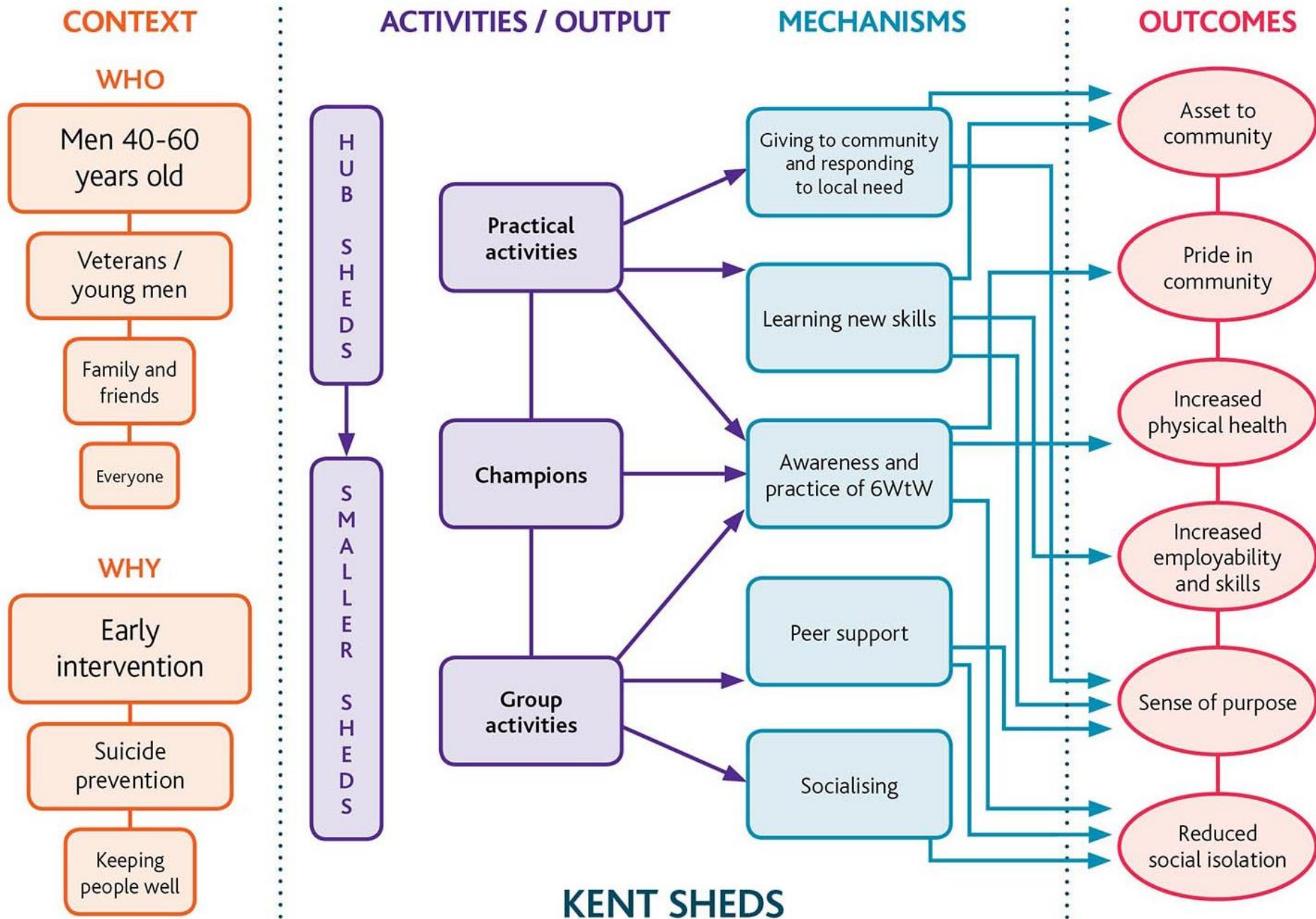
In Kent, the focus of the project includes ex-service personnel, of whom there are significant numbers in the county, and who are arguably more likely both to have mental health difficulties, and also to benefit from a shed community and the company of other men (cf. Brown, Golding & Foley, 2008). The Sheds project as a whole is part funded by the Libor fund, which aims to support ex-service personnel, and builds on the success of an established pilot shed called ‘Futures for Heroes’ located in Sandwich. However, the Kent Sheds project is also explicitly open to women.

A review of the literature – mostly in the Australian context – reveals that men’s sheds generally aim to target a range of marginalised male subpopulations that are at particular risk of social isolation (Cordier & Wilson, 2013). Based on extensive surveys and interviews with members of 25 community sheds across Australia, Brown, Golding and Foley (2008) provide an overview of the types of men who accessed sheds. The majority were retired, unemployed or isolated older men who were considered ‘economically inactive’ having fallen out of the labour market. 50% of the men who attended were over the age of 65, and 1 in 5 was ex-service personnel. Brown, Golding and Foley (2008) found that Sheddors sometimes report that they experienced ‘underfoot syndrome’ prior to joining the shed. This term is used to describe the experience of recently retired men who suddenly find themselves spending much more time at home than before, a state of affairs they find unfamiliar, and their wives or partners find disruptive.

Joining a shed can help alleviate this sense of feeling ‘underfoot’ in the home, as sheds often support the practice of ‘hands on’ activities, for instance the development of skills in woodwork or metalwork, including specialisms such as furniture-making and mending, toy-making or welding projects (Brown, Golding & Foley, 2008). Typically for these kinds of sheds, the shed space is the size of a double or triple car garage with a preparation area for food, tea and coffee. Some have annexed outdoor spaces with a barbeque and garden area, and some also have a recreation area with a pool table and lounge chairs (*ibid.*).

At a more analytical level, Cordier and Wilson (2014) propose that there is a distinct philosophical and functional separation between shed types. First, there are sheds that are primarily skills-based and encourage men to engage in occupational activities for the sheer joy of engaging in those activities. On the other hand, some sheds use the shed environment, and by extension occupational activities, to undertake a wider community-focussed agenda. It is these sheds that are more likely to engage with subpopulations of the community and offer programmes, information and activities that are focussed on promoting health and wellbeing.

The Kent Sheds model is not limited to either of these principles or functions, and aims instead to be as open and flexible as possible, with the focus of the individual sheds to be determined by the ideas and needs of members. As we shall see, the project leads felt that the Kent approach is unusually flexible, as it welcomes women and men of all ages to the sheds, in contrast to some of the more traditional sheds that have strict membership criteria. We shall also see that although the Kent sheds are activity- focused, engaging in a practical activity – whether skilled, community-focused, or both – is not the overriding principle that guides this intervention.



Discussion

Concept

As noted above, and in line with previous sheds initiatives, the Kent Sheds model aims to primarily target men between the ages of 40 and 60, as it is recognised that this group is especially likely to suffer from mental health problems, and also constitutes those most at risk of suicide. For the same reasons – and this is also linked to the funding structure of the programme – some of the sheds are to have an ex-service personnel focus. However, it aims to be inclusionary, and project leads emphasised that it was also open to younger men, and women of all ages. The intervention is therefore also intended to improve the wellbeing of the broader population, either when younger men and women become Shedders directly, or indirectly as a result of the positive outcomes for their male family members who are engaged with the Shed.

“We get calls from women asking where they can send their husbands.”

Kent Sheds Project Lead

There are two tiers of sheds within Kent Sheds – larger ‘hub-sheds’ that are expected to have a more sizeable membership, and smaller sheds that the hub sheds can offer support to. Networking and peer support *between* sheds (as well as within sheds by members) are fundamental to how the intervention aims to operate. Shed ‘champions’ – understood to be any Shedder who plays a particularly active role in promoting the sheds – are crucial to this, as well as to generating support for the sheds more generally.

The mechanisms through which the sheds achieve their outcomes include ensuring that their work is built on the principles of the Six Ways to Wellbeing. This is closely linked to mechanisms that follow from the ‘practical projects’ aspects of sheds operations – responding to local need and giving to the community, as well as learning new skills. The Six Ways are also closely linked to the mechanisms that follow from the ‘group activities’ aspect of the project – socialising and peer support.

The intended outcomes identified by the programme closely resemble those that have been documented in previous studies of men’s sheds, namely a sense of purpose and reduced social isolation, giving to the community and feeling part of the community, an increase in employability and skills, and improved physical health.

Activities and skills or purpose and belonging?

Again resembling previous iterations of sheds interventions, Kent Sheds constitute both a social space where people can come together as a group, and are also often focused around particular activities or practical projects. The nature of each individual shed is determined by the ideas and needs of Shedders themselves. In order to ensure that these were at the heart of the programme, the first phase consisted of a period during which a community organisation, Activemob, conducted intensive community engagement work across the county, sourcing local knowledge and identifying places where there might be a need for a shed and people who were keen to be part of responding

to that need. Membership could be drawn from an existing community group or a new one, on the condition that any shed would be inclusive and accept new members, and also that the shed was clear about how it promoted the wellbeing of its members. Once a group of prospective Shedders had been identified, Activemob managed a handover to a second organisation, Groundwork, who were responsible for supporting the Shed with its funding application, set-up if successful, and monitoring and data collection once established. This support was a crucial part of KCC's offer to prospective Shedders.

This phased process and flexibility in approach has meant that the Kent Sheds project has seen the emergence of a range of different kinds of sheds that do not lend themselves easily to broad generalisations. Although many of them have an ostensible 'practical' focus – such as wood-working, DIY work, or nautical activities, to give a few examples – project leads are quick to acknowledge that the skills aspect is often not the most relevant to the populations they are trying to engage. Rather, it is the sense of purpose and belonging that is paramount for many. Project leads explained how for some of the people engaging with the sheds, learning a new practical skill might be a long-term ambition, but the reality was that leaving their home and meeting in a social setting was a big step and achievement for them. Although there were some people who were keen to take on a leadership role, or who saw their sheds work as a direct way of building themselves up towards employment, shedders' aspirations could be much less ambitious.

“Some people who are joining the sheds haven't necessarily got a skill to share, but just want the social side. Just want that place to belong and make friends and have a cup of tea. Some of them are so lonely.”

Kent Sheds Project Lead

“More than anything, it gives them a sense of purpose. It's just knowing you have somewhere to go where you are part of something.”

Kent Sheds Project Lead

Although our ethnographic visits to the sheds have only just begun, we already had one opportunity to observe this dual focus of 'skilled activity' vs. 'socialising' in action. One of the sheds we are looking at in more detail offers both a specific activity – woodwork – and also a social meeting space with books, music and a pool table. During the visit, one of the leadership figures within the shed explained that although the men enjoyed the woodworking, as soon as they had the opportunity they would head straight for the pool table – and this was indeed what we observed during the visit.



Shed woodwork space, McPin Foundation



Shedders at pool table, McPin Foundation

Practical implementation

Although the Kent Sheds programme is still in its relatively early stages – with some sheds not yet up and running at the time of report-writing – these early stages have been characterised by a number of practical challenges. One of the challenges encountered by Activemob during the course of their community engagement work was that a minority of prospective shedders were put off from wanting to take things further because they felt that too many outsiders had come in and made them promises that were never kept. They liked the idea of setting up a shed, but were anxious about being disappointed and let down again, and were therefore reluctant to invest their time in the project.

During the funding application stage, it was felt that not all sheds gave careful consideration to what kinds of resources they would need to be able to operate. Instead, project leads felt that there was perhaps too much of a focus on securing the maximum funding (£25,000 for hub sheds, £5,000 for smaller sheds), with almost all sheds going for this – even when they did not appear to require this amount. It was suggested that it might have been better not to provide sheds with these figures, instead encouraging them to reflect more carefully on what resources they actually required funding for. It is worth mentioning here that the limit for hub sheds was later altered, and capped at £10,000, and also that funding for new sheds has had to be frozen for the time being due to unprecedented demand. There was a sense that perhaps it would have been better to have been able to fund more sheds, but with reduced investment in each – and here too, the amounts that the sheds were bidding for was called into question. However, it is also worth remembering that more sheds require more support from Groundwork, who already found themselves quite stretched due to the fact that demand for sheds exceeded expectations.

During application stage, there were also some issues around prospective sheds not wanting, or not being able, to fulfil the basic funding criteria – which consisted of evidencing the link between the shed’s work and mental wellbeing via the Six Ways to Wellbeing, and also ensuring that the shed would be open to all. Some organisations applied for Kent Sheds money as a way of continuing to fund their existing activities, without demonstrating a willingness to adapt what they were doing in these ways. However, the vast majority of sheds were founded on ideas that were well aligned with the Six Ways to Wellbeing.

“[The Six Ways] always fits really well anyway, but sometimes I try to point that out, go through the Six Ways and say, ‘look, you’re linking to this, this and this just by doing the one activity’”.

Kent Sheds Project Lead

The biggest challenge for those sheds that were successfully funded was the question of premises – which links to the issue of shed sustainability discussed below. Many of the sheds had struggled with securing premises that would be affordable in the long-term, and as a result, the process of setting the Sheds up took longer than expected.

Sustainability

Both KCC Public Health and the project delivery teams have been clear that the investment from Public Health is highly likely to be a one-off, and the question of whether the funded sheds can become sustainable in the long-term is of great interest to all stakeholders. The question of sustainability relates both to the material resources required for shed activity (premises, tools etc.) but also the knowledge and expertise to secure funding from elsewhere for inevitable expenses. In this instance, the sheds had benefitted from the guidance of an external organisation, Groundwork, to help with this bid-writing process – but this, too, has been the result of an investment that cannot be guaranteed in the future.

In order to address these challenges, the funded sheds, with support from Groundwork, have been looking to identify ways in which they can become sustainable. This has included thinking about how to secure premises at low-cost, or for free, or, in one instance, finding a way to run a ‘virtual shed’ whose activities always take place in the community and do not require a designated physical space. These approaches usually involve close integration within the community – which is a core sheds objective in itself – and relying on local resources, and sometimes goodwill. This kind of approach can also lead to donations of various forms – tools in particular were mentioned as being valuable.

In order to develop the sheds’ knowledge around writing bids and securing grants, Groundwork is also offering training and support in this field where required. Groundwork is also producing a toolkit, with input from existing Sheddors, which will offer guidance around how to set up a new shed for those with no pre-existing knowledge or experience of this.

“What I’m doing this year is working with the groups, especially those that don’t have experience of writing bids, [running] workshops to tell them where they can go for funding, where there are small pots of money for community groups. Because they will need funding...even if they manage

to bring in small amounts...some may charge a membership fee. But it's not going to be enough. So they will need some kind of experience in bid-writing."

Kent Sheds Project Lead

Implications for the evaluation

There are a number of implications for our evaluation that emerge from this discussion. The first is that as the process of setting up the sheds has taken slightly longer than expected in some cases, timescales will need to be pushed back accordingly. For example, one of the four sheds that we are focusing on as a case study is not up and running at the time of report-writing, and others are still in the early stages, meaning that it makes sense to wait a little longer before undertaking observations and interviews with shedders, and distributing surveys. However, we are pleased that we have managed to identify four very different sheds for these case studies that should demonstrate the diversity of the Kent Sheds programme. These include a shed based on a boat, the 'virtual shed' mentioned above, a 'mobile shed', and a hub shed. Among these are included an ex-service personnel-focused shed and a shed with a substantial female membership.

Another important feature of the Sheds project that will shape the evaluation is that as these are intended to be long-term initiatives, they do not have a clear 'end point'. Moreover, the structure of the sheds is fluid and flexible, allowing for people to take part as and when they please, without firm commitment. This has a number of implications for us. First, it might not be easy to identify someone who has 'disengaged' from the shed, as this person may well intend to return and is only temporarily absent. However, we will still attempt to do this based on what we learn from other shedders, especially those who have more of a leadership role. Second, it is important to note that WEMWBS cannot be collected 'post intervention' for this project – as there is no end point – and instead is being collected by Groundwork at three month intervals. Again, it is important to note that there are likely to be new shedders joining, and drop outs or temporary absences, and so it is not possible for us to estimate how many comparable WEMWBS forms we are likely to have (i.e. forms completed by a single shedder at different time points).

Similarly, it is worth pointing out that for practical reasons relating to the engagement patterns outlined above, our 'Six Ways survey' will not be administered at a particular time point in a shedder's 'shed journey'. Instead, all sheds will receive and distribute the survey at the same time (summer 2015, to be confirmed once all sheds are up and running). The survey questions will need to consider that some respondents may have been engaged with the shed for some time, with others recently joining, and that this will likely impact on their knowledge and uptake of the Six Ways to Wellbeing.

Finally, there are some doubts around the extent to which shed sustainability within the duration of the project timeframe can be measured, as only time will tell whether a Shed is sustainable once the funding period is finished.



Six Ways to Wellbeing Campaign

Background

A social campaign, according to Rice and Atkin (2001), is a purposive attempt to inform, persuade or motivate behavioural changes for non-commercial benefits to the individual and/or society at large. This definition is expanded on by Crawley (2009), who suggests that such campaigns typically take place within a given time period and use organised communication activities including mass media. The majority of social campaigns are designed to bring about behaviour change at an individual level, and are often promoted within public health arenas in an effort to tackle problematic behaviours that lead to detriment, or to encourage positive behaviours that are likely to improve individual or social wellbeing (*ibid.*).

The Six Ways to Wellbeing campaign run by Kent County Council Public Health is an example of the latter – an exercise in social marketing using different media forms that seeks to encourage people in Kent to make small changes in their day-to-day actions with a view to increasing their mental wellbeing. The campaign builds directly on the extensive research undertaken by the Mental Health Promotion Team at South London and Maudsley NHS Foundation Trust (SLaM) and their ‘Wheel of Wellbeing’ with which the Six Ways are directly aligned (see below), and KCC is only one of a number of organisations to have adopted their approach to mental health promotion. The Wheel of Wellbeing was a culmination of a five year Big Lottery funded mental health improvement programme - a partnership between the London Health Commission and six alliance organisations – to improve the health and wellbeing of people in London neighbourhoods experiencing the greatest health inequalities and social and economic disadvantage. This work was, in turn, closely linked to the New Economics Foundation’s (2008) development of the ‘Five Ways to Wellbeing’.

SLaM’s Wheel of Wellbeing consists of six segments which represent: body, mind, spirit, people, place and planet. For the purposes of the KCC Public Health campaign and broader Mental Wellbeing Programme, it was felt that messages containing clearly identifiable actions that could be easily put into practice would be the most impactful way of communicating the Six Ways and effecting behaviour change, rather than just raising awareness around mental wellbeing. For this reason, the Wheel of Wellbeing became the ‘Six Ways to Wellbeing’, which consisted of the following messages: be active (body), keep learning (mind), give (spirit), connect (people), take notice (place) and care (planet). The Wheel of Wellbeing imagery and branding has been retained throughout.

With a view to increasing the reach of the Six Ways message and making it as accessible as possible, KCC Public Health modified the original model in other ways too. For example, they diverged from the longer workshop / full day seminar format delivered by SLaM and adopted a more concentrated, activity-focused seminar format that would make it easier for more participants to be able to engage in ‘tasters’ of the Six Ways. Furthermore, it was recognised that the campaign would benefit from being more context specific and relevant to the everyday lives of ordinary Kent residents. For this reason, local resources and narratives were promoted via the Live It Well website – a resource that was revamped by Public Health in order to feed into their Mental Wellbeing Programme – as well as other media and social media communications.

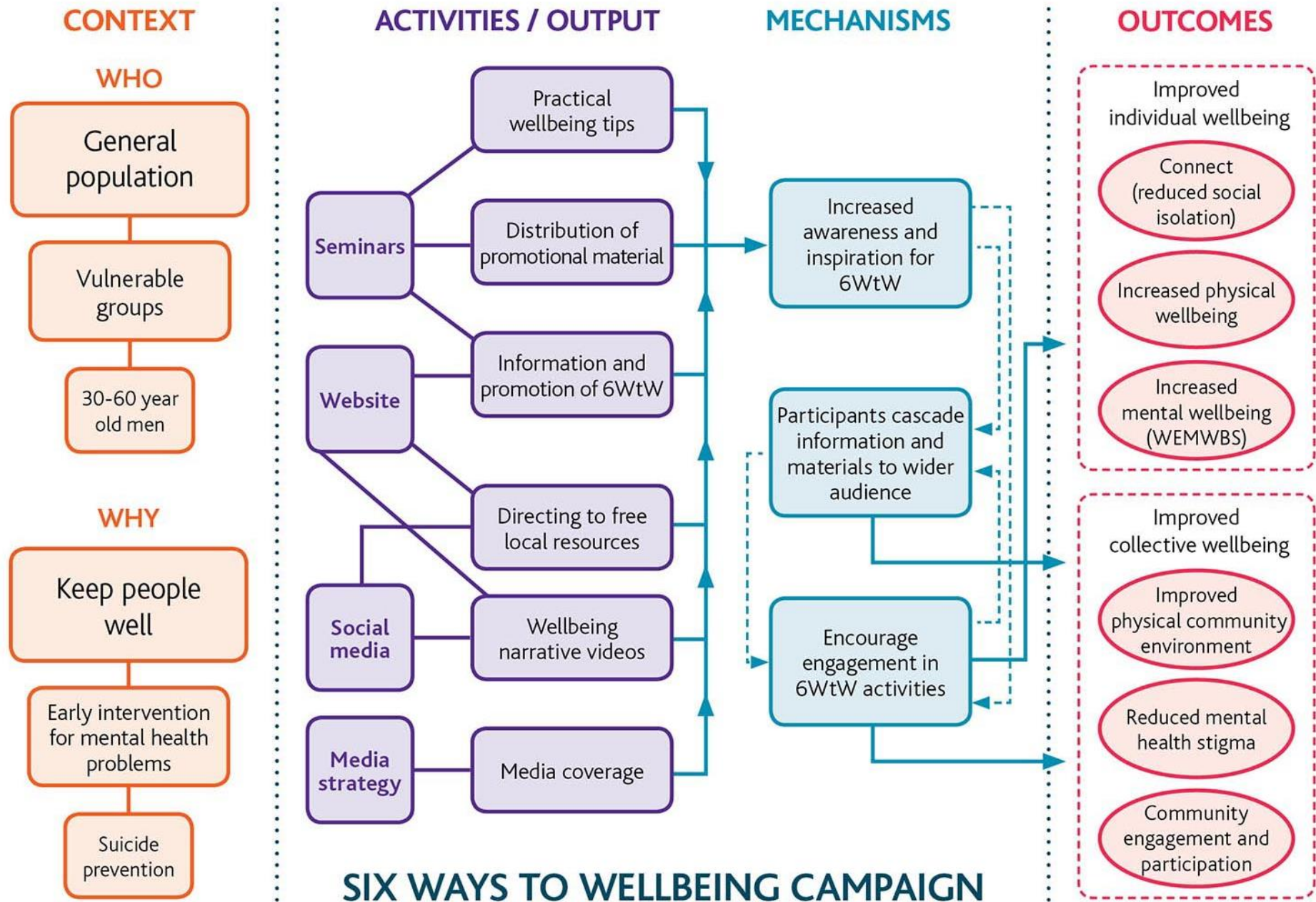
“We do still have secondary health information on there, but slightly changed the message towards the whole health population sort of thing. Mental wellbeing but linked up with all the other themes.”

Six Ways Campaign Project Lead

Crawley (2009) argues that there are a number of principles that need to be considered for a campaign to be successful in achieving attitudinal, knowledge or behaviour change. Several of these factors are highly relevant to the Six Ways to Wellbeing campaign. The first is that such campaigns must use strong and explicit messaging – a principle that is embodied in the language and branding of the Wheel of Wellbeing. Moreover, a successful campaign needs to have clear and agreed aims and objectives, including whether the campaign is aimed at affecting knowledge, attitudes or behaviour. The Six Ways to Wellbeing campaign is consciously focused on changing *behaviours* of the public, although, as can be seen in the concept map below, one of the mechanisms to do this is by increasing countywide knowledge of the Six Ways to Wellbeing. Finally, Crawley suggests that campaigns must target particular groups. Although the Six Ways to Wellbeing Campaign is aimed at the general population across the county, it is important to note that the provision of services across all of the mental wellbeing projects have been locally contextualised. In the context of the other interventions, then, this focus may increase people’s propensity to take up the desired behaviour change.

Overall, we found there to be limited literature that examines the impact of positive behaviour change campaigns such as the Kent Six Ways campaign. One study, by Cavill and Bauman (2004), reviews 15 mass media campaigns which aimed to increase physical activity among targeted audiences. They found that whilst these campaigns were highly successful in increasing knowledge and attitudes towards physical activity, there was little evidence that the campaigns led to actual increased physical activity. However, Borden et al. (2008) point out that although a causal link is yet to be established, there is some evidence of positive meaningful associations between individuals behavioural *intentions* and their behaviours. It will therefore be important for this evaluation to capture, at a minimum, participants’ perceptions of the extent to which they *intend* to engage with the Six Ways to Wellbeing activities in their everyday lives.





Discussion

Concept

The Six Ways to Wellbeing campaign is aimed primarily at the general Kent population, in line with its main motivation of ‘keeping people well’ – rather than early intervention or suicide prevention, which are more secondary objectives. The project leads observed on a number of occasions that success would be when a hairdresser (with no obvious mental health remit) booked onto one of the seminars. This example was used to illustrate that the campaign really wanted to target ordinary people with no explicit role in promoting mental wellbeing, but who would be in a good position to impact on the wellbeing of others through their social or employment networks.

To a much lesser extent, the campaign aims to reach more vulnerable individuals, notably 30-60 year old men, the population most at risk of suicide. One project lead explained that one way of reaching these vulnerable groups would be by targeting the general public – which would include these vulnerable individuals’ family and friends.

“But the main emphasis, although being mindful of that group who might have significant problems, it was actually trying to reach out to the wider population and demonstrating that the ways to wellbeing weren’t specifically or only about mental wellbeing, they were about our general level of feeling good, functioning well and thriving, as opposed to being linked with mental health problems or mental health issues.”

Six Ways Campaign Project Lead

The two most prominent strands of the Six Ways to Wellbeing campaign are the Six Ways seminars and the Live It Well website. Both of these promote awareness of the Six Ways to Wellbeing, and also encourage direct practice of them. Alongside this, the campaign has aimed to incorporate other communications aspects such as a media strategy and the use of social media to broaden levels of engagement of target audiences.

A crucial element at all levels of the campaign has been to trigger what has been variously referred to as a ripple, cascade or contagion effect. This occurs when an individual’s increased awareness and intention to engage with the Six Ways is shared with a much wider audience who may otherwise be less likely to engage with a public health behaviour change campaign. In this regard, the seminars in particular, but also the resources on the Live It Well website, may be seen in terms of a ‘train the trainer’ model.

“It’s the whole ripple effect. There’s only [project team] doing this, and even if we stretched ourselves very thin, we’re not going to hit enough people, so it’s about empowering people.”

Six Ways Campaign Project Lead

Other aspects of the campaign, such as the social media work and the wellbeing narrative films, are intended to have a more direct impact on those reached. For instance the wellbeing narrative films,

mostly promoted through social media, are intended to provide examples of free, easy, relatable practices that can easily be incorporated into most people's day-to-day lifestyles.

The outcomes for participants who are reached by, or actively engage with the campaign diverge into two branches. One leads to wellbeing outcomes at an individual level; the other to wellbeing outcomes that are best understood in terms of an impact on communities. This distinction is well aligned with the perspective of one stakeholder, who explained that the Wheel of Wellbeing encompasses both the individual 'self' and 'others' such as the wider community. The segments relating to the former are those of body, mind and spirit; the latter, people, place and planet.



Implementation in practice

There are several ways in which the actual running of the campaign has diverged from the concept map represented above. The first relates to target populations: although the campaign was intended to reach a broad cross-section of the Kent population, in practice, it appears that it resonates most with those who have a pre-existing involvement or interest in mental health and wellbeing. This is especially true of the Six Ways seminars. It is important to bear in mind, however, that this may increase the likelihood of certain vulnerable groups benefiting from Six Ways awareness and engagement by means of the cascade effect described above. However, this may shift the focus of the campaign in practice more towards the early intervention / mental health problems end of the spectrum than the stated aim of keeping people well. The Live It Well website is designed to be able to respond to needs that fall along all points of this spectrum, as the campaign leads regularly update content based on what users are searching for.

“How we’ve run with the seminars is to try and get to other people who might be working in the community groups or client groups or like health trainers and things like that [involved]. We do quite a lot of work with those, to try and spread the message there.”

Six Ways Campaign Project Lead

There has also appeared to be a substantial number of seminar attendees who work with children and young people. This may also have implications for the campaign – because, as one project lead pointed out, the Six Ways to Wellbeing and the Mental Wellbeing Programme as a whole are not designed to respond to children and young people’s wellbeing needs, but are strictly adult-focused.

One of the main challenges in reaching large numbers of ordinary Kent residents has stemmed from a series of problems with the campaign’s media strategy. This has been partly due to a lack of input from KCC’s communications team to run a proactive campaign – there was a sense of frustration that the Six Ways to Wellbeing had not been promoted more in the Council’s other work. However, Public Health have also admitted that the communications aspect of the campaign had not been well thought out at the beginning. These issues had been partially remedied when an external communications lead was recruited to the campaign to offer expertise in this regard. However, there are also ongoing concerns that communication has been hampered by the fundamental problem of the media being generally uninterested in ‘good-news stories’, as well as by the politics of other organisations and their policies around sharing content online.

“It does make me think of what my vision had been before and it was... it was this notion of producing good stories that could be not only feeding the Kent County Council website but also offered up as content for other websites, you know, organisations, charities, or partners that had an interest in health that would take that content, and it was the mechanics of getting that content out there that was more challenging than I thought.”

Six Ways Campaign Project Lead

There are, however, some important successes that were not necessarily part of the original concept for the campaign. For instance, there is a strong sense among project leads that the campaign has made an important contribution to reducing the stigma and discrimination that surrounds mental health.

“We’ve found that the Six Ways to Wellbeing is a way of talking about mental health without labelling it mental health and without bringing up. You’re still talking about it, but you’re not bringing out all the rest of the connotations of the psychotic or whatever it is.”

Six Ways Campaign Project Lead

Interestingly, Crawley (2009) suggests that a reduction in mental health stigma and discrimination should not be considered to be an outcome in itself, but rather as a means to a desired end. In line with this, Coe et al. (2004) argue that nobody benefits from attitude change on its own, and instead the desired *outcome* should be a resultant behaviour change. Whilst this is an entirely plausible longer-term outcome of the Six Ways to Wellbeing campaign, this would require a much more detailed, longitudinal examination of the impact that reduced mental health stigma has on behaviour, which lies beyond the remit of the current evaluation.

Implications for the evaluation

The evaluation of a behaviour change campaign is always challenging, as changes in behaviour are notoriously difficult to pin down and attribute to particular cause-effect chains. Collecting data around campaign-caused practice of the Six Ways to Wellbeing is likely to be particularly challenging, not only in relation to the campaign *per se*, but also the other mental wellbeing interventions underpinned by the Six Ways messaging. As mentioned above, it will be valuable to consider the link between behavioural intention and behaviour engagement, as well as the potential of the cascade effect in spreading the message further.

Whilst WEMWBS is a useful tool for measuring several of the individual outcomes postulated in the campaign concept map, it may not be able to capture some of the wider, community-level, longer-term outcomes that may result from the campaign. Further to this, inconsistent data collection in the early stages of the campaign may make it difficult to analyse some individual changes in WEMWBS scores, as the earlier seminars did not ensure that a unique identifier was assigned to each participant.



Creative Arts Partnerships

Background

The Creative Arts Partnerships commission has been developed through a partnership between KCC Public Health, KCC Arts and Culture Service, Royal Opera House Bridge and Artswork SE Bridge. The arts-based commissioners have for some time been interested in exploring the role of arts and culture in strategic commissioning, and in identifying a set of guidelines and recommendations that will help community-based cultural organisations to become ‘commissioning ready’ to take on public sector contracts. From their perspective, this commission has been a pilot – an exercise in supported commissioning from which important learnings about the potential of smaller cultural providers can be extracted. For this reason, important features of the programme include a support package to help the providers through the commission (consultant Linden Rowley), an independent evaluator tasked with evaluating the commissioning process (MB Associates), and working collaboratively with the New Economics Foundation (NEF) as one of two pilot sites for an Arts Council England funded Cultural Commissioning Programme.

However, from a Public Health perspective, and in the context of a commitment to improving the mental wellbeing of communities in Kent, the most important aspect of the Creative Arts Partnerships is the relationship between engaging with the arts in community settings, and mental wellbeing – with a particular focus on young people. There is a strong sense among the commissioners and other stakeholders that this link needs to be evidenced – even amongst those who firmly believe in the power of the arts to improve wellbeing – not least because creative arts organisations have not traditionally made this link explicit and are not accustomed to responding to these kinds of commissions.²

A review of the literature indicates that community arts projects are becoming increasingly recognised as a means to improving mental health and wellbeing, notably amongst children and young people. Barraket (2005, p.3) defines community arts as an ‘approach to creative activity that connects artists and local communities in using the arts as a means of expression and development’. Whilst there is much debate around what, precisely, ‘community arts’ means, there is a general consensus that it refers to arts practices that encourage participation based on a person’s membership within a particular community, rather than on their skills or experience as artists (Mills, 2006). This ‘levelling’ nature of community arts is also reflected in the range of art forms it encompasses: Michalos & Kahlke (2008) identify 66 arts-related activities that improve wellbeing, including music, visual arts and drama.

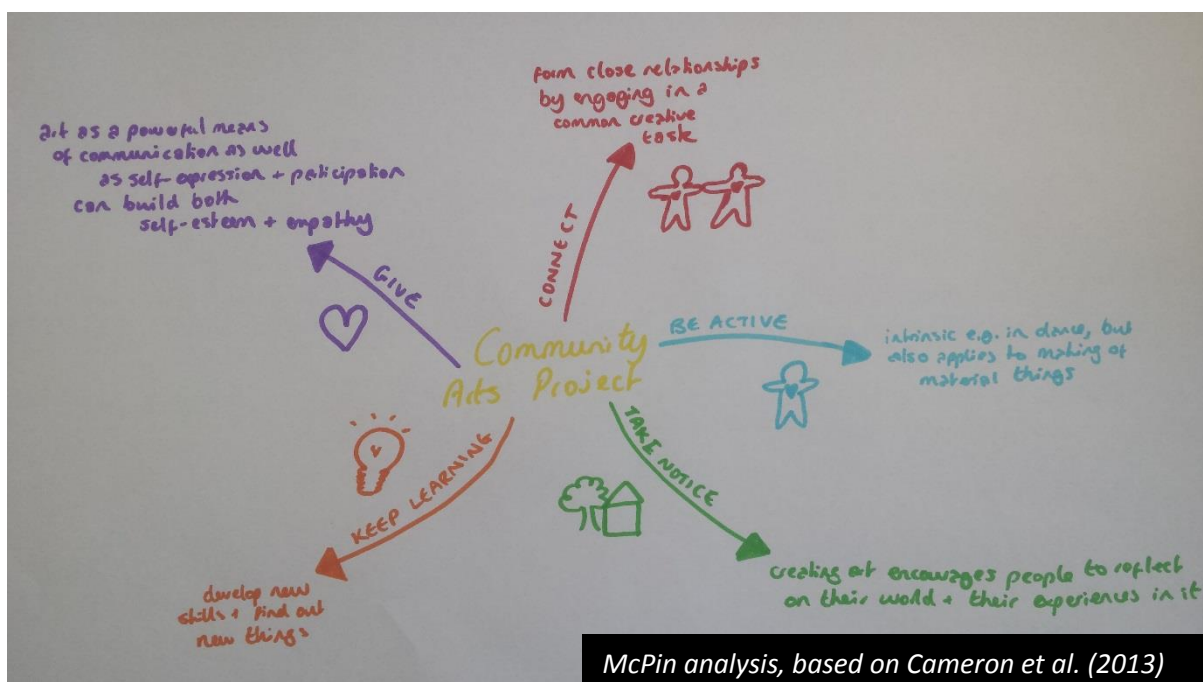
It has been argued that engagement with the creative arts can lead to a range of positive outcomes for individuals, including reduced levels of anxiety (Health Development Agency, 2000), improved educational outcomes including language development, and other social and creative skills (Johnson & Stanley, 2007), improved social relationships and social capital (Rhodes & Schechter, 2014), increased ethnic pride (*ibid.*), and increased self-esteem and self-confidence (Bungay & Vella-Burrows, 2013). Together, these factors lead to higher levels of emotional literacy (Everitt &

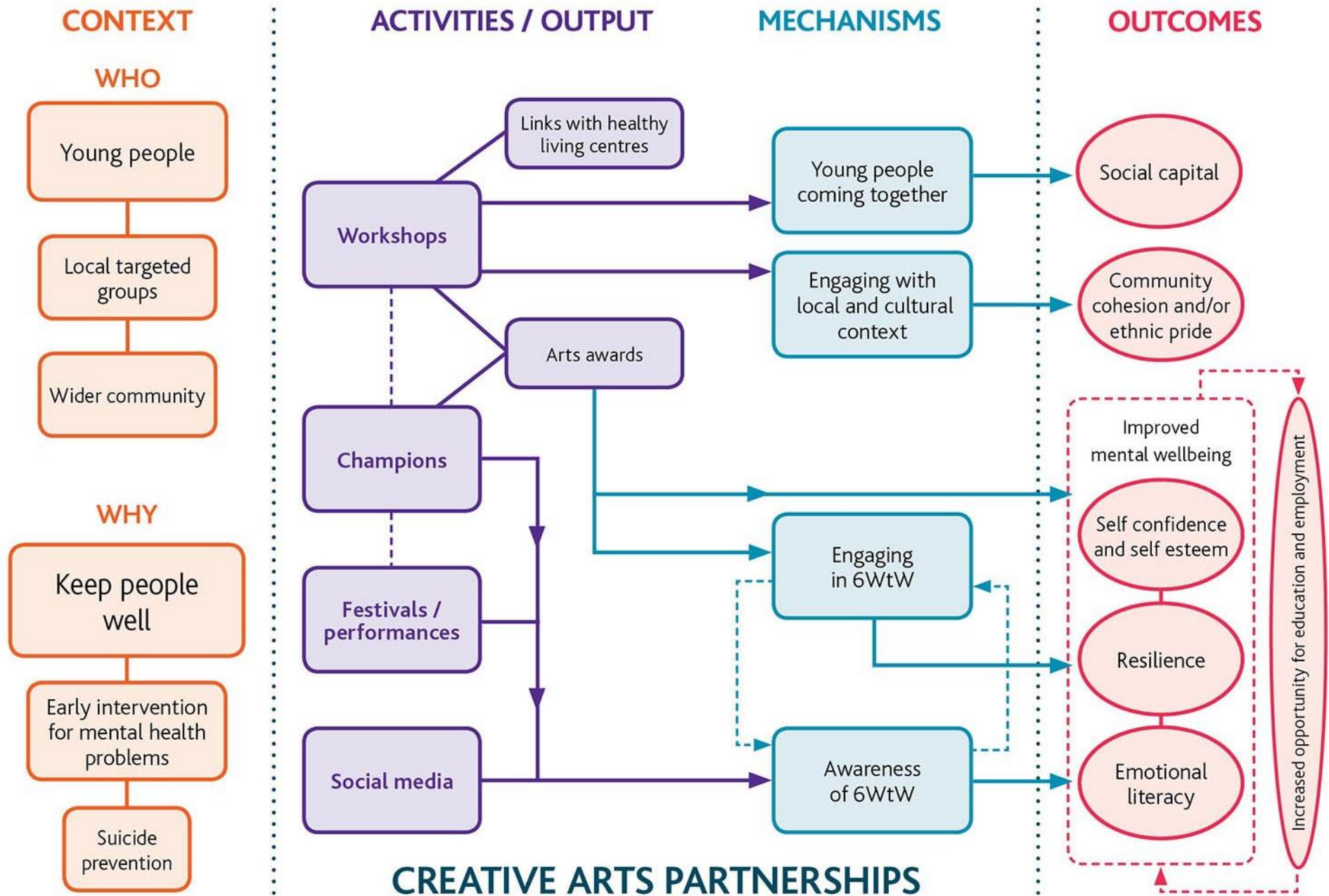
² An exception here are arts interventions such as art therapy that explicitly focus on promoting recovery, rather than keeping people well.

Hamilton, 2003), which in turn leads to resilience (Rhodes & Schechter, 2014) and improved mental wellbeing.

It has also been suggested that community arts projects improve health and wellbeing at a community level and can bring about social, economic and educational change. This includes cross-cultural community understanding and cohesion, income-generating opportunities and further investment in arts programs, and improved school performance. (Newman, Curtis & Stephens, 2003; White & Robson, 2003).

Of particular relevance to KCC Public Health's Mental Wellbeing Programme is Cameron et al.'s (2013) use of NEF's Five Ways to Wellbeing as a framework for illustrating how creative arts programmes can enhance wellbeing. They observe that creative arts programmes can help individuals to *connect* as close relationships are formed whilst engaging in a common task. *Being active* is intrinsic to several art forms, notably dance, but also applies to visual arts activities such as the creation of material things. The authors suggest that the process of creating art encourages people to *take notice* and reflect on their world and their experiences in it. Most obviously perhaps, community arts programmes give many people the opportunity to try something new and *keep learning* by developing new skills and expanding their knowledge of the world. Finally, community arts programmes provide a channel to *give*, as art can be seen as a powerful means of communication as well as self-expression, and participation can build empathy alongside self-esteem.





Discussion

Concept

The Creative Arts Partnerships commission resulted in six individual contracts being awarded to a range of creative arts providers working in partnership with other organisations, including Healthy Living Centres and libraries. The six projects took place across various districts within Kent during the second half of 2014, and were as follows:

- Dartford: Icon Theatre, delivering a programme of dance, drama, music and design.
- Dover & Shepway: Dover Arts Development (DAD) in partnership with the Jasmin Vardimon Dance Company, offering music, dance, poetry and drawing workshops structured around the theme of the father or significant male figure.
- Gravesham: LV21 and Kent Equality Cohesion Council, working with a range of artistic partners to create performance and visual art.
- Maidstone: Rhythmix, providing music-making activities to engage young people with the Six Ways to Wellbeing message.
- Swale: Ideas Test with Swale CVS, delivering a range of interventions integrating art, sculpture, film, photography and sports.
- Thanet: Turner Contemporary, working with local artists to explore a range of art forms in the context of two-day workshops.

There were two 'tranches' of commissioning – three of the organisations were commissioned following an initial tendering process, and three more were commissioned following additional market engagement work by the commissioners.

Each of the interventions had two key strands:

- Targeted interventions (e.g. workshops) with young people between the ages of 13 and 19.
- Public events (e.g. at festivals) aimed at the general population.

The focus on young people was primarily motivated by the interests of the Bridge organisations in promoting access to the creative arts among this population group, whereas the inclusion of public events was more aligned with Public Health's objective of improving the wellbeing of the general population. However, the focus on particular districts was also motivated by the recognition that particular local groups who may be isolated, marginalised or otherwise vulnerable could benefit greatly from this kind of wellbeing intervention. Above all, the commission was motivated by a desire to help keep people – and young people especially – well, and only secondarily positioned as a way of addressing mental health *problems*, or in terms of suicide prevention.

The targeted work with young people, mainly in the form of summer schools or workshops, was intended to help young people explore the Six Ways to Wellbeing in creative and innovative ways, and integrate these wellbeing behaviours into their daily lives. A key aspect of this was the social

benefits that would be achieved through the act of coming together with other young people and expanding one's social networks. Additionally, some young people were to be recruited as 'Wellbeing Champions' to help promote the benefits of the Six Ways to Wellbeing to their peers and wider community, and a further benefit was that many of the young people were to be supported to complete Arts Award accreditation.

The public events – which mainly took place in the context of summer festivals – were intended as an opportunity to showcase elements of the wellbeing work to a broader audience and raise awareness of Six Ways to Wellbeing, much as the formal Six Ways to Wellbeing Campaign (seminars, website, social media etc.) aims to do. In some instances, these public events were also intended as a recruitment channel for the targeted work with young people; whereas in other cases the young people already involved in the interventions helped promote the project to the wider public.

Together, the two strands of the Creative Arts Partnerships sought to achieve a number of wellbeing outcomes, at both an individual and community level. This included general measures of wellbeing such as improved confidence and self-esteem, resilience, and emotional literacy, which are in turn closely interlinked with improved educational and employment prospects, as well as increased social capital. These also benefit the community as a whole, as they can lead to stronger community networks and cohesion.

Promoting wellbeing

The providers were unanimous in their conviction that the arts and improved mental wellbeing are well aligned and 'dovetail' nicely, and all reported that they found it easy to ensure that the Six Ways to Wellbeing were integrated into the delivery of their interventions. The most frequently cited of the Six Ways in this regard were 'keep learning' (trying something new), 'connect' (by coming together with other young people) and 'be active' (primarily for movement-based activities such as dance). However, making the Six Ways *explicit* in the delivery of the projects proved to be more challenging for many of the providers. Some experienced reluctance from the young people to be 'taught' about the Six Ways, and believed that this felt 'too much like school'. There was a general consensus that the introduction to the Six Ways needed to be young person-led, rather than practitioner-led, and could not be made explicit at the outset. The integration of the Wellbeing Champions into the project design was one way of promoting young people's ownership of their engagement. Some of the providers felt that an intervention that was coproduced with young people from the outset would have been the best way of delivering the work, although project timescales did not allow for this level of involvement.

"Young people have to take responsibility for their own wellbeing; we wanted them to feel ownership over it."

Creative Arts Project Lead

The providers were resourceful in their approaches to this challenge. Most tried to ensure that the young people were presented with a choice over which art forms they engaged in, as it was felt this would contribute to a more positive experience and consequent sense of ownership of their own wellbeing (cf. Mulligan, Scanlon & Welch, 2008). The providers also worked hard to ensure that the

activities on offer were accessible to young people with little or no experience of 'extracurricular' art activities traditionally popular with more 'middle class' young people (cf. Hampshire & Matthijsse, 2010; Hinshaw et al., 2015). Although the young people were exposed to new activities, there was a recognition that it was important for them to be able to relate this to their everyday lives. Indeed, some of the providers viewed this kind of 'accessible art' as a means of engaging young people in what would otherwise be a much less accessible health intervention.

There was also a tendency to introduce the Six Ways at a very practical level – for example, by encouraging members of the public at events to simply 'have a go' at engaging with a particular art form, before asking them to reflect on how this made them feel. At the more targeted interventions with young people, one approach was to encourage the young people to think about the Six Ways in relation to their everyday lives first, so that they would feel less abstract and the young people would feel reassured that these were not complex unknowns, but everyday actions that they were already doing.

There were, however, some practical challenges to encouraging young people's ownership of their engagement. The tight timescales and recruitment pressures (see below) meant that some of the young people probably felt pressured to participate, especially those that were recruited via schools.

Overall, there was a strong sense that the Six Ways served as a valuable framework for reflection and an accessible way of articulating the positive wellbeing impacts of engagement with the creative arts. A minority of the providers felt that this level of reflection was unnecessary – emphasising that participation in an artistic practice was in itself sufficient to generate positive outcomes. The majority, however, felt that in order for there to be a legacy, or lasting impact, it was important for participants to reflect on *why* engagement made them feel a particular way or inspired them to make changes in their day-to-day actions, and be able to articulate this. One provider pointed out that this reflective process is, in fact, crucial to most artists' understanding of what artistic practice should be, and most of the providers enthusiastically documented the way in which their work was underpinned by the Six Ways to Wellbeing – creating films, books and online materials about their interventions. There were, however, some concerns about the use of WEMWBS as a measure of the intended wellbeing outcomes, with some providers noting that the tool did not appear to be appropriate for some of the young people engaged with, who struggled to understand the statements. There was also a lack of clarity among some of the providers around how to administer WEMWBS.

Although the providers generally felt that they had been successful in their mission to deliver a wellbeing intervention, there was some acknowledgment of the limitations they faced as arts organisations. In practice, the boundary between 'keeping people well' and helping someone with mental health needs was not clear cut, and some of the providers did not feel adequately prepared or supported to deal with more complex situations, with the exception of one organisation, who had support from a trained therapist. Some of the arts organisations found the Public Health funded Mental Health First Aid course helpful, but not all were aware of it, and those that were wished they had known about it before the start of the interventions.

"We don't have the capacity or expertise to deal with some things. It needs to be supported."

Creative Arts Project Lead

Practical challenges

There were a number of practical challenges to the smooth delivery of the interventions. The most significant of these were the project timescales and timings, and, connected to this, problems with recruiting young people to take part. The tight timescales meant that providers did not always feel they had sufficient time to promote their projects, which led to a pressurised recruitment process – e.g. providers having to chase schools to persuade them to put forward young people to take part. This was problematic partly because it had the potential to compromise young people’s ownership of their engagement, as discussed above. The timings – the projects were expected to kick off in the summer, shortly before the holidays – added to this pressure, and also created difficulties regarding the delivery of the projects at a time when young people were more likely to be away, otherwise occupied, and generally harder to access.

Related to these challenges was a sense among the providers that there had been a lack of clarity from the commissioners around recruitment targets and what was realistic for projects of this scale (see below for further reflections on the commissioning process). One of the key issues for the providers was how to balance reaching larger numbers of young people with a focus on more vulnerable young people who would likely benefit from a more focused intervention. Some providers ended up prioritising numbers and engaging with more ‘mainstream’ young people, while others focused on smaller groups of young people with more complex needs.

“You don’t want to stigmatise...middle-class kids can have wellbeing issues. But it’s a fact that some groups require more work to engage....One of the stated outcomes was reducing suicide, but for that kind of outcome, you need a smaller, more targeted intervention.”

Creative Arts Partnerships Stakeholder

In some instances, effective partnership working helped overcome some of the barriers to recruitment. This was especially the case for the second ‘tranche’ of organisations commissioned, as they were able to benefit from further market engagement by the commissioning evaluator, and feedback around partnership working. Several of the arts providers benefitted from partnering with community interest organisations, who were instrumental in assisting with recruitment. However, a number of the providers reported that they encountered challenges around working with the local Healthy Living Centres they were expected to partner with. This was attributed to a lack of clarity on the part of the Centres around their role and what would be expected of them – which was mainly help with recruitment and venue provision – and some indicated that they viewed the arts providers as competitors, rather than partners.

“We don’t want to appear to be coming in as a cut price version of what people working in youth centres for example used to do.”

Creative Arts Project Lead

Finally, there was at least one instance where project delivery had been hindered by a lack of foresight and ensuing staffing issues on the part of the provider.

Reflections on the commissioning process

As there is a separate stream of work focusing on evaluating and learning from the commissioning of the Creative Arts Partnerships, we do not discuss this aspect of the commission in detail here. However, it is important to note that there was a certain tension experienced by the providers between taking part in a *pilot* on the one hand, and, on the other, delivering on a *contract* that demanded results – against a backdrop of ever-increasing cuts to arts funding. This was *supported* commissioning, with the providers set up with an extensive support package that would facilitate the successful delivery of the projects and provide learnings for future commissions. However, the providers also felt under pressure to deliver to targets (recruitment, numbers achieving Arts Awards etc.) that they, and other stakeholders, did not always feel were realistic. From a commissioning learning perspective, it will be crucial to consider how this kind of outcomes-focused commissioning can succeed without the support provided through being part of a pilot.

Implications for the evaluation

The evaluation of these projects is challenging because of the timescales, with most of the delivery having been completed before the start of the evaluation. This means that we are limited in our ability to use qualitative methods to capture outcomes for participants.

As mentioned above, some of the outcomes highlighted in the concept map will be captured through the use of WEMWBS, which has generally been distributed by the delivery partners before, after and some months following the projects. There are particular challenges with some of this data however. In particular, where interventions were relatively short-term (less than two weeks) the before and after data may be difficult to rely on, since the WEMWBS items ask about a two week period. There is also – as would be expected – considerable drop out between the pre- and post-data collection and the follow-up. Finally, some of the young people who completed WEMWBS forms were under the age of 13, at which point the tool is no longer considered suitable and, as noted above, some providers raised concerns about the ability of young people aged 13 and over to understand the statements.

The WEMWBS data available will allow us to look at whether wellbeing related outcomes have been achieved through this programme, though with some caveats as discussed above. It will not be possible to get a good measure of all of the identified outcomes, however. Outcomes such as increased ethnic pride and ultimately education and employment outcomes would benefit in future evaluations from specifically designed measures or qualitative work.

Some of the mechanisms expected to lead to improved outcomes can be evidenced, however, including through the performances, films and other activities produced and documented by the creative arts providers. Being able to demonstrate that the mechanisms identified in the concept map above are in fact taking place in these projects will be an important aspect of assessing the success of these as a wellbeing intervention. We will also be able to draw on the KPI data (numbers reached etc.) as a means of evaluating the reach of the project.



Creative Arts Project, McPin Foundation



Creative Arts Project, 6WTW Gravesham

Happier@Work Workplace Wellbeing Pilot

Background

There is strong evidence that links happiness with longer lives, better mental and physical health, stronger relationships and a range of other psychological, social and economic benefits. Given the amount of time many people spend at work – a third of their lives, and half their waking hours (King's Health Partners, 2014) – it is perhaps not surprising that people who experience more positive emotions at work demonstrate better performance, less absenteeism and more positive relationships with colleagues (e.g. Kinder, Hughes & Cooper, 2008). It has also been argued that there is a link between happiness and workplace success. People who are happy at work tend to earn more money, display superior performance, and perform more helpful acts than their less content peers (Boehm and Lyubomirsky, 2013).

In practice, however, work is widely recognised to have the potential for negative effects on mental health and wellbeing. This often comes in the form of stress. Work-related stress is defined by The Health and Safety Executive (2008) as 'the adverse reaction people have to excessive pressure or other types of demand placed upon them'. Though pressure can encourage employees and inspire enhanced performance, when pressure outstrips an employee's ability to cope, it becomes a negative force in the form of stress. Working environments that pose risks for mental wellbeing put stresses on an individual without providing them with sufficient control and support to achieve these demands (NICE, 2009).

A government White Paper entitled 'Working for a Healthier Tomorrow' observes that mental health conditions are an important cause of absence, both due to work and non-work related issues (Black, 2008). The report also discusses the economic impacts of negative workplace wellbeing and the evidence that highlights that mental ill health is one of the main causes of low productivity in the workplace. A worker is likely to be off twice as long due to mental ill health than physical ill health. This difference is closely linked to the stigma surrounding mental health issues and how this may impact on people's approach to managing their sickness. For example, people are less likely to ask for time off to attend therapy than physical health appointments, thus missing crucial opportunities for early intervention.

On a more positive note, it is generally acknowledged that all other things being equal, being employed has a positive effect on a person's wellbeing (Department of Health, 2011; Waddell & Burton 2006). The workplace can provide vital opportunities for people to build resilience, cultivate social networks and develop their own mental capital. Individual and team wellbeing is likely to improve when an individual is able to fulfil their personal and social goals and realize a sense of purpose. Positive mental wellbeing at work, then, is determined jointly by the working environment, the nature of the work itself and the individual. Employers should be encouraged to supply work environments that are advantageous to good mental wellbeing and the development of mental capital (Government Office for Science, 2008). The question, therefore, is how employers and workplaces can build on these intrinsic positive values and opportunities, and support and promote the health and wellbeing of their staff.

There is some evidence that focused workplace-based wellbeing programmes can lead to positive outcomes such as reductions in sickness and absence, staff turnover, accidents and injuries, improved resource allocation, increased employee satisfaction, a better company profile, and improved productivity and economic performance (Black, 2008). The evidence indicates that initial wellbeing programme costs



McPin Foundation (stock image)

can quickly be translated into financial benefits, through business overhead savings or additional revenue generation (*ibid.*). It has also been noted that the most common barrier to employers proactively investing in the wellbeing of their workforce through such programmes are a lack of knowledge and access to information around workplace wellbeing initiatives (*ibid.*).

As part of the Mental Wellbeing Programme, in 2014 Kent County Council Public Health decided to offer a workplace wellbeing intervention to teams within KCC, initially as a pilot. The rationale behind this was twofold. On the one hand, there was a feeling that the wellbeing of KCC staff was core to the wellbeing of the broader population, and that it was important to 'practice what we preach'. On the other, there was a recognition that a focussed wellbeing intervention would be very timely, as the Council as a whole is in the process of going through major restructuring and organisational change that is likely to have a significant impact on its staff. However, it is important to note that the skills developed through this kind of wellbeing intervention were deemed to be useful to an organisation at any time, and that mental health has been a priority on the HR agenda for some time now, as there is a recognition that it is often an underlying factor in absence and illness, employee grievances, disciplinary procedures and dismissals

"It really was about how they're going to work in the future. How are they going to be leaner, smarter, all the management speak...and have to do more with less."

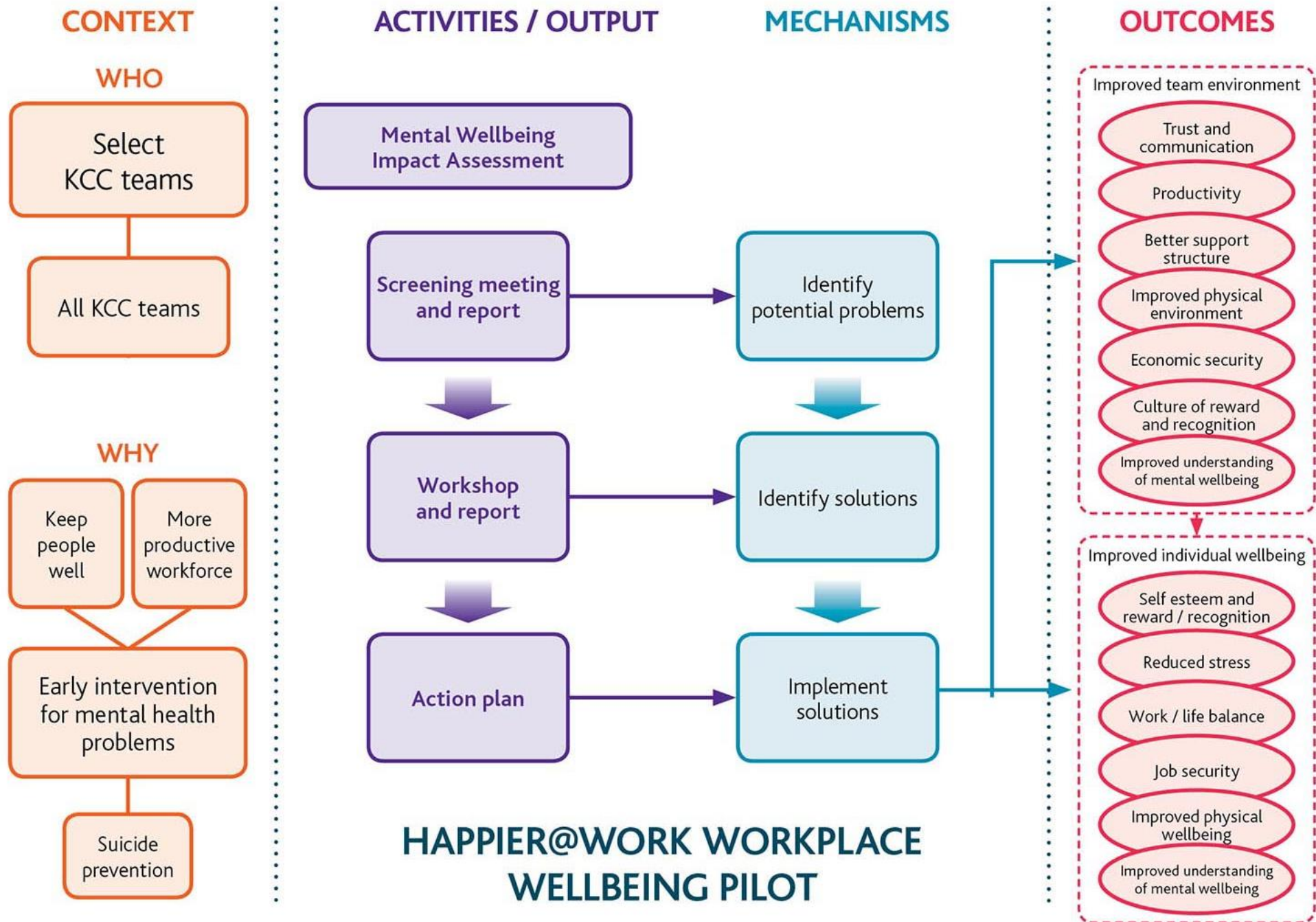
Happier@Work Project Lead

"We are 14,000 strong you know...We're trying [to implement this] because many of our employees are also the community."

Happier@Work Project Stakeholder

The pilot was implemented by the Happier@Work team, led by South London and Maudsley NHS Foundation Trust (SLaM), who worked closely with the KCC Public Health and HR teams throughout. Happier@Work is a unique intervention that was developed and piloted by the team with King's Health Partners from 2011 onwards and aimed to identify and promote factors that lead to positive mental wellbeing in the workplace, and address the issues that lead to stress, absenteeism and negative wellbeing (King's Health Partners, 2014).





Discussion

Concept

The KCC Happier@Work intervention was intended to be piloted with a small number of KCC teams, with the prospect of some form of wider roll-out among other KCC teams at a later stage. As noted above, the motivation for the programme was both that KCC staff are as deserving of mental wellbeing support as anyone else and that it is important to 'practice what we preach', and also a recognition that planned changes and restructuring might have an impact on staff wellbeing and, crucially, productivity that it is important to manage.

The programme spans the whole of the mental health / wellbeing spectrum. Although its main objective is to help promote positive wellbeing within KCC, the intervention also seeks to ensure that people who are struggling receive the help that they need.

"It puts the emphasis on mental wellbeing, and not just [being] judgmental around mental illness."

Happier@Work Project Lead

The KCC intervention was based closely on a toolkit called the Mental Well-being Impact Assessment (MWIA), which also formed part of the King's Health Partners pilot. The MWIA is a toolkit for wellbeing that 'enables people and organisations to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's wellbeing' (Cooke et al., 2011; p.1) and is well-suited to be used by organisations undergoing change. There is significant overlap between the developers of the MWIA and the SLAM-led team delivering the KCC Happier@Work pilot. In the context of Happier@Work, the MWIA was used as part of a Double Diamond Design process to '**Discover** what's impacting on well-being for staff, **Define** the key issues and support KCC to **Design** solutions and **Deliver** a programme that support well-being at individual, team and organisational levels' (KCC Happier@Work, 2014; p.1).

"It's about providing a framework to bring people together and identify the positive things that they can do about something."

Happier@Work Project Lead

The MWIA can be broken down into various stages. First, initial commitment from teams must be sought, after which a screening meeting takes place. This consists of a preliminary assessment of the impact of changes and helps those in management positions consider how the current work environment and proposed changes might impact on staff wellbeing. A decision is then made whether to undertake a more intensive MWIA, which is the next stage of the process.

"Contracting with teams for the next stage of the work after the initial assessment is really key. It's important to establish a clear commitment to listening and being prepared to take action. There is no point in asking staff what will make a difference to their wellbeing if the management team are unable or unwilling to do anything differently as a result. In fact, it's potentially detrimental."

Happier@Work Project Lead

The more in-depth MWIA consists of a facilitated team workshop, which enables staff in a range of positions to identify the challenges they face, and propose solutions to those challenges. The Happier@Work team then produce a detailed report based on the workshop, in which the ideas generated by the staff are discussed and analysed, and which staff were asked to comment back on.

“It’s important for everyone to be taking responsibility for their own wellbeing [in a work setting] but within a framework – they need some guidance”

Happier@Work Project Lead

“It gives you a much broader understanding about mental wellbeing, and finding potential solutions, and that it can be owned by the workforce as well as by the [employer].”

Happier@Work Project Lead

“The workshop is one part of evidence gathering, it enables you to collect stakeholder views on what they think is impacting on wellbeing. It also creates ownership of the findings. The workshop is structured to enable staff to explore both potential positive and negative impacts on wellbeing; it’s not just an opportunity for staff to moan. This stakeholder evidence is then considered alongside the published literature and a team profile to inform an action plan. In this way you are not simply taking what people are saying at face value but checking out against other sources of evidence to inform suggestions and recommendations.”

Happier@Work Project Lead

The final output of the workshops is an action plan containing practical next steps, developed by the KCC team with or without input from the Happier@Work leads, which are intended to lead to a range of individual and team outcomes. At an individual level, these include improved self-esteem and feeling of recognition in the workplace, reduced stress and a better work-life balance, improved job security, improved physical health, and improved understanding of one’s own mental health. At a team level, intended outcomes include improved trust, communication, reward / recognition and support structures, greater productivity, an improved physical environment and improved understandings and attitudes regarding mental health and wellbeing. Although there was a feeling that these outcomes were achievable to some extent, it was also recognised that there was a risk that the onus to implement change could end up falling on individuals, rather than at a more structural level in terms of policies and procedures.

“Staff are human beings. They’re realistic. They know that things have to change. And if you involve them in the change process, and if you communicate with them, you bring them along with you.”

Happier@Work Project Lead

“There is a danger that the responsibility for wellbeing is focused on the individual and what the individual can do rather than the system or organisation. While we all have a responsibility to look after our own wellbeing, it’s also important to create an environment in which staff can flourish. This is a tension that needs to be held.”

Happier@Work Project Lead

Practical implementation

The Happier@Work pilot was implemented across a small number of KCC teams in the spring and summer of 2014. Teams were identified with the support of HR management staff, and were selected according to some broad criteria. Crucially, all teams had an engaged and enthusiastic management team who were interested in promoting staff wellbeing. The teams that were selected were also recognised to be facing a range of current or future challenges to staff wellbeing that senior management were keen to understand and respond to. These included issues around restructuring and outsourcing, as well as more general workload and wellbeing issues. Initially, seven teams were approached to take part, and one declined as they did not feel that they had the capacity to be part of the pilot due to other areas they needed to focus on. However, the remaining six teams expressed a clear interest, and their management staff (and, in some instances, some frontline staff) went through the screening process. The six teams that took part were as follows:

- Customer Services
- Swale Family Support Team
- Employment Strategy Groups (HR Assistants)
- Libraries, Registration and Archives middle management staff
- Thanet Assessment and Early Intervention Team
- Consultation and Engagement service

All of the teams were keen to progress to the MWIA workshop phase of the intervention, although only the first four of those listed above have completed their workshops. At the time of writing, it was made known to us that Public Health would not be funding the final two workshops, but that there was a possibility that KCC HR would take on the work. The lack of clarity around whether the final two workshops will happen has been challenging, both for Project Leads but also for the teams in question, who completed their screening meeting almost a year ago.

Following the completed workshops, the Happier@Work team produced detailed reports for each of the four teams, as well as shorter summary of each report. The teams were asked to comment on the reports. The process of creating the reports took longer than expected, and there was a sense that perhaps the reports were too detailed for staff to be able to engage with properly.

“It took ages. Even though they were really committed to the process, it took a long time for them to come back with comments and for us to amend it and get it back again. So you were in danger of losing momentum on it.”

Happier@Work Project Lead

Following the finalisation of the reports, the four teams were asked to develop action plans with clear next steps, which were likely to include offers such as mindfulness courses or Six Ways to Wellbeing Seminars, as well as structural policy changes. Some of the action plans were produced with the support of the Happier@Work team, whereas other teams created theirs internally. The Happier@Work team is in the process of arranging follow-ups with the individual teams to establish what they have achieved in the last 6-12 months since their action plan was finalised.

Implications for the evaluation

As mentioned, the Happier@Work team are in the process of doing some qualitative follow-up work with the four teams that completed their MWIA. We also intend to do similar work, in particular interviews with team leaders and frontline staff, and it will be important to ensure that the two strands of work complement, rather than replicate each other, that learnings are shared, and that the teams do not feel over-burdened by our engagement. We are in conversation with the Happier@Work team about how to go about this. It is also important to note that due to the timescales, there is likely to be some change in the teams since last year, with at least one team having a new manager. This should not be a big issue, as the impacts of the intervention should be felt throughout the team as a whole, but it may mean that not all interviewees are able to provide detail about the experience of having taken part in the pilot.

If the final two workshops take place, we will aim to attend one or both of these in an observer capacity, which will provide us with a richer, first-hand understanding of how the intervention works in practice. Alternatively, we may also be able to observe a separate MWIA workshop run by the Happier@Work team in London, which will give us a better grasp of how the intervention worked in practice.

Finally, it is important to highlight a couple of challenges regarding WEMWBS data capture, which was intended to measure changes in wellbeing as a result of the pilot and should have been collected for staff members in the four teams before they went through the full MWIA. We are hoping to collect follow-up WEMWBS for these teams over the coming months. First, it is likely that WEMWBS scores will have to be aggregated across the teams, due to changes in staffing (and in any case, not all members of a team were present at the workshops). More worryingly, it appears that of the first batch of WEMWBS collected by the Happier@Work team and Public Health, three have been misplaced and have not been shared with us to date. If these pre-intervention WEMWBS forms are not found, there will be little sense in conducting a follow-up, as there will be no baseline to compare it to.



McPin Foundation (stock image)

Mental Health First Aid

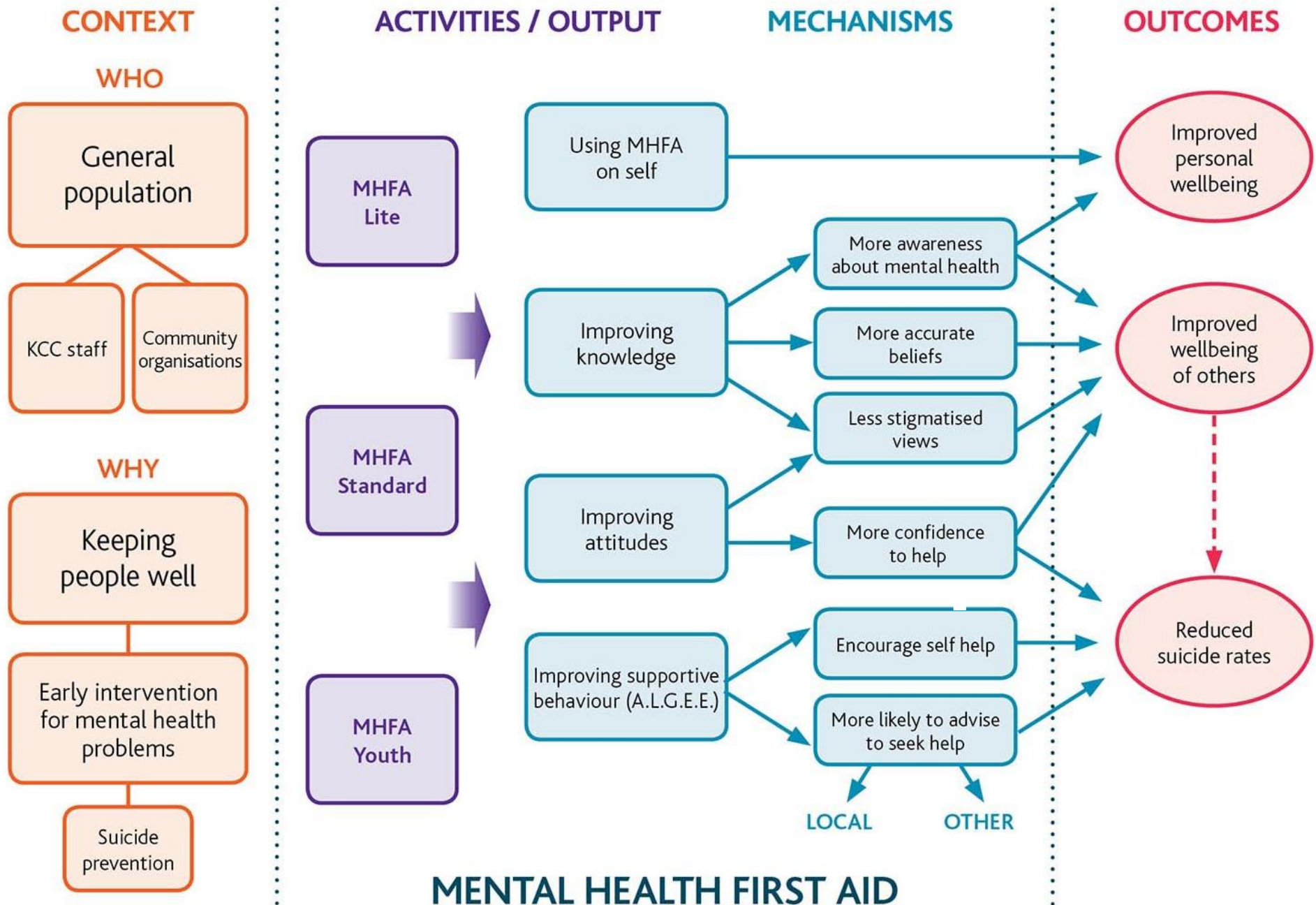
Background

Mental Health First Aid is a nationally recognised educational training course that teaches people how to identify, understand and help a person who may be developing a mental health condition. The course is inspired by the concept of first aid training, widely used to teach individuals how to help someone with a physical disorder or injury, and translated to the mental health field (Jorm et al., 2007). Whilst the training was first developed in Australia (Kitchener & Jorm, 2002), it is now standardised and used in over 20 different countries around the world, including the UK (Kitchener & Jorm, 2008). The MHFA course can only be delivered by accredited trainers.



Several evaluations of MHFA training courses have already been conducted, and there is strong evidence that it can lead to a number of positive outcomes. First, MHFA substantially improves attendees' knowledge or beliefs about mental health. Participants are more likely to recognise a mental health problem following engagement, and their understanding and beliefs around treatment become more closely aligned with those of professionals (Brett-Jones, 2011; Jorm et al., 2004; Kitchener & Jorm, 2002; Kitchener & Jorm, 2004). Second, it has been demonstrated that MHFA training courses improve attendees' attitudes towards those with mental health problems – leading to reductions in stigma and discrimination. Participants are less likely to be socially distant from people with mental health problems, and report increased confidence in helping someone with a mental health problem (Kitchener & Jorm, 2002; Robson & Bostock 2008; Zilnyk, 2010). Finally, MHFA training has been shown to have significant improvements on attendees' subsequent behaviour, specifically their propensity to advise and encourage someone with a mental health problem to seek further help (Borrill, 2010; Jorm et al., 2004; Kitchener & Jorm, 2004). One study found that 78% of course attendees felt they had provided mental health first aid following their training (Jorm, Kitchener & Mugford, 2005).

For some time, Kent County Council Public Health had promoted MHFA training internally to KCC staff. However, with the development of the Mental Wellbeing Programme, Public Health identified an opportunity to make the training available at no cost to a range of other individuals and organisations – including, but not limited to, statutory agencies, small and medium-sized enterprises, and third sector organisations – in order to increase the help available for people with mental health problems across the county, including areas with high levels of social deprivation. Following a rigorous commissioning process, they awarded an 18 month contract to Sevenoaks Area Mind, who coordinate the courses and run the bookings through their website. The work is managed by Sevenoaks Area Mind with input from Public Health. It is worth noting that this is a significant and high profile roll-out of MHFA training, and for this reason, the intervention has been working closely with the MHFA central body throughout.



Discussion

Concept

The MHFA training is similar to the Six Ways to Wellbeing campaign in that it endeavours to reach a wide cross-section of the population. As with other projects that are part of the Mental Wellbeing Programme, the example of a hairdresser was used to illustrate the kind of person that the course really seeks to target – someone who may not identify themselves as needing to be aware of mental health problems, but who might be in a good position to help others due to their position in the community. In practice, however, interviewees recognised that those initially attracted to the course would be more likely to work in the voluntary or statutory health and social sectors. In general, these would be people who were already interested in mental health, but wanted to deepen their knowledge further. Several project leads spoke about the desire to target private business networks more, but recognised that this would be a harder group to reach and might require more focused engagement work with employers. The example of a hairdresser as the ideal audience for this training came up in several interviews.

"I hope it's not too narrow. I hope we're not just getting the people that are really interested in this, that turn up anyway. Because yes, it's great that we're up skilling those people, but actually, we want to take it much broader and get this mythical hairdresser."

MHFA Project Lead

Project leads explained that the training should be seen to span the whole spectrum of mental health, including promoting wellbeing, intervening early for mental health problems, and supporting those with more severe mental health problems who are most likely to be at risk of suicide.

"It helps right down the scale. So it helps people who are well to stay well. It helps people who are struggling to get help earlier, and right down to the severe depression and psychosis, it, hopefully, helps people get appropriate professional help and stops them killing themselves."

MHFA Project Lead

However, the main focus is on keeping people well on a day-to-day basis, and this ties in with the project's aim to educate the general public, not just professionals. It is expected that this will lead to an increased awareness of mental health problems amongst the general population, thereby reducing stigma and discrimination around mental health in the longer-term. It is also hoped that MHFA training attendees will be able to use the skills acquired through the training in everyday contexts. The practical training tool (ALGEE) that is part of MHFA is designed so that it can be used both by professionals, but also by lay people who want to help family or friends who may be struggling with mental health issues.

"Increasing the general awareness of mental health issues and hoping that more people know what to do if their friends, family, someone they pass on the street etc. is in trouble. So that's very simply the aim."

MHFA Project Lead

Although suicide prevention is one of the underlying motivations for commissioning MHFA in Kent, project leads emphasised that MHFA can only play an indirect role in this work. Directly working towards suicide prevention is a vastly difficult task due to the difficulties around identifying someone who may be at risk of suicide, and it was also pointed out that most people with a mental health problem do not take their own lives, whilst some people without mental health problems do. For this reason, the main focus of MHFA is around raising awareness and enabling more people to recognise the early signs of a mental health problem and act accordingly – which should, in the long run, contribute to a reduction in suicide rates.

"It's very unlikely someone's going to do a two day training course, and then find someone about to jump off a bridge, and so it's mainly about just increasing awareness of mental health issues amongst the general population."

MHFA Project Lead

There are three different types of MHFA courses – the standard, two day course, a shorter half-day course, and a course that is tailored especially for individuals who work with young people. All three of the courses have similar mechanisms and aims – although the shorter course is intended as a ‘taster’ that will motivate people to sign up for the standard first aid training. As with previous iterations of the training (see above), the key mechanisms can be broken down into improving people’s knowledge, awareness and behaviours around mental health. These lead to a series of interlinked outcomes that have been evidenced by previous MHFA evaluations: greater awareness and more accurate beliefs around mental health issues; less stigmatised views and greater confidence to help others; and people being more likely to both encourage self-help, and also advise someone to seek further specialised support. These in turn are expected to lead to improvements in mental health and wellbeing among the wider community, though this outcome may be harder to identify and measure. Finally, it was noted that the intervention also has the potential to increase the wellbeing of the attendee by making them more aware of their own mental health.

"I think it's good for people's wellbeing because it gets them to think about their own mental health in a positive way, in the same way that they're already conscious of their own physical health."

MHFA Project Lead

Practical implementation

It was generally felt that there have not been many challenges in implementing the MHFA training, mainly due to the relatively straightforward nature of delivering a nationally accredited training program which in any case does not allow for much flexibility. There have been several minor frustrations, however. The first – which relates back to some of the tensions highlighted above around who the intervention is intended to reach – involved the issue of organisations attempting to ‘block book’ MHFA sessions. There was a sense that if organisations wanted all their staff to attend this training, they should fund this themselves. Organisations are therefore limited to four free places each (five on the Lite course), with the hope that those who had attended might perhaps encourage their employer to book a standard course from MHFA for other colleagues. This ‘cascade

effect' differs from the one identified as a mechanism within the Six Ways to Wellbeing Campaign, as it is definitely not intended to take the shape of a 'train the trainer' model – people only experience the full benefits of MHFA if they themselves attended a training. However, it was questioned whether this was the right approach to take, with one project lead mentioning that they would be interested in what the outcomes may have been had they instead agreed to deliver training to entire companies who showed interest in the training.

"I would like to kind of double check in six months' time, and think, well actually, would we have had a greater impact, if we had just said right, let's hit the police. Yes they should be paying for it themselves but if they're not going to, let's just get every frontline officer in Kent Mental Health First Aid training. Would that deliver us more outcomes, in the long run, than this very, this kind of wide but shallow kind of reach, that we've got at the moment?"

MHFA Project Lead

Interestingly, although there were concerns that employers might be more reluctant to allow for time off for a two-day training, the standard courses have received more interest than the Lite courses, a few of which have had to be cancelled due to low numbers. The full-length courses have, however, been fully booked out months in advance, and there is also healthy demand for the Youth courses, which aims to be met by the next tranche of trainings due to be delivered from April onwards. Overall, Public Health have been very satisfied with Sevenoaks Area Mind's programme delivery.

"Sevenoaks Mind put the best bid together in terms of cost effectiveness, and quality control mechanisms, so it was relatively straightforward. And actually working with them since has been really easy, we haven't had to fight to try and get people to come onto the courses."

MHFA Project Lead

The other main issue that was spoken about by project leads was the question of sustainability. It was recognised that it is important to evidence the benefits of the training in order to justify further Public Health spending on the initiative. However, it is clear that this is not straightforward, due to the programme not being able to deliver immediate returns. For instance, it is not going to be possible to state how many lives have been saved by the scheme, which, as one project lead noted, makes it hard to get crucial buy-in from politicians and other decision-makers.

"I think what we're doing at the moment is trying to raise awareness of this issue, and but also this product. And we're saying this is a good way of increasing awareness. Get it out there, get people talking about it and wanting to use it, and hopefully then, they'll pay for it themselves."

MHFA Project Lead

Promoting wellbeing

Due to MHFA being a licensed training, this Public Health intervention is somewhat limited in its ability to explicitly promote the Six Ways to Wellbeing. However, Sevenoaks Area Mind have

successfully incorporated local Kent resources, including the Live It Well Website and the Six Ways to Wellbeing, into the courses at suitable points. At the end, they also provide hand-outs directing attendees to Kent-based resources, specifically the Live It Well website and the Six Ways to Wellbeing. However, the extent to which this happens depends partly on the background of the trainer; those who are located in Kent are able to provide more detailed knowledge about local resources than those who are recruited in from other parts of the country. In addition to this, attendees are given promotional materials with the Six Ways to Wellbeing branding and literature with more detail on the concept.

It is important to note that there has been a lot of mutual promotion and collaboration between the Kent MHFA training and other interventions that sit under the Mental Wellbeing Programme. For example, MHFA and the Six Ways seminars signposted to each other, with some attendees booking onto MHFA while attending a seminar. Indeed, there was a sense that the Six Ways to Wellbeing seminars and the MHFA training were quite similar in their approach. As one project lead explained, the first section of both were very similar and aimed to educate on a general level about mental health. They then diverged somewhat, with the Six Ways to Wellbeing seminars focusing more on the "much lighter, more positive wellbeing" side of things, and the MHFA training discussing aspects of specific mental health problems. One project lead stated explicitly that the Six Ways to Wellbeing campaign and MHFA shared the same aims of increasing awareness of mental health amongst the general population and reducing stigma, although MHFA may provide this in "deeper and more substantial" ways than the Six Ways to Wellbeing campaign. It would appear, therefore, that MHFA and the Six Ways to Wellbeing campaign use different mechanisms to achieve similar results.

"They all come under the umbrella of our mental health Live It Well strategy. They definitely have the same aim of improving the mental health of the people of Kent. They have different ways of reaching that goal, because obviously the Six Ways is targeted at trying to prevent illness, how people stay well. But some of the mental health first aid is actually, okay, someone has a problem, how do you respond? How do you improve their lives? But yes, I think it's all working for the same goal, just slightly different ways of getting there."

MHFA Project Lead

Implications for the evaluation

As noted above, there have been several previous evaluations of Mental Health First Aid training courses which we have, and will continue to use to inform our evaluation. At present, we feel that the mechanisms outlined in the concept map above should be relatively straightforward to capture, though there may be challenges in measuring changes in behaviour. As with the Six Ways to Wellbeing campaign, our survey will endeavour to capture attendees' perceptions of intended behaviour, which has been proved to have a clear link with subsequent behaviour (see Six Ways to Wellbeing Campaign section of this report). From an evaluation perspective, it is helpful that the courses are to continue throughout the year, as it will make the process of recruiting participants to take part in interviews more straightforward.

MindFull Pilot in Schools

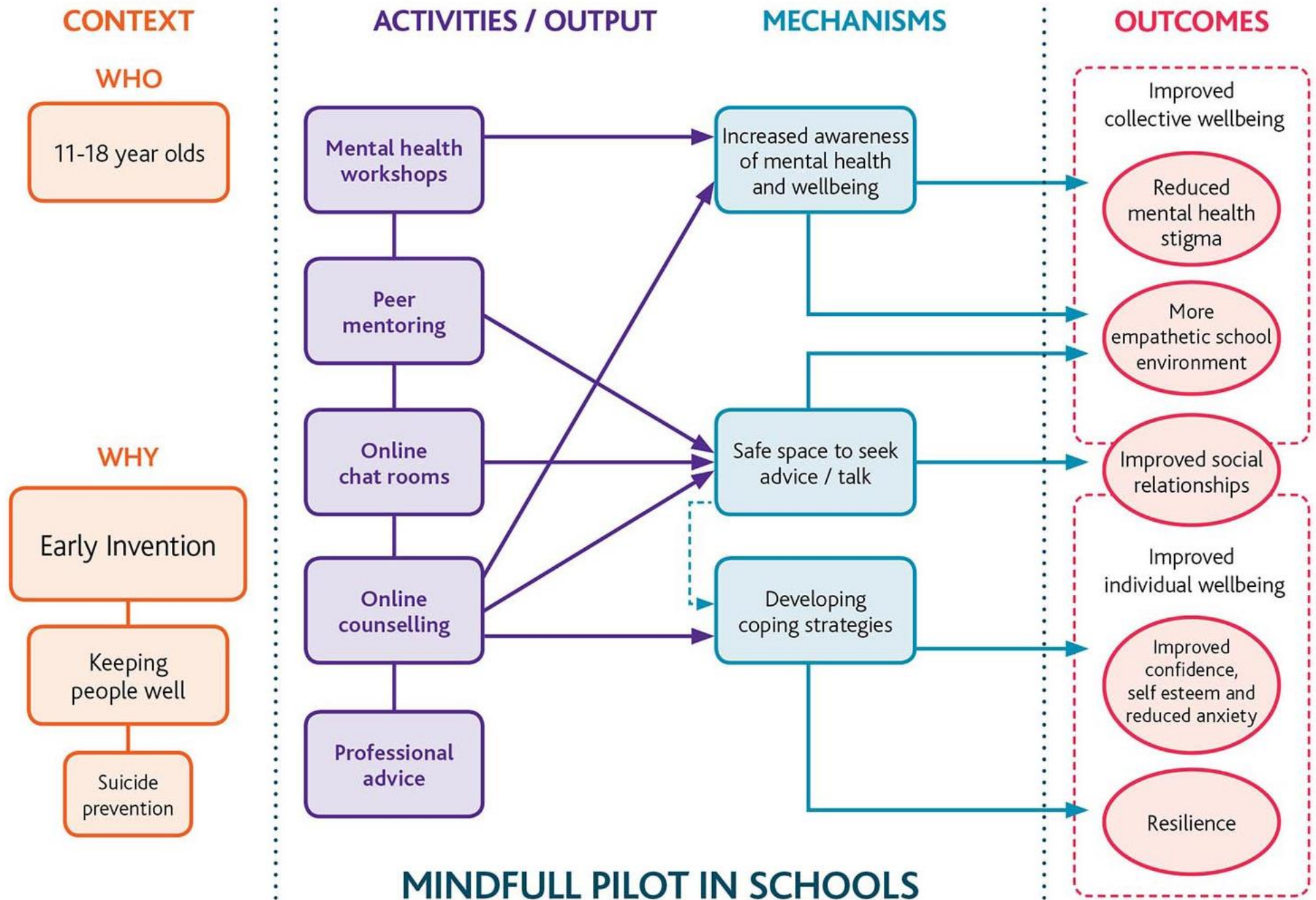
Background

The MindFull pilot in schools was a peer support and online counselling programme focused on young people attending three secondary schools in Kent. It was delivered by MindFull, which was part of the BeatBullying group of charities, and ran for six months in 2014. It was one of two interventions within Kent County Council Public Health's Mental Wellbeing Programme that was aimed at young people (the other being the Creative Arts Partnerships). The rationale for including this pilot within an adult-focused mental wellbeing programme was in part to support the Council's aim to secure a grant from the Big Lottery funded HeadStart pilot (which it successfully obtained several months after the commissioning of MindFull). The HeadStart initiative is aimed at improving resilience in 10 to 14 year olds, and initially, it is trialling and evaluating a series of pilot schemes across the United Kingdom with a view to providing further funding for the most successful programmes.

It was recognised that a Public Health young person-focused wellbeing initiative could both support a HeadStart bid, and, if successful, would also benefit from being part of a broader focus on young people's wellbeing. The service specification drawn up by Public Health was informed by a wealth of evidence around how best to support young people's mental wellbeing. The most salient questions appear to be around the *medium* of support most appropriate to this age group. Some evidence suggests that the Internet has the potential to become an important source of mental health services due to its ability to reach those who do not have access to the traditional routes of mental health support, or who choose not to access these (King, Spooner & Reid, 2003). Online counselling in particular is seen as a private and emotionally safe domain in which adolescents feel secure and less vulnerable than they may do using more conventional telephone or face-to-face counselling (King et al., 2006). However, there is also some evidence that suggests that young people may prefer face-to-face over online counselling (Rochland et al., 2004). The Public Health initiative sought to include both of these aspects in its pilot, offering face-to-face peer support, online counselling, and also the opportunity for anonymous peer support in moderated chat rooms.

Peer support can be defined as 'a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful' (Mead, Hilton and Curtis, 2001). Methods of peer support are now well established and there is a clear body of evidence to suggest that it leads to a range of positive outcomes, including reduced symptoms, increased social networks, increased quality of life, a reduction in hospitalisations, improved coping, lower levels of worrying, improved daily functioning and improved illness management (Davidson et al., 1999; Galanter, 1988; Raiff, 1984; Powell et al., 2001).

The need for peer support has been strongly identified within young people and student populations, with the Mental Health Foundation (2002) reporting that when asked who they would turn to for help, the top option chosen by students was to 'speak to a friend', while using counselling services or speaking to a social worker was a clear last choice.



Discussion

Concept

The MindFull pilot aimed to work with secondary school children in Kent. Three pilot schools were selected to take part – all had to have either a 'Good' or 'Outstanding' Ofsted rating, and were also required to demonstrate that students' wellbeing was already high on their agenda in order to qualify for inclusion. The overarching motivation of the project was to build resilience among young people and help them develop coping strategies during their formative years, but also to help some young people in relation to more serious issues affecting their wellbeing.

The concept for the intervention has four main strands. They are: a peer mentoring programme in the school environment, peer mentoring in an online chat room, access to free online counselling and, at a later stage, mental health workshops, to be held in the pilot schools and some additional schools, which are intended to help to improve mental health awareness and reduce discrimination.

The peer mentoring element of the programme involved the training up of a minimum of 60 peer mentors – young people put forward by the schools – to be able to support others with common wellbeing issues that affect young people including friendship, family, schoolwork and homework. Staff members were given briefings about the programme so that they could support the mentors, both emotionally but also with logistics and practicalities, but it is important to emphasise that the intervention was led by the peer mentors. This meant that students took control of the administrative duties such as managing rotas for the mentors, and identifying a space for the peer mentors to base themselves. All of the peer mentoring sessions took place during school hours.

The online counselling from accredited counsellors was available to students between the hours of 10am to midnight, 365 days a year and consisted of an initial set of 6 sessions which could be extended if desired. Counsellors had expertise in a range of fields, including person-centred counselling, CBT and psychodynamic counselling. Students were also able to choose the format of counselling including real time private chat, asynchronous private messaging or audio and video chat which allowed easier access for people with literacy problems, disabilities or other access issues. In addition, students were able to choose which counsellor they had, using a 'stick or twist' process whereby the student was able to speak to three different counsellors and choose which one to continue with.

Finally, students in the pilot schools were made aware of online chat rooms run by MindFull, and accessible to young people beyond Kent, where they could go to talk about any concerns they might have and seek support from peers anonymously.

Project leads articulated how the different aspects of the MindFull program improve wellbeing or increase resilience. There was a sense that the peer mentoring in schools was slightly more focussed on 'keeping people well' than the online counselling, which was more likely to be aimed at solving specific problems. Whilst the MindFull programme did not seek to directly integrate practice of the Six Ways to Wellbeing in its peer mentoring or counselling operations, the organisation has promoted the campaign in the schools.

“The online counselling was the next level up. It gives them that person to talk to, somebody who’s a bit more specialist, a bit more trained for young people who probably need something maybe a bit more in depth.”

MindFull Project Lead

There are a number of preliminary outcomes that ultimately feed into increased resilience. This includes improved self-esteem, confidence, belief in one’s own self-worth, the capacity to deal with change and adaptation and a range of social problem solving skills (cf. Department for Education, 2015). This is supported by evidence from the World Health Organisation (2015), which argues that achieving resilience can help to alleviate a range of mental health problems including anxiety, depression and eating disorders.

MindFull discontinuation

The pilot started off promisingly, with over 75 mentors across the three schools receiving their training prior to the 2014 summer holidays as planned, and mentoring commencing. However, things took an unfortunate turn in August / September when it became clear that the BeatBullying group was struggling and likely to go into administration. This was confirmed to Public Health in October 2014. There was no further work in schools as of the summer. In October, the schools were able to identify the students who had started the online counselling process – six in total – and directed them to other pastoral care within the school (see below). There was no further engagement work with the peer mentors from this point. The chat rooms also ceased to operate – and in any case, this aspect of the intervention was never intended to be monitored or evaluated – and the mental health workshops had not yet taken place at this point.

Although MindFull is no longer in operation, in early 2015 some elements of the MindFull programme have been revived in two of the three schools under the HeadStart umbrella, but using money from the MindFull budget. The third MindFull school is not a HeadStart school, and as there had been no contact with this school since July 2014, it was felt that it would be difficult to reinstate contact given the circumstances. However, in the HeadStart schools, a new cohort of mentors is being trained up to deliver peer support. This links up well with other aspects of the HeadStart pilot, including the provision of ‘Safe Spaces’ in schools.

Challenges

During the period that MindFull operated in the pilot schools, there emerged a number of practical challenges that Public Health and MindFull were seeking to resolve at the time of administration. First, there was some difficulty in engaging the young people in the schools, and enthusiasm for the online counselling had been lower than expected. After six months, only six young people had activated an online counselling code – although it is important to remember that the summer holidays fell within this period. In addition, there was a considerable dropout rate of peer mentors from the initial training to the time of first supervision. It was emphasised that the timing of the training may have contributed to the lack of peer mentor engagement as well, as all the mentors

were trained before the summer holidays, and upon returning were noticeably disengaged with the program. Furthermore, although all students were encouraged to access the online chat rooms over the summer holidays, it was not clear whether this had happened. MindFull was aware of the problematic timings, and had intended to re-launch the intervention in all three of the schools in September, although this did not happen due to the ensuing difficulties.

“They were trained up before the summer, and then obviously they went away for six weeks over the summer holidays. They came back and they were quite disengaged from it. It might have been GCSE year, they were starting to get geared up for their exams and stuff, but a lot of the young people fell out of it.”

MindFull Project Lead

Project leads also suggested that the selection of students by teachers to fulfil the peer mentor role may have hindered their engagement with the programme. It was mentioned that the peer mentors had not volunteered to take part, yet this would have been a preferable way to ensure passion and commitment to the programme. There was also a feeling that some of the schools at least were choosing very high achieving students to be peer mentors, and that although there might be some logic behind this in terms of managing school commitments, this might not be the best way to ensure that the peer support on offer felt accessible to a wide range of students.

“If they said they had problems at home or they were feeling a bit depressed or whatever, we wanted young people that would have come from the same situation so could maybe speak from experience. I’m not saying that the children that were chosen by the school weren’t like that, but I imagine the school would have chosen young people that would have maybe been prefects or, you know, kind of, like the good role models.”

MindFull Project Lead

Another issue that may have impacted on the success of the project was staff engagement. There were suggestions that some staff could have done more to support and encourage the peer mentors, and that this may have influenced the drop-out rates. It was noted, however, that teachers are often under a lot of pressure to take the lead on ‘extra-curricular’ activities that they don’t realistically have time to commit to. The HeadStart programme has sought to remedy this issue and has sourced dedicated pastoral support for peer mentors, rather than relying on internal staffing support.

There were also issues around confidentiality and anonymity of students seeking support via the programme which is likely to have had a significant impact on numbers. There was a lot of confusion around the administering of the online counselling activation codes that would allow students free access to the service. In some instances, it became clear that schools were uncomfortable with allowing students to access online counselling without their knowledge due to safeguarding procedures, and required students to obtain an activation code from their teacher. However, this severely compromised the anonymity that is a key principle of the online counselling, and arguably served to reinforce some of the barriers that young people feel they face when trying to access mental health services. MindFull emphasised that they had their own safeguarding procedures, and were in the process of attempting to remove this barrier to access at the time of administration. On

the other hand, it was thanks to this compromising of students' anonymity that the schools were able to follow-up with the six students who had started the counselling and ensure that they could have other support after MindFull went into administration.

“Some of the schools found some of the paperwork a bit more confusing for MindFull, so they had to do a risk assessment and something else with the young person to get them signed up to the online counselling.”

MindFull Project Lead

Finally, it was mentioned that the schools were not always able to provide appropriate premises for the face-to-face peer support. Although this element of the project had only just started when MindFull went into administration, there was a report that in one case, the room to be used for the peer mentors during lunch break was adjacent to the Head Teacher's office – which was not felt to be conducive to the aims of the peer mentoring.

Implications for the evaluation

The ceased activity of MindFull has clear implications for this evaluation. We have only been provided with KPI data for quarter one, which does not include any information regarding the online counselling – and several key monitoring questions were to be asked at the end of the counselling sessions. We do, however, have a small amount of data pertaining to the peer mentoring aspect of the work which we have reported on in our Interim Report.

We have discussed with both the HeadStart evaluation team and Public Health what the best way forward is likely to be. We understand that a baseline WEMWBS was collected across the three MindFull pilot schools. There is a possibility that we may be able to collect follow-up WEMWBS in the two MindFull schools that are now participating in HeadStart – we are in the process of trying to establish how feasible this is. However it is important to note the practical and theoretical challenges that surround this. First, schools may not be willing to engage in the evaluation due to the pressures and time constraints of partaking in HeadStart and its separate evaluation. There is also an element of sensitivity around the matter, due to the manner in which MindFull withdrew engagement. Second, we would only be able to infer an aggregate change in WEMWBS scores, and would not be able to identify what proportion of students increased or decreased their individual WEMWBS scores. Finally, it is important to consider what a change in WEMWBS has the potential to demonstrate. It is likely to be very difficult at this stage to differentiate between the impact that HeadStart has had on wellbeing and the impact that MindFull's intervention almost a year ago had.



Conclusions

The findings from the first phase of this evaluation have provided a good overview of the intended and actual projects that form Kent County Council's wellbeing programme. This programme is ambitious in its scope and encompasses a wide range of different approaches to improving wellbeing and targeting different sections of the population.

The idea of mapping out the concepts of an intervention – often referred to as a Theory of Change – is generally recommended at the start of an intervention when planning the design, delivery and evaluation. In most cases, the projects discussed here are well underway or have even been completed already. As a result, it can be difficult to disentangle what a project was *intended* to achieve and what it *actually* achieved. The stakeholders we interviewed had already been involved in adapting the projects to the arising challenges, and it was not always easy to pinpoint where, how and why the original ideas may have changed along the way. As far as possible, we have developed maps to reflect what the intended aims and outcomes of a project were, and discussed how these have been adapted in the narrative sections each intervention.

Some themes have emerged from this initial work that are important to highlight in thinking about the overall aims of the wellbeing programme:

A spectrum of mental health and wellbeing

First, there are several broad aims to the programme which can be perceived as sitting on a spectrum. Promoting positive mental wellbeing, or 'keeping people well' sits at one end of this spectrum, and the reduction of suicide rates at the other – with early intervention for emerging or low-level mental health problems in the middle. Inherent in this is the idea that by improving wellbeing for everyone, including those who are most struggling, the risk of people taking their own lives will be reduced. These two aims have influenced the target groups for the individual projects, with an explicit target of middle age men, particularly in relation to Kent Sheds and the Primary Care Link Worker project.

The assumed link between wellbeing and suicide prevention may need further investigation, however. A number of project leads have expressed concerns about the potential to reach people who might be at risk of suicide, and did not generally feel that their work would be likely to result in reduced suicide rates except in a very indirect and long-term way. We will consider this theme further throughout the evaluation, though it is unlikely that we will be able to gather quality evidence to test this assumption in the scope of this work.

Hard to reach audiences

A second theme is the disconnect observed at times between the ideal target audience of the programme and the actual group engaged. This was particularly true for the campaign seminars and the Mental Health First Aid projects. The group engaging with the projects tended to be those who were already a 'warm audience' to mental wellbeing and mental health. The idea of the hairdresser came out in a number of interviews as being the exemplar of someone who may not already have a strong connection to mental health but who could have a powerful influence on wellbeing in the

community. In general, however, it was not felt that this type of person had been reached with the projects. There was also a wider challenge about reaching the general population in Kent through the media and KCC communications which was felt to have been less effective than initially hoped.

Individual vs. community wellbeing

A third theme is the dual aim of improving personal wellbeing for individuals and community wellbeing. Several of the projects have an ambition of improving the wellbeing of the individuals they worked with directly through, for example, improved social inclusion and confidence, but many also had the ambition of improving the wellbeing of the wider community through spreading awareness of the six ways to wellbeing, improving the response of participants to others' mental health needs, and in some cases by improving the community environment. Capturing the impact on the wider community is challenging because of the distance between intervention and outcome and the impossibility of identifying who in the community will benefit from this wider impact. Nonetheless, public health interventions of this nature do need to consider these outcomes and we will be looking at some proxy measures for this where possible in the evaluation.

Sustainability

A fourth area of interest is the question of sustainability, and whether the investment in the interventions by Public Health can be sustained in some form after project completion without continued funding. This is especially relevant for projects that have the potential to offer long-term, rather than time-limited support, such as Kent Sheds and the Library Wellbeing Hubs. However, it will also be important to consider whether interventions that are time-limited have any kind of 'legacy' – for example, in terms of being motivated to secure funding from elsewhere (e.g. Mental Health First Aid, Happier@Work, Creative Arts Partnerships). Although it may be possible to answer some of these questions through our continued monitoring of project progress, it is important to note that, in some cases, only time will tell whether an intervention has become sustainable, and that this may be some time after project and evaluation completion.

Six Ways to Wellbeing

Finally, our evaluation will continue to consider the way in which the principles of the 'Six Ways to Wellbeing' underpin the various wellbeing interventions, how they promote project successes, and where improvements to the model could be made. It is already clear that although the Six Ways to Wellbeing guide the Mental Wellbeing Programme as a whole, the extent to which they are deployed at individual project level is highly variable, and has met with some challenges as well as success.

We hope that this report will be valuable to those delivering the projects (where delivery is still ongoing) and other stakeholders, and also hope that it can inform the design and delivery of similar interventions in the future. This report does not provide a full summary of evaluation progress to date, including data collected, but may be read in conjunction with our Interim Report submitted to KCC Public Health in April 2015 which provides this detail.

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This evaluation has been commissioned and funded by Kent County Council.

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We would also like to acknowledge the Mental Health Promotion team at South London and Maudsley NHS Foundation Trust who developed the Wheel of Well-being.

Wheel of Well-being



Funded by

