Mental Well-being Impact Assessment

A toolkit for well-being

Mental Well-being Impact Assessment (MWIA) 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 mental well-being.

Published by the National MWIA Collaborative (England)
May 2011

Members of the National MWIA Collaborative (England)

University of Liverpool impact

Inukshuk

Local Government Improvement and Development

Lynne Friedli

Jude Stansfield

Kate O'Hara

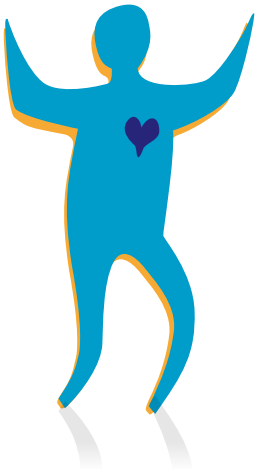
nef economics as if people and the planet mattered

NHS Confederation

South London and Maudsley NHS Foundation Trust

West Midlands Public Health Observatory WMPHO

Contributors and acknowledgements



Authors

Anthea Cooke, Inukshuk Consultancy
Lynne Friedli, Mental Health Promotion Specialist
Tony Coggins, South London and Maudsley NHS Foundation Trust
Nerys Edmonds, South London and Maudsley NHS Foundation Trust
Juliet Michaelson, new economics foundation
Kate O'Hara, Freelance Public Health Specialist
Lynn Snowden, Inukshuk Consultancy
Jude Stansfield, Freelance Public Health Specialist
Nicola Steuer, new economics foundation
Alex Scott-Samuel, IMPACT, University of Liverpool

Contributors and reviewers

Jonathan Campion, Department of Health
Hilary Dreaves, IMPACT, University of Liverpool
Sue Wright, West Midlands Public Health Observatory

MWIA National Collaborative group members

Jonathan Campion, Department of Health
Tony Coggins, South London and Maudsley NHS Foundation Trust
Anthea Cooke, Inukshuk Consultancy
Hilary Dreaves, IMPACT
Nerys Edmonds, South London and Maudsley NHS Foundation Trust
Lynne Friedli, Mental Health Promotion Specialist
Kate O'Hara, Freelance Public Health Specialist
Juliet Michaelson, new economics foundation
Alex Scott-Samuel, IMPACT, University of Liverpool
Hilary Dreaves, IMPACT, University of Liverpool
Lynn Snowden, Inukshuk Consultancy
Martin Seymour, Local Government Improvement and Development
Jude Stansfield, Freelance Public Health Specialist
Nicola Stevenson, NHS Confederation
Sue Wright, West Midlands Public Health Observatory
Gregor Henderson, former National Mental Health Development Unit (2009-2011)

Organisations and participants involved in piloting and giving valuable feedback

Paxton Green Timebank, London
Lambeth Expert Patients Programme, London
NHS Lambeth, London
London Borough of Lewisham
Well London MWIA Project participants
MWIA Pioneers in North West England
MWIA Champions in West Midlands
Colleagues at international, national and regional conferences and MWIA Networking events

Funders

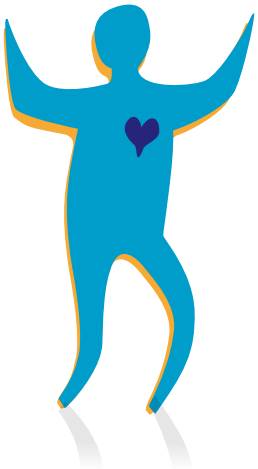
Former National Mental Health Development Unit (2009-2011)
South London and Maudsley NHS Foundation Trust (in kind contribution)
Inukshuk Consultancy (in kind contribution)

In memorial

Sadly, a keen contributor and promoter of MWIA died unexpectedly during the finalisation of this toolkit. The National MWIA Collaborative wish to acknowledge the contribution that Nicholas Henry made in turning MWIA into best practice particularly in Lambeth, London.

Reference

Cooke, A., Friedli, L., Coggins, T., Edmonds, N., Michaelson, J., O'Hara, K., Snowden, L., Stansfield, J., Steuer, N., Scott-Samuel, A. (2011) 3rd ed., London: National MWIA Collaborative



Mental Well-Being: making an impact locally – and making it now

We live in uncertain and turbulent times. The recent economic recession has brought with it significant hardships for communities, neighbourhoods, organisations, businesses, families and many others. Having a way of building our collective resilience to manage through these tough times and emerge in good and even better shape is something that this toolkit on mental well-being impact assessment can help achieve. Understanding what puts our individual and collective mental wellbeing at risk and the role that key determinants have on our well-being is a fundamental first step. This is a starting point to developing what might help. By identifying the contributions we can and do make individually and collectively we can begin to improve and sustain mental well-being. This enables us to develop the capability and capacity to build a collective and stronger sense of wellbeing that makes an impact now. Why wait?

We know that good mental health and well-being is fundamental to all our lives and to the communities where we live. It underpins everything we do, how we think, feel, act and behave. It is an essential and precious individual, family, community and business resource that needs to be protected and enhanced. There is increasing evidence and understanding of the importance of good mental health and well-being and more is now known about what can be done to sustain mental health and well-being for organisations, communities, families and individuals of all ages.

The National Mental Health Development Unit (NMHDU) has supported the development and implementation of Government mental health policy over the last two years. The new policy, *No health without mental health* (DH, 2011) places improving mental well-being central to the Government's outcomes and priorities for action. The population mental health and well-being team at NMHDU has provided a specific focus on building knowledge and capability within the NHS, local authorities and key partners in improving and sustaining community, family and individual well-being.

NMHDU has seen how Mental Well-being Impact Assessment provides a unique and effective approach to creating policy and services that have the best possible impact on people's mental well-being. The MWIA Toolkit has been developed on sound evidence and tested and used successfully in a number of local areas across the country. We are keen to see it used much wider. For the last year NMHDU has funded a development and capacity building programme to support its application throughout England. This second edition of the toolkit has been refined following further use and updated with the current policy context.

I commend MWIA as a key improvement tool written and designed to enable organisations and communities to engage with and improve mental health and well-being. The work is relevant to anyone wishing to refocus or focus their work to specifically achieve wellbeing and public health outcomes or to integrate these into other impact assessment approaches. We hope that the growing network of MWIA practitioners and growing interest nationally and internationally in MWIA, its use and development, continues to flourish.

NMHDU would like to thank all those who have contributed to the development of this tried and tested tool, spanning more than seven years of hard work. Special thanks to Jude Stansfield and Kate O'Hara from NMHDU, the Inukshuk SLAM Partnership who have led this work, the partners on the MWIA National Collaborative who have steered it and to the www.hiagateway.org.uk for hosting all the MWIA information and resources.

Gregor Henderson
Wellbeing and Public Mental Health National Lead,
National Mental Health Development Unit
From 1 April 2009 – 31 March 2011. www.nmhdu.org.uk

May 2011

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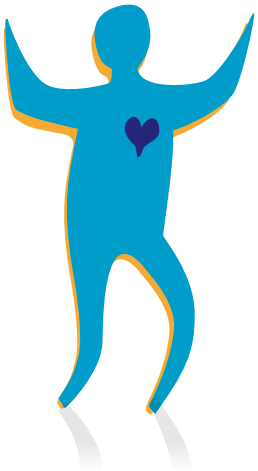

This MWIA toolkit for well-being provides an evidence based framework for improving well-being through commissioning processes, project and service design and delivery, community engagement and impact assessment. It enables people and organisations to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's mental well-being, and to identify ways to measure those impacts.

It has been developed by a partnership of specialists and organisations bringing together mental health and well-being and Health Impact Assessment (HIA) knowledge and skills. There has been a development process over seven years beginning in Lewisham and Lambeth and developed further in the north west of England and latterly supported and funded by the former National Mental Health Development Unit (NMHDU). A National Collaborative steering group oversees the development and implementation of MWIA, including capacity building and policy development.

The MWIA Toolkit introduces the user to the policy and evidence base for mental well-being (in England), and provides a framework and resources to undertake a MWIA. It is published in sections that follow the MWIA process. Some sections can be used as a 'stand alone' resource such as the Screening Toolkit and the Indicator section.

"Top tips" are shared throughout the sections to help the user make best use of the resource.

1 provides an **overview of MWIA**, including the policy context

2 is a detailed account of the current evidence and debate on what **influences mental health using the evidence base for MWIA**. It is fully referenced and can be used as a "stand alone" resource

3 is a desk top **Screening Toolkit.** This can be used as a 'stand alone' process, undertaken by one or two people to make an initial assessment of the potential impact on mental well-being of the project. It will assist with deciding if further in-depth MWIA would be helpful

4 How to do a complete MWIA:

- **screening** – deciding whether to do an MWIA
- **scoping** – planning your MWIA
- **appraisal** – gathering and assessing the evidence
- **formulating** – recommendations, monitoring and evaluating your MWIA

5 is a detailed discussion on the need to monitor the subsequent impact of the proposal on mental well-being following the MWIA process. It contains detailed guidance on **identifying and developing indicators** to complete the MWIA process.

6 is a **set of resources** to support the MWIA process and a master reference list

Section 1

Mental Well-being Impact Assessment

An **overview of MWIA**, including the policy context.

"There is growing evidence that mental well-being is a key pathway through which inequalities impact on health. The importance of mental health and well-being is directly and indirectly related at every level to human responses to inequalities" (Friedli 2009)[1]

1.1 Introduction

This section of the MWIA Toolkit introduces the context and value of the Mental Well-being Impact Assessment (MWIA) process. It outlines the benefits, aims of MWIA, the policy context and a brief overview of the MWIA process.

1.1.1 About MWIA

MWIA is similar to Health Impact Assessment (HIA) except that it has a specific focus on mental well-being. The aim of MWIA is to maximize positive and minimise negative impacts on mental health and well-being. Like HIA, MWIA focuses on population groups who may experience health inequalities and social injustice with a particular emphasis on those most at risk of poorer mental well-being. It also makes the link with social determinants, and can be adapted to be used alongside HIA or as a separate process. MWIA goes further in developing indicators to measure the actual impacts over time.

Value of the MWIA process

The MWIA process enables a shift in thinking and focus to improve mental well-being. It can contribute to re-aligning resources and models of service from those that concentrate on managing the consequences of poor mental well-being (high crime, unemployment, illness, intolerance, and underachievement) to ones that tackle the determinants of good mental well-being: control, resilience, participation and inclusion.

The benefits of MWIA are clear[2] and it has a role to play in:

- Re-focusing efforts to create better existing and new services to improve mental well-being
- Developing shared coherent understandings of mental well-being with a range of stakeholders
- Ensuring policies, services, programmes or projects have a positive impact on mental well-being
- Actively engaging all partners in service development and fostering co-production of mental well-being
- Supporting community needs assessment and the development of relevant and meaningful local indicators

Application of MWIA

MWIA is an innovative and effective tool to ensure proposals improve people's mental well-being as much as possible. The toolkit can be used by anyone with an interest in the potential mental well-being impact of policies, services, programmes or projects in a wide range of settings and across all sectors.

Potential proposals on which an MWIA may be carried out are wide ranging. The MWIA process can be used to generate debate about mental well-being, and assess the potential impact on:

- Commissioning of new or reconfigured services, e.g. extended schools, social prescribing programmes, new supermarket opening, open air swimming pool closure, and new or existing mental health services
- Planning or development proposals, e.g. the location of a casino, football club or fast food outlet, sale of school playing fields, wind farm development, and culture initiatives

- Specific projects or programmes, e.g. health-promoting schools, parenting skills training, and employment support
- Policy implementation, e.g. tobacco control, workplace health, school meals, anti-social behaviour orders, and dispersal of refugees and asylum seekers
- Strategy development, e.g. economic strategy, transport plans, community strategy, and obesity strategy
- Major strategic plans in a locality or region for example Local or Multi-Area Agreements.

Related impact assessment processes

MWIA has been developed to enable a specific focus on the determinants of mental well-being. It is designed as a stand alone tool and is particularly useful when the focus of interest is specifically on mental well-being, mental health or well-being.

The framework for assessing mental well-being can also be incorporated into related impact assessment processes such as Health Impact Assessment (HIA), Equality Impact Assessment, Socio Economic Assessment and Environmental Impact Assessment. These all cover some aspects of exploring mental well-being, however, are unlikely to use an updated evidence framework such as in MWIA. These more generic assessments may also highlight mental well-being, mental health or well-being as a key priority, whereupon a detailed MWIA can follow. This integration has been achieved in some HIAs. NMHDU are keen for people to draw from and adapt MWIA within other impact assessments and to feedback on how this has worked for them.

1.1.2 Output and outcomes from MWIA

The main output of a MWIA is a "set of evidence based recommendations" specifically designed to influence planners, funders and those delivering proposals. These recommendations are specifically designed to maximise potential positive impacts and minimise potential negative impacts.

The outcome framework for MWIA

The outcome framework in table 1.1 sets out the indicators that can be used to measure the process (inputs/ activity), outputs and impact of conducting MWIA, with the ultimate outcome of improved mental wellbeing.

Table 1.1: The outcome framework for MWIA

Process	Output	Impact	Outcome
Mental Wellbeing Impact Assessment undertaken with stakeholders	Set of evidence based recommendations agreed	Improvements made to proposal (which maximise the positive impacts it has on mental wellbeing and minimise the negative)	Improved mental well-being (and/or its determinants)

1.1.3 The role of "evidence" in MWIA

It is important when making an assessment to have relevant and credible information and evidence. The type and quality of evidence varies with the level of assessment. There are generally three types of evidence used in MWIA's:

- Community profiling
- Literature review
- Stakeholder and key informant.

In this toolkit the user is encouraged to draw on all three sources and to place them within an evidence based assessment framework provided. Published research evidence is provided in the appendices, and there is a growing library of completed MWIA's available at www.hiagateway.org.uk. Transferable lessons and information can be gained from these completed reports. The fourth section of the toolkit explains what types of evidence are generally used in each category.

1.1.4 The assessment criteria for MWIA

The MWIA Assessment criteria are also evidence based and drawn from a review of the literature and extensive piloting with people across a wide range of backgrounds. They have a specific focus on the factors that protect and promote mental health and well-being – a salutogenic approach. Salutogenesis asks, *"What are the causes and distribution of health and well-being in this group, community or country's population"*. Epidemiology asks *"what are the causes and distribution of disease and early death in this group, community or population"*. (Harrison *et al*. 2004, p. 9)[3]

The core protective factors for mental well-being used in MWIA are grouped under three areas:

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

The strength of evidence for both the determinants of mental well-being and the relationship between mental well-being and other outcomes (e.g. physical health, education, crime) varies. This toolkit attempts to ensure that research papers and reviews are cited as sources of evidence, and to indicate areas where there is considerable debate or uncertainty.

1.2 Policy support for MWIA

The World Health Organisation European Declaration on Mental Health (2005a) confirmed the policy context for developing the MWIA toolkit:

> "There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment."
>
> (WHO 2005a, p1)[4]

Within Europe

Within Europe, the World Health Organisation (WHO) and the European Commission emphasise the contribution of mental health to future health and prosperity. Mental well-being impact assessment is recognised as an important action to improve population health. The European Union Mental Health Action Plan for Europe calls for action to *"assess the potential impact of any new policy on the mental well-being of the population before its introduction and evaluate its results afterwards."* (WHO 2005b, p.4)[5]. This is reiterated in the European Union Green Paper (2006)[6] on mental health and subsequent European Pact for Mental Health and Well-being (2008)[7], which is likely to make a further contribution to raising the profile of mental health.

Within United Kingdom

The policy context for measuring well-being has increased significantly over recent years and momentum continues to grow around the importance of measuring well-being outcomes.

The most recent, and perhaps most significant, policy announcement in this area came from Prime Minister David Cameron in November 2010. He asked the Office for National Statistics (ONS) to lead a programme of work exploring how best to measure national well-being, and announced the inclusion of subjective questions measuring well-being in one of the largest government surveys, the Integrated Household Survey, from April 2011.

The *Foresight Review on Mental Capital and Well-being* (Government Office for Science 2008)[8] cemented cross government commitment to addressing well-being. It defined well-being as:

> "… a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community".
>
> (Government Office for Science 2008, p10)[9]

The *Marmot Review*[10] provided a strategic review of health inequalities and emphasises the social determinants of health, above all social justice, as future areas of focus. The priorities align to the MWIA assessment factors of control, resilience and community assets and participation & inclusion (see Section 2 of this MWIA Toolkit).
The review further recommends a re-focusing and measurement of inequalities in well-being.

The policy environment provides a framework for integrating MWIA with existing efforts to improve mental health and well-being and with wider regional, national and international initiatives relevant to mental health, e.g. human rights and civil liberties, social inclusion, anti-poverty, reducing inequalities and addressing violence.

The current Public Health white paper *Healthy Lives Healthy People* (DH 2010)[11] provides a policy response to the Marmot Review and sets out a new approach to public health with mental health as an integral and complementary part of the proposed new direction. It places health improvement as everyone's responsibility and provides a comprehensive approach to addressing mental health and well-being. It recognises that mental health and well-being is central to physical health and to wider outcomes such as education and productivity at work. Factors of self-esteem, confidence and resilience are seen as key to health behaviour change and also affected by a wide range of influences such as our physical, living and working environment and local community. The prevalence and burden of mental health and inequalities is increasing and prevention and promotion of mental health and well-being are important priorities. The range of actions cited to promote well-being includes addressing many of the factors within the MWIA tables at an individual and community level e.g. control, resilience, green space, self-esteem, social networks.

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The Mental Health Strategy *No health without mental health* (HMG 2011)[12] builds on the Public Health white paper with a strong public mental health approach throughout. It is a cross government strategy, signifying the relevance of mental health and well-being to a range of policy areas, and as such it covers all ages. The strategy aims to *"improve the mental health and well-being of the population and keep people well"* alongside *"improve outcomes for people with mental health problems through high-quality services that are equally accessible to all"*. Within the supporting document *Delivering better mental health outcomes for people of all ages* (HMG 2011) the Mental Well-being Impact Assessment Toolkit is cited (p26) as a useful approach to achieving the strategy's first objective of "more people will have good mental health". The other five objectives of the strategy focus on recovery, physical health, positive experience of care, less avoidable harm and less stigma and discrimination – all of which are also included within the MWIA process.

A Vision for Adult Social Care policy (DH 2010)[13] also places well-being and prevention high on the agenda. This includes the quality of life for individuals and building stronger communities and assets.

The policy environment therefore provides a framework for integrating MWIA with existing efforts to improve health and well-being, prevent ill-health and to wider national and international initiatives relevant to mental well-being, e.g. human rights and civil liberties, social inclusion, anti-poverty, reducing inequalities and addressing violence.

In addition, recent guidance documents on well-being have cited MWIA as a useful tool for raising awareness and understanding of contributions that interventions and organisations can make to promoting mental well-being and as a tool to assist with measurement of their impact. These resources are listed in Section 6, Resource K.

1.3 The Mental Well-being Impact Assessment framework

The flow diagram in Figure 1 shows the stages of the MWIA process and how these relate to the sections within the MWIA toolkit:

Figure 1: Stages of the MWIA process

Screening – Deciding should you carry out an MWIA?
Making an initial assessment of your proposal and deciding if further investigation is required

↓

Scoping – How you will carry out the MWIA
Initial policy appraisal, community profile, options for geographical boundaries and assessment of impacts.

↓

Appraisal process – gathering and assessing the evidence
- Community profiling
- Stakeholder and key informant – MWIA workshop
- Research such as Literature Review

↓

Identification of potential positive or negative impacts

↓

Identification of indicators
for monitoring impacts of your proposal on mental well-being and implementation of recommendations

↓

Identification of recommendations and report

How to use the other sections in the MWIA toolkit:
The MWIA Toolkit is published in sections that follow the MWIA process. Some sections can be used as a 'stand alone' resource such as the Screening Toolkit and the Indicator section.

Section 2 is a detailed account of the current evidence and debate on **what influences mental well-being using the evidence base for MWIA**. It is fully referenced and can be used as a "stand alone" resource. This section should definitely be read before undertaking a MWIA.

Section 3 is a desk top **Screening Toolkit**. It can be used as a 'stand alone' process, undertaken by one or two people to make an initial assessment of the potential impact on mental well-being of the proposal. It will assist with deciding if further in-depth MWIA would be helpful.

Section 4 describes how to do a complete MWIA appraisal:

- **screening** – deciding whether to do an MWIA
- **scoping** – planning your MWIA
- **appraisal** – gathering and assessing the evidence
- **indicators** – to measure impact on mental well-being (covered in detail in section 5)
- **formulating** – recommendations, monitoring and evaluating your MWIA

Section 5 is an overview on policy context and benefits to monitoring the subsequent impact of a proposal on mental well-being following the MWIA process. It contains detailed guidance on **identifying and developing indicators** to complete the MWIA process.

Section 6 is a **set of resources** to support the MWIA process and a master reference list

1.4 Outcomes from the development of the MWIA Toolkit

The development of the MWIA Toolkit has been an iterative process and has involved extensive piloting feeding directly into the process. Outcomes from this process are as follows:

- The former National Mental Health Development Unit (NMHDU) funding a national programme of MWIA promotion and capacity building (2010-2011)
- MWIA reflected in national policy and guidance documents as best practice
- 500 or more MWIA's undertaken
- One comprehensive MWIA on the Liverpool 2008 European Capital of Culture (www.liverpool08.com); recommendations are now being taken forward
- Proposals being improved as a result of recommendations from MWIA
- Indicators of Mental Well-being used to measure the impact of proposals and used to demonstrate benefits of proposals and support funding applications
- Over 3000 downloads of the MWIA toolkit from the website when earlier version launched in October 2010
- 1500 hard copies of the earlier MWIA toolkit distributed
- 65 teams of three or more people from various organisations trained and supported in undertaking MWIA and 200 people attending Introduction or taster sessions across England between 2010 and 2011
- An established programme of MWIA networking events for trained MWIA practitioners and more recently including people interested in MWIA
- MWIA presented at numerous national and international conferences
- Four journal articles published
- MWIA has been recognised as a tool for whole system reform to enable a focus on well-being
- MWIA has collaborated with WHO, EC and European partners, governments in New Zealand and Canada
- Extensive MWIA library built on the HIA Gateway website: www.hiagateway.org.uk
- A MWIA Communities of Practice has been established with over 100 members. To join please go to http://www.communities.idea.gov.uk/welcome.do and register

The report, "Improving Mental Well-being Through Impact Assessment" (2009)[14] details the development of MWIA over recent years and showcases different MWIA's.

1.5 In summary...

This section has presented a brief overview of the benefits of undertaking MWIAs and sets it in the current policy context. One of the strengths of using this toolkit is that it is based on a rigorous review of the published research on the causes and determinants of mental well-being. The assessment process has been piloted with many communities and stakeholders who have further validated the evidence, along with the process.

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1.6 References for section 1

1 Friedli, L. (2009) *Mental health, resilience and inequalities – a report for WHO Europe and the Mental Health Foundation*. London/Copenhagen: Mental Health Foundation and WHO Europe. Available at: http://www.mentalhealth.org.uk/publications/?entryid5=68603

2 Cooke A. & Stansfield J. (2009) *Improving Mental Well-being through Impact Assessment: A summary of the development and application of a Mental Well-being Impact Assessment Tool*, London: National Mental Health Development Unit. Available at: http://www.apho.org.uk/resource/item.aspx?RID=76823

3 Harrison, D. *et al*. (2004) Assets for Health and Development (AHDP) Developing a Conceptual Framework. Copenhagen: World Health Organisation Regional Office for Europe.

4 World Health Organisation (2005a) *Facing the challenges, Building Solutions*. Ministerial Conference on Mental Health. EUR/04/5047810/6. Helsinki/London: World Health Organization. Available at: http://www.euro.who.int/document/MNH/edoc06.pdf

5 World Health Organisation (2005b) *Mental Health Action Plan for Europe: facing the challenges, building solutions*. Copenhagen: World Health Organisation.

6 European Green Paper and Consultation (2006) *Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union*. Brussels: European Union. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf

7 European Union (2008) *High-level Conference. European Pact for Mental Health and Wellbeing*. Brussels: European Union. Available at: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

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

9 From the Foresight Review

10 Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review. Available at: http://www.marmot-review.org.uk

11 Department of Health (2010) *Healthy lives healthy people: Our strategy for public health in England London*: HMG

12 Department of Health (Feb.2011) *No health without mental health* London: HMG. Available at: http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

13 Department of Health (2010) *A vision for social care: Capable communities and active citizens* London: HMG. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

14 National Mental Health Development Unit (2009) *Improving Mental Well-being through Impact Assessment. A summary of the development and application of a Mental Well-being Impact Assessment Tool*. London: National Mental Health Development Unit. Available at: http://www.apho.org.uk/resource/item.aspx?RID=76823

What influences mental well-being: using the evidence base for MWIA

A detailed account of the current evidence and debate on the **influences of mental well-being and the evidence base for MWIA**. It is fully referenced and can be used as a "stand alone" resource.

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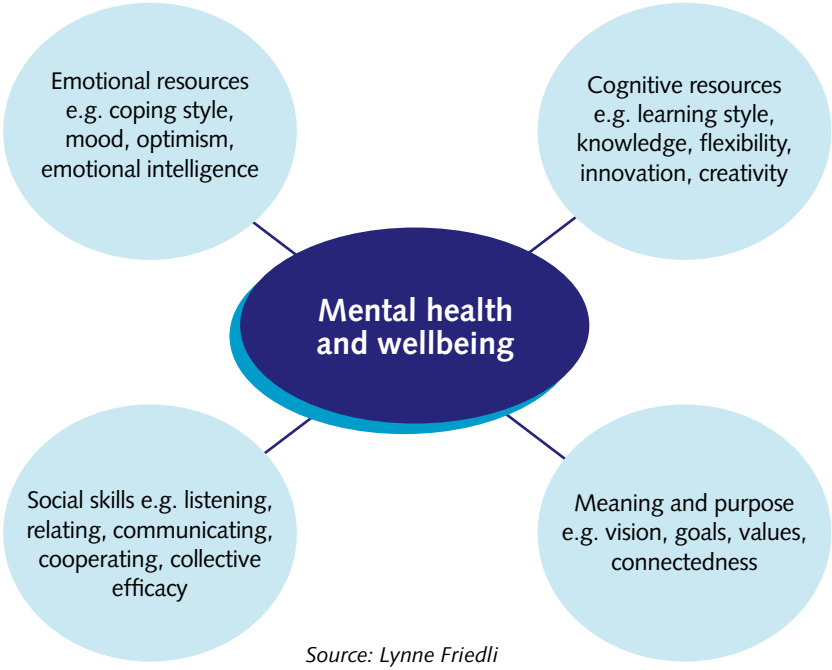
2.1 Introduction

This section provides a summary of the evidence on the key factors that influence different aspects of mental health (Figure 2.1): the dimensions of mental well-being. This evidence review has been undertaken to inform the mental well-being assessment framework and criteria for the MWIA Toolkit. However, it is an invaluable resource in it's own right and can be used for a wide range of purposes such as research, policy development and raising awareness and understanding of the dimensions and determinants of mental well-being.

Please note that the evidence base for mental well-being has mainly been drawn from a mental health perspective where there are overlaps in terminology with well-being and mental well-being. Hence, the language used is drawn from these sources yet is all part of the same discourse.

Figure 2.1: Dimensions of mental well-being



Source: Lynne Friedli

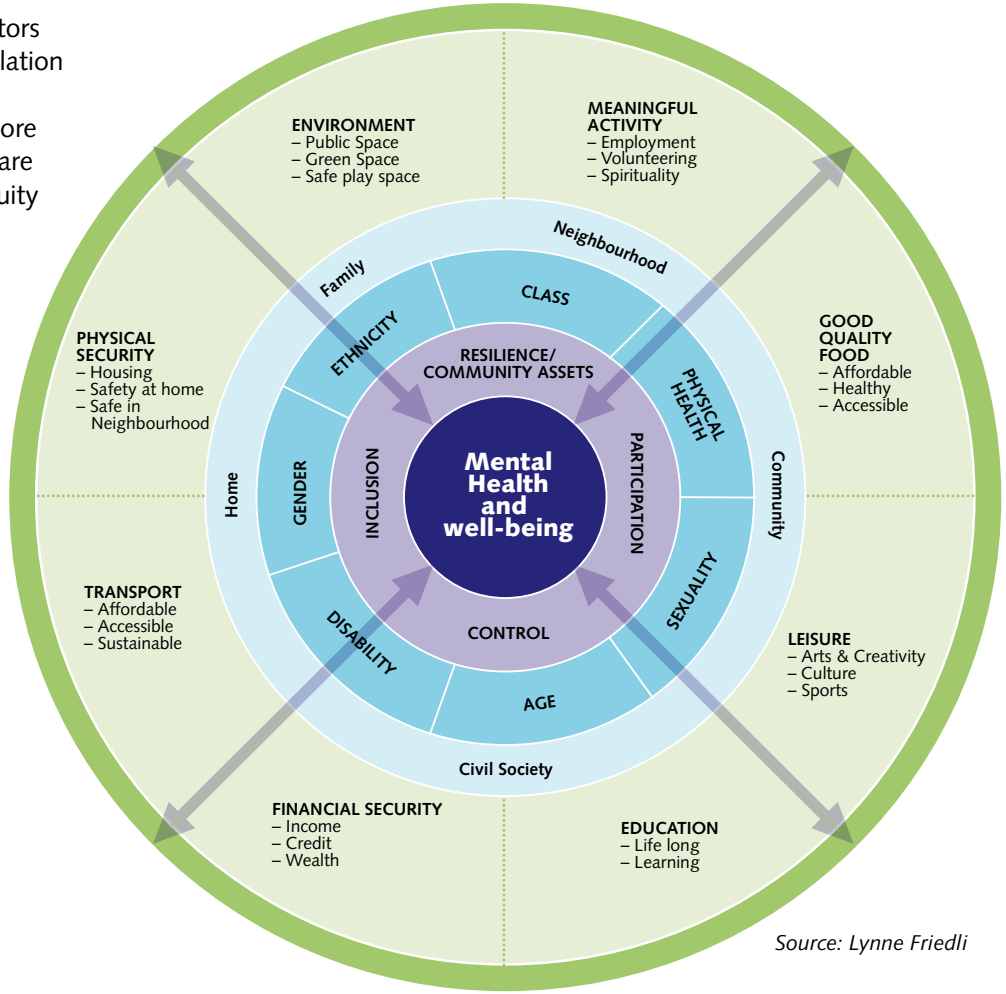
It includes the evidence base on:

1. **MWIA core protective factors**
   (control, resilience/community assets, participation and inclusion)
2. **Population characteristics** e.g. age, class, ethnicity
3. **Social relationships and the core economy**
   (friends, family, neighbours and civil society
4. **Wider determinants:**
   e.g. financial security, environment, transport, education
5. **Core values:** equity and social justice

(see Figure 2.2: A dynamic model of mental well-being for assessing mental well-being impact)

Figure 2.2: A dynamic model of mental well-being for assessing mental well-being impact

The four protective factors are influenced by population characteristics, wider determinants and the core economy. All of which are influenced by levels equity and social justice.



Source: Lynne Friedli

Equity and social justice	Wider determinants	Social relationships and the core economy	Population characteristics	Four protective factors	Lynne Friedli MWIA Collaborative April 2009

2.2 Core Protective factors

2.2.1 Introduction

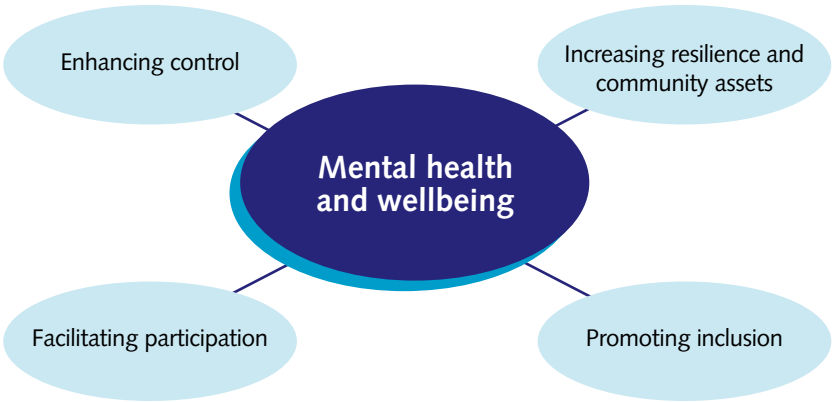
The MWIA toolkit uses a four factor framework (adapted from Department of Health 2001[1]) for identifying and assessing mental well-being impact (Figure 2.3).

MWIA aims to identify the specific influence of a project or development on **mental well-being**. To do this, it asks whether a proposed development or project has a positive or negative effect on core protective factors for mental well-being:

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

Please note that the MWIA Toolkit Assessment tables have put the latter two protective factors together: Facilitating participation and promoting inclusion.

Figure 2.3: Core protective factors for MWIA



Source: Lynne Friedli

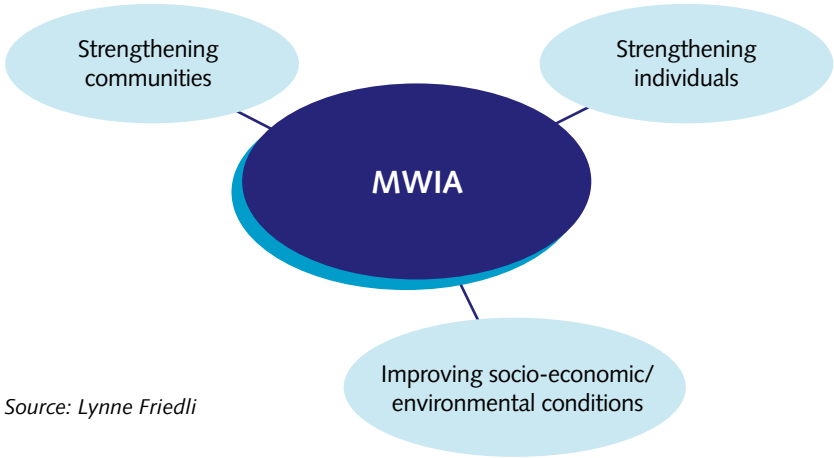
Clearly, there is a dynamic relationship between the core protective factors and mental well-being. For example, the skills and attributes associated with good mental health (confidence, optimism, self efficacy, problem solving) contribute to resilience and community assets. They may also make it easier to participate and to be included at all levels e.g. to make a complaint, to seek help, to build social networks, to access services and other resources. However, lack of control or exclusion are also significant risk factors for poor mental health e.g. depression. In other words, mental health may be either a determinant or an outcome.

For this reason, MWIA uses a framework for assessing the core protective factors *in the context of the key influences on mental well-being* illustrated in Figure 2.2. Individual psychological skills and attributes (e.g. autonomy, positive affect and self efficacy) need to be understood in the context of the circumstances of people's lives: relationships, housing, employment, income and status.

Core Protective Factors

Enhancing control, increasing resilience, facilitating participation and promoting inclusion have a significant influence on the mental well-being of individuals and communities. These four factors are important pathways through which wider social determinants – for example financial security, housing, education, employment – influence outcomes. For each factor, Mental Well-being Impacts can be considered at three levels: individual, community/social and socio-economic/environmental, although in practice it can be difficult to separate out the three levels (Figure 2.4 Assessing protective factors at different levels).

Figure 2.4: Assessing protective factors at different levels



Source: Lynne Friedli

2.2.2 Enhancing control

The extent to which individuals and communities have control over their lives has a significant influence on mental health and overall health. In a major global report on inequalities in health, the Commission on Social Determinants of Health[2] identified *'control over our lives'* as one of three key domains for action and empowerment:

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

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

"Health promotion is the process of enabling people to increase control over, and to improve their health[3]".

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

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

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

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

- Work which provides fulfillment and allows individuals control over their working lives confers considerable health benefit
- Types of job which are lacking in self-direction and control have far fewer health benefits, and people with such jobs have consistently higher rates of mortality and morbidity
- Low job control is associated with increased sickness absence, mental illness and cardiovascular heart disease[3], as well as with markers of stress response e.g. lower levels of cortisol and blood pressure
- Evidence from Sweden shows how changing employment conditions towards less job security and control are impacting upon people's health and well-being in a high income country, influencing rates of cardiovascular disease, alcohol misuse and suicide
- Factors which diminish a sense of control, for example job insecurity, low pay and adverse workplace conditions may be more damaging than unemployment, notably where high unemployment is the norm.

2.2.3 Increasing resilience and community assets

> "Communities have never been built upon their deficiencies. Building community has always depended upon mobilising the capacities and assets of people and place[4]."

> "Resilience reflects the extent to which communities are able to exercise informal social controls or come together to tackle common problems. It is people's social networks, more than any physical characteristics of place, that appear to be most crucial in creating a sense of attachment to place[5]."

Resilience is broadly defined as "doing better than expected in the face of adversity". The evidence on resilience is part of an emerging literature on salutogenesis[6]. Salutogenesis asks, "What are the causes and distribution of health and well-being in this group, community or country population?". Epidemiology asks, "What are the causes and distribution of disease and early death in this group, community or population?" Health assets and capability are concerned with the determinants of health, rather than the causes of illness.

A focus on resilience and assets helps to explain the factors that protect some individuals and communities, notwithstanding adverse conditions/exposure. Although material resources, socioeconomic position, health behaviours and genetic inheritance are significant health determinants, *known risk factors do not explain all the variation in mortality, morbidity* or in other outcomes e.g. education, crime, alcohol and drug misuse. Coronary heart disease is the classic health example: 20% of CHD patients have none of the four main risk factors (smoking, diabetes, high blood pressure, high cholesterol levels) and nearly 50% have only one. So known risk factors are only one part of the picture. Conversely, not everyone who is exposed has poor outcomes.

A major programme of research[7] exploring common factors that make resilience possible and increase human capability found that these "*mostly have to do with the quality of human relationships and with the quality of public service responses to people with problems*".

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

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

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

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

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

Table 2.1: Examples of Community Assets

• Know how • Creativity • Resourcefulness • Tradition • Intergenerational solidarity • Collective efficacy	• Equity • Control • Safety • Participation • Local democracy • Social networks • Mutuality • Trust	• Culture • Sport • Lifelong learning • Access to nature • Shared public spaces • Informal economy • Tolerance

Research on resilient localities and/or communities attempts to explain why poverty or other adverse conditions are more damaging in some places than in others. Although the explanations for resilience in these studies are not conclusive, they might include a stable population (i.e. factors that strengthen neighbourhood attachment), selective migration and protective characteristics of the community e.g. collective action.

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

A growing body of evidence suggests that nature and access to the natural environment strengthen the resilience of individuals and communities; populations exposed to the greenest environments (parks, woodlands, open spaces) also have lowest levels of income-related inequality in health. Possible mechanisms include stress buffering, physical activity and the direct relationship between contact with nature and reduced blood pressure (see section 2.5).

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

2.2.4 Facilitating participation

Please note: In the following sections facilitating participation and promoting social inclusion are discussed separately. As pointed out earlier they are presented in one table in the MWIA assessment tables in other sections of the MWIA toolkit.

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

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

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

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

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

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

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

There is very robust evidence that participation in employment, notably good quality employment, is good for mental health and, even more unequivocally, that unemployment is bad for mental health. (Waddell and Burton, 2006)[8].

2.2.5 Promoting social inclusion

> "…a lack or denial of access to the kinds of social relations, social customs and activities in which the great majority of people in British society engage. In current usage, social exclusion is often regarded as a 'process' rather than a 'state' and this helps in being constructively precise in deciding its relationship to poverty[9]."

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

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

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

2.3 Population characteristics

Age, gender, class, race/ethnicity, disability, sexuality and physical health influence risk and protective factors for mental health and the way in which mental distress is expressed. The relative impact of population characteristics is in turn affected by wider factors: the experiences of childhood, old age, coming from a working class family, belonging to a Black or Minority Ethnic community, being gay or lesbian, living with a physical or learning disability or suffering from chronic illness vary considerably. Fiscal policy, welfare benefits, housing, education, legislation on age, racial and sex discrimination all contribute to the mental health impact of growing old, for example. (See Table 2.2 and Bibliography).

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Table 2.2 Population Characteristics
Risk and Protective factors for mental well-being

Population characteristics
Age
Early Years: Foundations for good mental health lie in the perinatal period and early childhood. Parenting style and attachment are the key factors. The quality of "home learning environment", quality of pre-school and amount of time in pre-school are all associated with greater "self regulation", an attribute strongly linked to improved educational outcomes.
Adolescence: Protective factors include attachment to school, family and community, positive peer influence, opportunities to succeed and problem solving skills. "Social capital" indicators (friends, support networks, valued social roles and positive views on neighbourhood) predict onset and persistence of emotional and behavioural disorders.
Old Age: The five main areas that influence mental health in later life are discrimination, participation, relationships, physical health and poverty.
Gender
Gender has a significant impact on risk and protective factors for mental health and the way in which the experience of mental distress is expressed. Depression, anxiety, parasuicide and self harm are more prevalent in women, while completed suicide, drug and alcohol abuse, crime and violence are more prevalent among men. Women are much more vulnerable to poverty, unemployment, domestic violence, sexual violence, rape and child sexual abuse.
Race/ethnicity
Racial and ethnic differences in levels of mental well-being and prevalence of mental disorders are due to a complex combination of socio-economic factors, racism, diagnostic bias, and cultural and ethnic differences, in the way in which both mental health and mental distress are presented, perceived and interpreted. Different cultures may also develop different responses for coping with psychological stressors. However, a major qualitative study found that idioms of distress bore great similarity across ethnic groups, although some specific symptoms were different.

Socio-economic position and class
Socioeconomic position (SEP) refers to the position of individuals and families, relative to others, measured by differences in educational qualifications, income, occupation, housing tenure or wealth. Socioeconomic position is generally analysed by quintile, for example comparing health or other outcomes of those in the poorest fifth of the population with those in the richest fifth. Socioeconomic position shapes access to material resources, to every aspect of experience in the home, neighbourhood, and workplace and is a major determinant of health inequalities. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation, support and inclusion. Social position also influences areas like identity and social status, which impact on well-being, for example through the effects of lowself esteem, shame, and disrespect.
Disability
Life chances (notably education, employment and housing), social inclusion, support, choice, control and opportunities to be independent are the key factors influencing the mental health of people with disabilities.
Sexuality and transgender
Some studies suggest that gay, lesbian, bisexual and transgender peoples are at increased risk for some mental health problems - notably anxiety, depression, self-harm and substance misuse - and are more likely to report psychological distress than their heterosexual counterparts, while being more vulnerable to certain factors that increase risk, e.g. bullying, discrimination and verbal assault.
Physical health
Poor physical health is a significant risk factor for poor mental health; conversely, mental well-being protects physical health and improves health outcomes and recovery rates, notably for coronary heart disease, stroke and diabetes. Poor mental health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet. Stress epidemiology demonstrates the link between feelings of despair, anger, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. For heart disease, psychosocial factors are on a par with smoking, high blood pressure, obesity, and cholesterol problems.

2.4 Social relationships and the Core economy

> "The challenge was: how to value the labour and contribution of those whom the market excluded or devalued and whose genuine work was not acknowledged or rewarded[10]."

There is robust evidence that good quality social relationships across the life course protect health, are associated with a wide range of other beneficial outcomes and that these effects are both individual and ecological. Although direction of causation is not always easy to establish, these findings are increasingly confirmed in longitudinal studies. Mechanisms include:

- Stress buffering
- Access to information
- Health behaviour/help seeking
- Psychological benefits
- Functional: practical and material help
- Access to valued resources e.g. employment opportunities
- Improving quality of life

Contextual factors have a significant impact on social relationships: for example the increase in spatial polarization of wealthy and poor people from 1970 – 2005 and the urban clustering of poverty. The quality, nature, scope and history of social relationships also influence neighbourhood outcomes.

> "People expressed attachment to the communities in which they lived and to their networks of families and friends, rather than to the physical places… Social and family networks and feelings of safety were what helped to retain people in deprived areas[11]."

Economic growth at the cost of social recession has been described as a tension between two economies: the core economy of home, family and community relations and the money economy. The use of the term "core economy" is part of a broader attempt to recognise social values and social outcomes and to include these in decision making. Neva Goodwin, who coined the term "core economy" argues that many social problems can be traced to the fact that the core economy has been damaged by the money economy and the commodification of life – sometimes described as the difference between a democracy of *citizens* versus a democracy of *consumers*. There is a growing literature and public debate on factors that damage social relationships and 'community connections': day to day opportunities for social interaction and "collective efficacy".

Recognizing and rebuilding the core economy has also been seen as critical for the future of public services. Co-production, developed from the principles of *time banking* (the recognition of the exchange value of time), is one mechanism for attributing value to the core economy. Co-production has important policy implications for public services and service delivery: although it recognises that relationships are at the heart of public services, it draws on a very specific understanding of the relationship between communities and the statutory sector. The point is not to consult more, or involve people more in decisions: it is to encourage them to use the human skills and experience they have to help deliver public or voluntary services.

The principles of co production are:

- social networks make change possible and are the life blood of communities
- the equally important role played by those on the receiving end of services
- relationships need to be reciprocal for change to happen

A key role for MWIA will be to raise awareness of the strong ecological and contextual effects for social relationships: to look beyond individual factors and to highlight the influence of policy, planning, design and provision of services, the built and natural environment, cultural attitudes, employment practice, as well as levels of material affluence or deprivation in localities.

2.5 Wider determinants

MWIA uses a framework for assessing the core protective factors *in the context of the wider determinants of mental well-being*. These are:

1 Physical security e.g. housing, safety at home and in the neighbourhood

Relatively little research covers the impact of housing on mental health and well-being. However, people living with the highest level of street level incivilities are twice as likely to report anxiety and 1.8 times more likely to report depression[12]. Crowding, graffiti, abandoned buildings, vandalism, street litter, poor maintenance of buildings, traffic, parking, dampness, lack of places to stop and chat, poor personal safety, lack of recreation facilities and green spaces, and noise all predict distress and depression[13]. Another systematic review highlighted the association between poor mental health and neighbourhood disorder such as crime and vandalism[14]. People experience more stress from the fear of crime and safety issues than from any direct experience of crime[15].

More amenities and fewer 'incivilities' (such as litter and graffiti) have been associated with 32% lower rates of anti-depressant prescriptions after controlling for socio-economic status[16]. A systematic review also found that housing improvement interventions had a positive impact on physical and mental health outcomes as well as on the perceptions of safety, crime, social and community participation[17]. A further systematic review found consistent evidence for improved mental health after housing and neighbourhood regeneration[18]. Enhancements to neighbourhood can also bring about positive change in mental well-being[19].

The homeless experience particularly 40-50 higher levels of mental health problems than the general population[20] and therefore are an important high risk group. Similarly, a third of prisoners are homeless on entering prison while a further third lose their accommodation due to being imprisoned.

2 Environment e.g. green space, safe play space, quality of the built environment

A number of studies highlight how socio-economic inequalities influence experience of the natural environment. For example, one study found that populations exposed to the greenest environments (parks, woodlands, open spaces) had 25% lower all cause death rates and 30% lower circulatory disease death rates compared to those in areas with low green environment after controlling for deprivation[21]. The health gap was roughly halved compared with those with fewest green spaces. Possible mechanisms include physical activity, stress buffering and the direct relationship between contact with nature and reduced blood pressure. These findings have recently been replicated in relation to disease clusters including anxiety and depression in a major Dutch study, with particular benefits for children and lower socio economic groups[22]:

Deterioration in the social life of streets occurs with heavy motor vehicle traffic[23]. The average resident on a busy street had less than one quarter of local friends compared with those living on a similar street with little traffic. Levels of motor traffic on residential streets were associated both with poor health and weakened social cohesion.

In light traffic streets, the "home territory" i.e. the area over which people feel a sense of responsibility is far broader than in heavy traffic areas and included three times the number of "gathering spots". The study controlled for personality differences, showing that the primary influence was the external effect of traffic, with a particular toll on children and the elderly. Another study from Ireland found that "persons living in walkable, mixed use neighbourhoods were more likely to know their neighbours, participate politically, trust others and be socially engaged, compared with those living in car-oriented suburbs[24].

The mental health benefits of activities in a natural environment[25] have been identified as:

- Social, emotional, creative and cognitive development of children and young people
- Quality of life and relaxation
- Recovery from stress
- Relief of symptoms
- Therapeutic and healing; spiritual
- Physical activity; sport; adventure; challenge
- Learning; intellectual and creative development
- Sense of meaning/purpose/perspective
- Social contact; cohesion; belonging; identity
- Volunteering; conservation; "giving something back".

3 Meaningful activity

Work can promote mental well-being and have a positive effect on mental health[26] although beneficial health effects depend on the nature and quality of work. It is important for self-esteem and identity, and can provide a sense of fulfilment and opportunities for social interaction. For most people, work also provides their main source of income[27].

Unpaid work such as volunteering can also promote well-being as well as a sense of meaning and purpose within the context of community activity. Different studies demonstrate a correlation between well-being and activities involving participation and volunteering[28].

Both work and volunteering are among a number of intentional activities which can have significant impact on well-being[29]. These include socializing, exercise and engagement in meaningful activity,

Social participation and capital: Social prescribing is a term used for non-medical interventions to improve mental health and well-being. It facilitates linking of primary care patients with other non-medical sources of support within the community. Social prescribing can improve mental health outcomes, improve community well-being and reduce social exclusion[30]. Initiatives such as Exercise on Prescription, Prescription for Learning and Arts on Prescription, have been used with vulnerable populations, including those with mental health problems, and have been found to result in a range of positive outcomes such as enhanced self-esteem, self-efficacy and improved mood and social contact[31].

A further example of 'meaningful activity' is Timebanking. For instance, Welsh Timebanks are 'hosted' within public and community agencies. Community members are then invited to actively engage and take ownership of public services. The 'host' agency acts as the central bank and acknowledges members for their time with credits. These credits can then be used for recreational services, to go on trips or attend local events. This model aims to promote participation and mutual activity, encourage civil renewal and build social capital. The results are dramatic, levels of active engagement rapidly increase, negative social problems decrease and the negative cycles of dependency and inactivity begin to unravel[32].

4 Good quality food e.g. affordable, accessible

Good nutrition is important for both physical and mental health. However, evidence that nutrition influences mental health is from mainly observational studies. Healthy eating can help reduce the risk of disease such as cancer[33] and ischaemic heart disease, as well as obesity[34]. Obesity is also a risk factor for other chronic diseases (e.g. diabetes), in addition to poorer health and mental health and well-being.

Lack of sufficient, safe and nutritious food is associated with maternal depression and higher rates of behaviour problems in children[35]. Food also impacts directly on children with better daily and long-term academic performance in those who eat breakfast[36]. Behaviour of children with ADHD can also be significantly affected by artificial food colours and other food additives[37] which also affects behaviours of children in the general population[38]. A good diet also protects health with those consuming whole foods associated with lower risk of depression and high consumption of processed being associated with higher risk of depression[39].

Sugars, caffeine, nicotine and alcohol can have a direct effect on mood and mental health and well-being[40].

People with mental illness often have less healthy diets and make poorer dietary choices than people without mental illness thereby impacting on their recovery[41].

5 Leisure e.g. arts and creativity, sport, culture

Creative pursuits improve confidence, self-esteem, motivation, happiness and reduce stress and enhance control. Leisure and physical activity enhance well-being by increasing feelings of competency and relaxation, distracting from difficulties, as well as enhancing social inclusiveness and support[42]. Leisure also results in improved well-being through associated meaningful engagement, self-expression, creativity and the opportunity to experience control and choice over such activities. Opportunities for increased social contact is an important factor in explaining positive mental health outcomes for creativity, but there is some evidence of independent benefits.

Participation in arts enhances well-being though direct engagement in art activity although this facilitates social participation which also enhances well-being. A review of arts and health highlighted a large amount of effective work resulting in improved health, well-being and quality of life[43]. It suggested the valuable contribution of arts to major health priorities, improving clinical outcomes, as a way of improving understanding between staff and recipients of their care, and in supporting and training staff. It can also facilitate recovery from mental illness[44] with a review of participatory art projects for those with mental health problems highlighting reduced social exclusion, improved mental health and in particular empowerment[45].

A review of 60 community-based arts projects found that participation resulted in a wide range of benefits, including increased confidence, community empowerment, self-determination, improved local image and identity and greater social cohesion[46]. Another study of ten arts projects in Wales found that a focus on cultural well-being, people's ability to express themselves and engage their creative instincts had a major impact in revitalising run down neighbourhoods[47].

6 Education e.g. lifelong learning, pre-school

Education Education protects mental health across the lifecourse. Preschool and early education programmes are associated with improved cognitive skills, school readiness, improved academic achievement and positive effect on family outcomes including for siblings[48]. In children, learning plays an important role in social and cognitive development while continuation of learning through life has the benefits of enhancing an individual's self-esteem, encouraging social interaction and a more active life[49]. Learning also raises earnings and employability which protects well-being and also reduces risk of poor mental health and low levels of life satisfaction during adulthood[50]. Low educational attainment is a risk factor for common mental health problems[51]. Higher educational attainment is associated with lower smoking rates, reduced obesity and increased likelihood of exercising regularly[52] as well as improved life satisfaction, race tolerance and participation/engagement[53].

Education is associated with reduced risk of poor mental health and depression with secondary education qualification associated with 5-7% lower risk of depression at age 42 and 50% lower risk for those with the highest qualifications[54]. Education at all ages reduced the risk of transition to depression and improved mental health with the effect significantly stronger for women[55].

Learning improves health outcomes partly by its effects on four types of capital: economic capital (e.g. employment opportunities), human capital (knowledge and skills), social capital (e.g. levels of civic engagement and social cohesion) and identity capital (confidence and self-esteem).

Learning during adulthood also improves well-being, life satisfaction and optimism[56] as well as improved health behaviour[57]. This is partly as a result of the resulting increased social capital resulting from developing social skills and extending social networks[58].

7 Transport e.g. affordable, accessible, sustainable

Neighbourhoods where residents make high use of local amenities are associated with more walking[59] and walkable neighbourhoods are associated with double the number of weekly walking trips[60].

Active Travel Town Schemes result in increased active (non-car) travel[61,62]. Reducing traffic levels and traffic speed can increase play, social interaction between residents and quality of life[63].

8 Financial security e.g. income, credit, assets

A social gradient in health exists in that better social and economic position results in better health[64]. Those people in the lowest 20% of household income have an almost three fold increased risk of mental illness[65]. Unemployment is also associated with an almost three fold risk of common mental disorder and four fold risk of disabling mental disorder[66].

Job insecurity is one of a number of work risk factors that can contribute to poor mental health[67]. Debt is also associated with increased risk of mental disorder with a three-fold increase in common mental disorder, alcohol dependence and drug dependence and a four-fold risk of psychosis[68].

Improving financial capability enables to manage their finances better, reducing the risk of getting into debt and also reducing the impact of debt. Financial capability is also associated with a 5.6% increase in psychological well-being, 2.5% increase in life satisfaction and 15% reduction in risk of anxiety and depression[69]. Debt advice is also beneficial and is associated with a 56% likelihood of debt becoming manageable for face to face advice[70] and 47% for telephone advice[71].

Summary

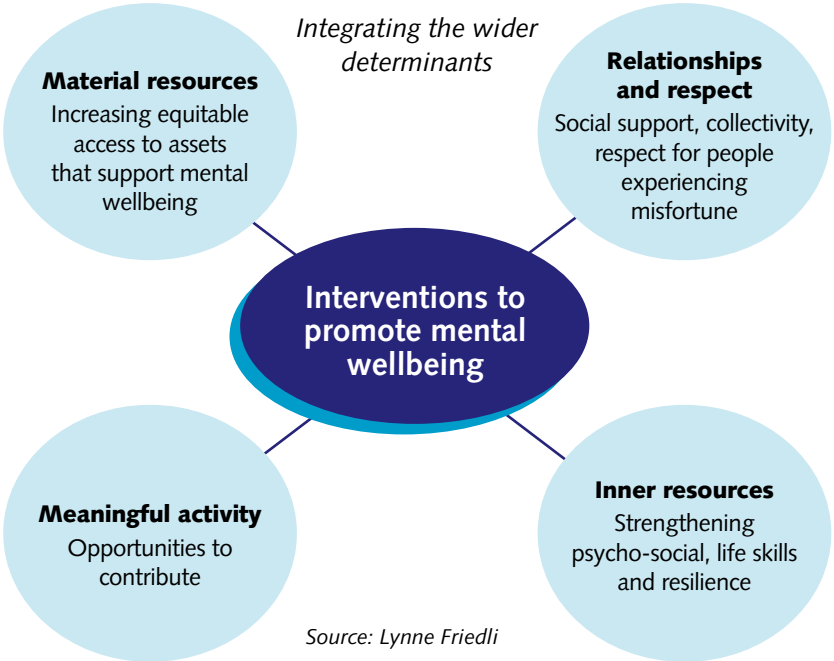
There is a dynamic relationship between mental health and different factors. Strategies to improve public mental health should include interventions which address such wider determinants (see Figure 2.2). Mental well-being is an outcome of the circumstances and experiences of our lives: individual psychological resources such as confidence, self efficacy, optimism and connectedness are embedded within social structures such as work, home, and public spaces. However mental health is also a determinant: the presence or absence of positive mental health and well-being influences a very wide range of outcomes includinghealth behaviour, physical health, educational attainment, employment and earnings, relationships, crime, quality of life, improved recovery rates, fewer limitations in daily living. Mental well-being may also explain the wider international data which shows that socio-economically disadvantaged conditions are not universally correlated to all forms of health-damaging behaviours.

Untangling the relative strength of different determinants is part of a broader debate about the relative contribution to health and other outcomes of:

- Individual skills and attributes (affect, social skills, cognitive function, agency)
- Social relationships, support and networks
- Material circumstances (indicators of wealth and income)
- Inequalities (indicators of socio-economic position i.e. circumstances relative to others)

These debates are considered in more detail in section 2.6: equity and social justice.

Figure 2.5: Scope of public mental health



2.6 Core values – equity and social justice

An important body of research suggests that the significance of mental health is directly and indirectly related at every level to human responses to inequalities. In other words, mental health is seen as a key pathway through which inequality impacts on health and other outcomes. For this reason, levels of mental distress among communities can be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological well-being.

In this analysis, one explanation for the strong social gradient in health is that *relative deprivation* is a catalyst for a range of negative emotional and cognitive responses to inequity. These are both conscious and unconscious reactions, influencing health through:

- physiological reactions
- the impact of low status on identity and social relationships
- a range of damaging behaviours that are a direct or indirect response to the social injuries associated with inequalities

Feelings that trigger these responses – anger, frustration, shame, despair, hopelessness, exclusion, lack of control – are related to the circumstances of people's lives, magnified by inequity, notably in situations of social comparison. Inequality is both a key cause of stress in itself and *also exacerbates* the stress of coping with material deprivation.

While psycho-social stress is not the only route through which disadvantage affects outcomes, it does appear to be pivotal. Firstly, psychobiological studies provide growing evidence of how chronic low level stress *"gets under the skin"* through the neuro-endocrine, cardiovascular and immune systems, influencing hormone release (cortisol), cholesterol levels, blood pressure and inflammation e.g. C-reactive proteins. This can also be seen in the example of "metabolic syndrome". This is a combination of risk factors for cardiovascular disease, type two diabetes and liver disease that is linked to blood pressure, weight distribution, lipid levels, cholesterol levels and the way in which glucose is metabolised. Metabolic syndrome is strongly associated with chronic stress and is also inversely related to a history of positive social relationships.

It is the extent to which socio-economic position (SEP – our position on the social hierarchy relative to others) involves exposure to psychological (in addition to material) risks and buffers that is of special interest from a mental well-being perspective. SEP structures individual and collective experiences of dominance, hierarchy, isolation, support and inclusion. Social position also influences constructs like identity and social status, which impact on well-being, for example, through the effects of low self esteem, shame, disrespect and "invidious comparison". These "relational features of deprivation" have stimulated a greater focus on

the psycho-social dimensions of poverty, for example feeling humiliated by the lack of valued goods, being ashamed to appear in public and not being able to participate in the life of the community.

An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. Evidence of the shame and humiliation that accompany poverty demonstrates the importance of addressing both the material and social dimensions of deprivation. MWIA is an invaluable tool for including the views and experiences of people likely to be affected by a proposal. Hence, those undertaking MWIA should endeavour to include and involve those with direct experience of living in poverty to enable an improved understanding of this and to develop effective ways of tackling the mental well-being impacts of poverty.

References

[1] Department of Health (2001) *Making it Happen: A guide to delivering mental health promotion,* London UK. Available at: http://dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007907

[2] Commission on the Social Determinants of Health. (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health Geneva:* World Health Organization (WHO). Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

[3] World Health Organisation (1986) Ottawa Charter for Health Promotion Geneva: WHO

[4] Kretzmann, J.P. and McKnight, J.L. (1993), *Building Communities from the Inside Out: a Path Toward Finding and Mobilizing a Community's Assets*. Evanston IL: Institute for Policy Research.

[5] Taylor, M. (2008) *Transforming disadvantaged places: effective strategies for places and people*. York: Joseph Rowntree Foundation

[6] Harrison, D. et al. (2004) Assets for Health and Development (AHDP) Developing a Conceptual Framework, p. 9) Copenhagen: World Health Organisation Regional Office for Europe.

[7] Bartley, M. (2006) (ed.) *Capability and Resilience: beating the odds*. ESRC Human Capability and Resilience Research Network. London: UCL Department of Epidemiology and Public Health. Available at: www.ucl.ac.uk/capabilityandresilience

[8] Waddell G & Burton AK (2007) *Is Work Good For Your Health & Well-Being?* London: Independent Review for DWP, DoH, HSE London

[9] Gordon, D., Adelman, L., et al. (2000) *Poverty and Social Exclusion in Britain*. York: Joseph Rowntree Foundation.

[10] Edgar Cahn in Stephens, L., Ryan-Collins, J. et al (2008) *Co production: a manifesto for growing the core economy*. London: New Economics Foundation. Available at: http://www.neweconomics.org/gen/z_sys_publicationdetail.aspx?pid=257

[11] Livingston, M., Bailey, N. et al (2008) *People's attachment to place: the influence of neighbourhood deprivation*, pg 3. Coventry: Chartered Institute of Housing.

[12] Curtice, J., Ellaway, A., Robertson C et al (2005) Environment Group Research Findings No. 25/2005 Public Attitudes and Environmental Justice in Scotland. Available at: http://www.scotland.gov.uk/Publications/2005/10/1395043/50440

[13] Cooper R, Boyko C, Codinhoto R, (2008) Mental Capital and Well-being: Making the most of ourselves in the 21st century. State-of-Science Review: SR-DR2 The Effect of the Physical Environment on Mental Well-being. Foresight Mental Capital and Well-being Project. Available at: http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/ProjectOutputs.asp

[14] Clark C, Candy B, Stansfield S (2006) A systematic review on the effect of the built and physical environment on mental health. Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Queen Mary's School of Medicine and Dentistry, University of London

[15] Cooper R, Boyko C, Codinhoto R, (2008) Mental Capital and Well-being: Making the most of ourselves in the 21st century. State-of-Science Review: SR-DR2 The Effect of the Physical Environment on Mental Well-being. Foresight Mental Capital and Well-being Project. Available at: http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/ProjectOutputs.asp

[16] Ellaway and MacIntyre – reference to follow

[17] Thomson H, Petticrew M, Morrison D. (2001). Health effects of housing improvement: systematic review of intervention studies. BMJ 323: 187-90.

[18] Clark C, Candy B, Stansfield S (2006) A systematic review on the effect of the built and physical environment on mental health. Centre for Psychiatry, Wolfson Institute of Preventive Medicine, Queen Mary's School of Medicine and Dentistry, University of London

[19] Barnes – to follow

[20] Rees S (2009) Mental Ill Health in the Adult Single Homeless Population; a review of the literature Crisis, PHRU

[21] Mitchell, R. and Popham, F. (2008) Effect of exposure to natural environment on health inequalities: an observational population study. *The Lancet*, 372(9650), pp.1655 – 1660. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61689-X/abstract

[22] Maas J, Verheij RA, de Vries S et al (2009) Morbidity is related to a green living environment Journal of Epidemiology and Community Health 63 pp 967-973. Available at: http://jech.bmj.com/cgi/content/abstract/63/12/967?etoc

[23] Hart, J. (2008) *Driven to excess: impacts of motor vehicle traffic on residential quality of life in Bristol*. Bristol: University of West of England. Available at: http://www.2shared.com/file/3788304/f7ea0c6c/DrivenToExcess.html

[24] Leyden, K. (2003) Social capital and the built environment: The Importance of Walkable Neighbourhoods. *American Journal of Public Health*, 93(9)

[25] Mitchell, R. and Shaw, R. (2008) Health impacts of the John Muir Award. Glasgow: University of Glasgow. Available at: http://www.gcph.co.uk/content/view/165/68/

[26] Waddell G, Burton AK (2007) *Is work good for your health and well-Being? Independent Review for DWP, DoH, HSE London*. Available at: http://www.workingforhealth.gov.uk/documents/is-work-good-for-you.pdf

[27] NICE (2009) *Promoting mental wellbeing at work: full guidance*. http://guidance. nice.org.uk/PH22/Guidance/pdf/English

[28] Dolan P, Peasgood T, White M (2006) *Review of research on the influences on personal well-being and application to policy making*. London: DEFRA

[29] Lyubomirsky S, King LA, Diener E (2005). The benefits of frequent positive affect. *Psychological Bulletin*, 131, 803-855

[30] Friedli L, Watson S (2004) *Social prescribing for mental health* Leeds and York: Northern Centre for Mental Health

[31] Mentality (2003). Making it effective: a guide to evidence-based mental health promotion. Radical Mentalities Briefing Paper 1. London: Mentality

[32] Public Service Management Wales (2008) *Sowing the Seeds Time Banking: Public Service delivery with Time Credits* Cardiff: Welsh Assembly Government. Available at: http://www.justaddspice.org/docs/Timebanking%20SS.pdf

[33] Key TJ, Appleby PN, Spencer EA, Travis RC, Roddam AW, Allen NE. (2009). Mortality in British vegetarians: results from the European Prospective Investigation into Cancer and Nutrition (EPIC-Oxford) The American journal of clinical nutrition, 89 (5), pp. 1613S-1619S

[34] McMichael AJ, Powles JW, Butler CD, Uauy R. (2007) Food, livestock production, energy, climate change, and health. *The Lancet*.; 370:1253–1263

[35] Melchior M, Caspi A, Howard LM et al (2009) Mental health context of food insecurity: a representative cohort of families with young children. *Paediatrics* 124; e564-e572

[36] Wesnes KA, Pincock C, Helm G, Hails S (2003) Breakfast reduces declines in attention and memory over the morning in schoolchildren *Appetite* 41(3): 329-331

[37] Schab DW, Trinh NT (2004) Do artificial food colours promote hyperactivity in children with hyperactive syndromes? A meta-analysis of double-blind placebo-controlled trials.J Dev Behav Pediatr 2004; 25: 423–34.

[38] McCann D, Barrett A, Cooper A et al (2007) Food additives and hyperactive behaviour in 3-year-old and 8/9-year-old children in the community: a randomised, double-blinded, placebo-controlled trial DOI:10.1016/S0140-6736(07)61306-3

[39] Akbaraly TN, Brunner EJ, Ferrie JE, Marmot MG, Kivimaki M, Singh-Manoux A (2009). Dietary pattern and depressive symptoms in middle age. The British Journal of Psychiatry, 195, 408–413. doi: 10.1192/bjp.bp.108.058925

[40] Cornah D (2006) Feeding Minds: The Impact of Food on Mental Health. London: Mental Health Foundation www.mentalhealth.org.uk

[41] McCreadie (2003) Diet, smoking and cardiovascular risk in people with schizophrenia British Journal Of Psychiatry (2003), 183, 534-539

[42] Caldwell LL (2005). Leisure and health: Why is leisure therapeutic? British Journal of Guidance and Counselling, 33, 7–26

[43] Department of Health (2007) Report of the Review of Arts and Health Working Group. Available at: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073589.pdf

[44] Staricoff RL (2004) Arts in health: a review of the medical literature. Research report 36. Arts Council England. Available at: http://www.nasaa-arts.org/nasaanews/B-Health-MedLitReview.pdf

[45] Secker J, Hacking S, Spandler H et al (2007) Mental health, social inclusion and arts: developing the evidence base. Anglia Ruskin University

[46] Matarasso F (1997) Use or ornament? The social impact of participation in the arts. Comedia. ISBN 1 873667 57 4

[47] Dwelly T (2001) Creative Regeneration: lessons from ten community arts projects, York: Joseph Rowntree Foundation

[48] Anderson LM, Shinn C, Fullilove MT et al (2003). The effectiveness of early childhood development programs: A systematic review. American Journal of Preventive Medicine, 24(3S), 32-46

[49] Kirkwood T, Bond J, May C et al (2008) Foresight Mental Capital and Wellbeing Project. Mental capital through life: Future challenges. The Government Office for Science, London

[50] Searle B (2008) Well-being: In search of a good life? Bristol, Policy Press

[51] Feinstein, L., Hammond, C., et al. (2003) *The contribution of adult learning to health and social capital London*: Centre for Research on the Wider Benefits of Learning.

[52] Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review. Available at: http://ucl.ac.uk/marmotreview

[53] Feinstein, L., Hammond, C., et al. (2003) *The contribution of adult learning to health and social capital* London: Centre for Research on the Wider Benefits of Learning.

[54] Chevalier, A. and Feinstein, L. (2006) Sheepskin or Prozac: The Causal Effect of Education on Mental Health. London: Centre for Economics of Education. Available at: http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf

[55] Chevalier, A. and Feinstein, L. (2006) *Sheepskin or Prozac: The Causal Effect of Education on Mental Health*. London: Centre for Economics of Education. Available at: http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf

[56] Feinstein L, Budge D, Vorhaus J, Duckworth K (2008) The social and personal benefits of learning. A summary of key research findings. Institute of Education. University of London. Available at: http://www.learningbenefits.net/Publications/FlagshipPubs/Final%20WBL%20Synthesis%20Report.pdf

[57] Feinstein L, Sabates R (2007) The public value of adult learning: Skills and social productivity. Available at: http://archive.niace.org.uk/lifelonglearninginquiry/docs/Feinstein-Sabates12.pdf

[58] Schuller T, Preston J, Hammond C et al (2004). The benefits of learning: The impact of education on health, family life and social capital. Routledge Falmer

[59] McCormack G, Giles-Corti B, Lange A (2004) An update of recent evidence of the relationship between objective and self-measures of the physical environment and physical activity behaviours. *Journal of Science, Sport and Medicine*, 7(1 Supplement), 81-92.

[60] Giles-Corti et al. (2005). Increasing walking: how important is distance to, attractiveness, and size of public open space. *American Journal of Preventative Medicine*, 28(2S2), 169-176.

[61] Sustrans Active Travel. (2008). *Active travel and health inequalities: How walking and cycling can benefit the health of the most disadvantaged people*. Bristol.

[62] Transport for London. (2007). *Central London Congestion Charging: Impacts monitoring. Fifth Annual Report*.

[63] Hart, J. (2009). No Friends? Blame the traffic... *Living Streets/ Street Life, Winter*, 6-7.

[64] Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review. Available at: http://ucl.ac.uk/marmotreview

[65] McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England 2007. Results of a household survey. The Health & Social Care Information Centre, Social care Statistics.

[66] Melzer D, Fryers T, Jenkins R. (2004) Social Inequalities and the Distribution of Common Mental Disorders. Maudsley Monographs Hove, Psychology Press.

[67] Ferrie JE (editor) (2007) Work, stress and health: Findings from the Whitehall II study London: Cabinet Office/ University College London.

[68] Jenkins R, Bhugra D, Bebbington P, Brugha T, et al (2008). Debt, income and mental disorder in the general population. Psychological Medicine 38, 1485-1494.

[69] Taylor M, Jenkins S, Sacker A (2009) Financial capability and well-being: Evidence from the BHPS. Financial Services Authority, Occasional Paper Series 34.

[70] Williams K, Sansom A (2007) Twelve months later: does advice help?

[71] The impact of debt advice - advice agency client study. London: Ministry of Justice.

[72] Pleasence P, Balmer NJ (2007) Changing Fortunes: Results from a Randomized Trial of the Offer of Debt Advice in England and Wales *Journal of Empirical Legal Studies* 4 (3):465-475.

Bibliography: Control

Bartley, M., Sacker, A., *et al*. (2005) *Work, non-work, job satisfaction and psychological health. Evidence review.* London: Health Development Agency.

Commission on the Social Determinants of Health (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health Geneva: World Health Organization. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Ferrie, J.E. (2007) (ed.) *Work, stress and health: Findings from the Whitehall II study*. London: Cabinet Office/University College London.

Samman, E. (2007) *Psychological and subjective well-being: a proposal for internationally comparable indicators*. Oxford: University of Oxford/Oxford Poverty and Human Development Initiative. Available at: http://www.ophi.org.uk/pubs/Samman_Psych_Subj_Wellbeing_Final.pdf

World Health Organisation (1986) *Ottawa Charter for Health Promotion* Geneva: WHO.

Bibliography: Resilience and community assets

Bartley, M. (2006) (ed.) *Capability and Resilience: beating the odds*. ESRC Human Capability and Resilience Research Network. London: UCL Department of Epidemiology and Public Health. Available at: http://www.ucl.ac.uk/capabilityandresilience/beatingtheoddsbook.pdf

Clements, A., Fletcher, D. *et al*. (2008) *Three years on: survey of the emotional development and well-being of children and young people*. London: ONS. Available at http://www.statistics.gov.uk/cci/article.asp?id=2063

De Silva, M.J. *et al*. (2005) Social capital and mental illness: a systematic review. *Journal of Epidemiology and Community Health*, 59, pp.619-627.

Friedli, L. (2009) *Mental health, resilience and inequalities – a report for WHO Europe and the Mental Health Foundation*. London/Copenhagen: Mental Health Foundation and WHO Europe. Available at: http://www.who.it/document/e92227.pdf

Friedli, L. and Carlin, M. (2009) *Resilient relationships in the North West: what can the public sector contribute?* Manchester: Department of Health/NHS North West

Jones, C. *et al*. (2006) Studying social policy and resilience in families facing adversity in different welfare state contexts – the case of Britain and Sweden. *International Journal of Health Services*, 36 (3), pp. 425–442.

Kretzmann, J.P. and McKnight, J.L. (1993), *Building Communities from the Inside Out: a Path Toward Finding and Mobilizing a Community's Assets*. Evanston IL: Institute for Policy Research.

Lawlor E, Neitzert E and Nicholls J (2008) *Measuring value: a guide to social return on investment* London: New Economics Foundation Available at: http://www.neweconomics.org/gen/uploads/jkefez55axlzer31smpvcp4520062008134406.pdf

Livingston M, Bailey N *et al*. (2008) *People's attachment to place: the influence of neighbourhood deprivation* Coventry: Chartered Institute of Housing

Local Government Association (2004) '*Community cohesion: an action guide*' London: LGA Publications

McKenzie, K. and Harpham, T. (2006) *Social Capital and Mental Health*. London: Jessica Kingsley.

Minton A (2009) Ground Control: Fear and Happiness in the Twenty-First-Century City London: Penguin. Available at: http://www.culturewars.org.uk/index.php/site/article/the_new_public_space

Morgan, A. and Swann, C. (2004) *Social capital for health: issues of definition, measurement and links to health*. London: Health Development Agency

Netuveli, G., Wiggins, R.D., *et al* (2006) Quality of life at older ages: evidence from the English longitudinal study of aging (wave 1). *Journal of Epidemiology and Community Health*, 60, pp. 357-363

Ryan-Collins J, Stephens L (2008) *The new wealth of time: how timebanking helps people build better public services* London: New Economics Foundation. Available at: http://www.timebanking.org/documents/Publications/New_Wealth_of_Time.pdf

Schoon, I. (2006) *Risk and Resilience. Adaptations in changing times*. Cambridge: Cambridge University Press.

Taylor, M. (2008) *Transforming disadvantaged places: effective strategies for places and people*. York: Joseph Rowntree Foundation

Weyer S, Dragano N, *et al* (2008) Low socio-economic position is associated with poor social networks and social support: results from the Heinz Nixdorf Recall Study *International Journal for Equity in Health* 7:13

Woodcraft S (2009) *Neighbourhood working: where do we go from here? Towards a new research agenda* London: Young Foundation Available at: http://www.youngfoundation.org.uk/neighbourhood-working-where-do-we-go-here-towards-a-new-research-agenda-saffron-woodcraft-2009

Bibliography: Participation

Arah, O.A. (2008) Effect of voting abstention and life course socioeconomic position on self reported health. *Journal of Epidemiology and Community Health*, 62: 759-760.

Bynner J. and Parsons S. (2001) Qualifications, Basic Skills and Accelerating Social Exclusion *Journal of Education and Work*, 14, 280-291

Centre for the Wider Benefits of Learning (2007) *The wider benefits of learning: a synthesis of findings from the Centre for Research on the wider benefits of learning 1999-2006* London: DCFS. Available at: http://www.dcsf.gov.uk/research/data/uploadfiles/RCB05-06.pdf

Chevalier A and Feinstein L (2006) *Sheepskin or Prozac: The Causal Effect of Education on Mental Health* London: Centre for Economics of Education. Available at: http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf

Department for Communities and Local Government (2008) *Communities in Control: real people, real power*. London: The Stationary Office. (available: http://www.communities.gov.uk/publications/communities/communitiesincontrol)

Dolan, P., Peasgood, T. *et al* (2006) *Review of research on the influences on personal well-being and application to policy making*. London: DEFRA. Available at: http://randd.defra.gov.uk/Default.aspx?Menu=Menu&Module=More&Location=None&Completed=0&ProjectID=14000

Dugdale, G. and Clark, C. (2008) *Literacy changes lives: an advocacy resource*. London: National Literacy Trust. Available at: http://www.literacytrust.org.uk/assets/0000/0401/Literacy_changes_lives_2008.pdf

Government Office for Science (2008) *Foresight mental capital and well-being project: final project report*. London: Government Office for Science.

Feinstein, L., Hammond, C., Woods, *et al*. (2003). *The Contribution of adult learning to health and social capital. Wider Benefits of Learning Research Report No.8*. London: The Centre for Research on the Wider Benefits of Learning. Available at: http://www.learningbenefits.net/Publications/ResReps/ResRep8.pdf

Hammond, C. and Feinstein, L. (2005) The effects of adult learning on self-efficacy *London Review of Education*, 3(3), pp. 265-87.

Hammond, C. and Feinstein, L. (2006) *Are those who flourished at school healthier adults? What role for adult education?* Wider Benefits of Learning Research Report No. 17.

Pevalin, D.J. and Rose, D. (2003) *Social capital for health: investigating the links between social capital and health using the British Household Panel Survey*. Wivenhoe: Institute for Social and Economic Research, University of Essex.

Schuller, T., Preston, J., *et al*. 2004. *The Benefits of Learning: The impact of education on health, family life and social capital*. London: Routledge Falmer.

Stansfeld, S.A. (2006). *Social support and social cohesion. in: Marmot, M., Wilkinson, R. (Eds.), Social determinants of health*. Oxford: Oxford University Press.

Waddell G & Burton AK (2007) *Is Work Good For Your Health & Well-Being?* London: Independent Review for DWP, DoH, HSE London.

Bibliography: Social inclusion

Bates, P. (2002) *Working for Inclusion: making social inclusion a reality for people with severe mental health problems*. London: Sainsbury Centre for Mental Health.

Berkman, L.F., Glass, T., *et al*. (2000) From social integration to health: Durkheim in the new millennium. *Social Science & Medicine*, 51, pp. 843-857.

Brugha, T. S., Weich, S., *et al*. (2005) Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout GB. *Psychological Medicine*, 35 (5), pp. 705-14. Available at: http://wrap.warwick.ac.uk/247

Gordon, D., Adelman, L., *et al*. (2000) *Poverty and Social Exclusion in Britain*. York: Joseph Rowntree Foundation.

Sayce, L. (2000) *From psychiatric patient to citizen: overcoming discrimination and social exclusion*. Basingstoke: Macmillan.

Social Exclusion Unit (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London: Office of the Deputy Prime Minister.

Social Exclusion Unit (2005) *Excluded Older People: Social Exclusion Unit Interim Report*. London: Office of the Deputy Prime Minister. Available at: http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/excluded_older_responses.pdf

Watts, B. (2008) *What are today's social evils: the results of a web consultation*. York: Joseph Rowntree Foundation. Available at: http://www.socialevils.org.uk/documents/social-evils-report.pdf

Weyer, S., Dragano, N., *et al*. (2008) Low socio-economic position is associated with poor social networks and social support: results from the Heinz Nixdorf Recall Study. *International Journal for Equity in Health*, 7(13). Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2424055/

Bibliography with some annotations: Population Characteristics

General: Adults and Children

Clements, A., Fletcher, D. *et al* (2008) *Three years on: survey of the emotional development and well-being of children and young people*. London: Office of National Statistics. Available at: http://www.statistics.gov.uk/cci/article.asp?id=2063 *This three-year study tracked the emotional well-being of a sample of children and young people between 2004 and 2007 and reviewed the factors likely to be associated with the onset or persistence of emotional and behavioural disorders. Found that "social capital" indicators (friends, support networks, valued social roles and positive views on neighbourhood) predicted both.*

Equalities Review (2007) *Fairness and Freedom: the final report of the equalities review*. London: Cabinet Office. Available at: http://www.theequalitiesreview.org.uk *An independent review of all forms of inequality and discrimination in Britain*.

Green, H., McGinnity, A. *et al*. (2005) *Mental health of children and young people in Great Britain 2004*. London: Office of National Statistics. Available at: http://www.statistics.gov.uk/downloads/theme_health/GB2004.pdf *Prevalence of mental disorders in children and changes since 1999. Includes sections on medication, absence from school and risk and protective factors e.g. social networks and socioeconomic/demographic variables*.

King, M., Semlyn, J., See Tai, S., Killaspy et al (2008). *Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people: a systematic review of the literature*. BMC, 8:70.

McManus, S., Meltzer, H., *et al*. (2009) *Adult Psychiatric Morbidity in England, 2007: results of a household survey*. The NHS Information Centre. Available at: http://www.ic.nhs.uk/pubs/psychiatricmorbidity07 *The most recent data on prevalence of mental health problems in England by age, gender, household income and a range of risk factors e.g. financial strain. Includes trends since 1993 e.g. the rate of common mental disorders among women aged 45-64 rose by about a fifth. Previous surveys were conducted in 1993 (16-64 year olds) and 2000 (16-74 year olds) and covered England, Scotland and Wales.*

Singleton, N. and Lewis, G. (2003) Better or Worse: *a longitudinal study of the mental health of adults living in private households in Great Britain*. London: Stationery Office. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4081091

Age: early years

Aked J *et al* (2009) *Backing the Future: why investing in children is good for us all* London: New Economics Foundation. Available at: http://www.neweconomics.org/sites/neweconomics.org/files/Backing_the_Future_1.pdf

Department of Health (2008) South East Public Health Observatory (2008) *Children and Young People: promoting emotional health and well-being*. London: CSIP South East. Available at: http://www.sepho.org.uk/Download/Public/11536/1/Information%20Series%20-%20CYP%20Emotional%20Health%20and%20Well-being24PP%20-%20Sallie%20Bacon%20-%20June%202008.pdf

Accessible summary of data on children and young people.

Feinstein, L. and Duckworth, K. (2006). *Development in the early years: its importance for school performance and adult outcomes*. London: Centre for Research on the Wider Benefits of Learning. Available at: http://www.learningbenefits.net/Publications/ResReps/ResRep20.pdf

Hutchings, J., Bywater, T., *et al*. (2007) Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. British Medical Journal, 334,

Irwin, L.G., Siddiqi, A., *et al*. (2007) *Early Child Development : A Powerful Equalizer Final Report for the World Health* Organization's Commission on the Social Determinants of Health. Geneva: CSDH Available at: http://www.who.int/social_determinants/resources/ecd_kn_report_07_2007.pdf)

Poulton, R. *et al*. (2002) Association between children's experiences of socioeconomic disadvantage and adult health: a life-course study. *British Medical Journal*, 360, pp. 1640-5.

Sources of resilience:

Bywater, T, Hutchings, J, *et al*. (2009) Long-term effectiveness of a parenting intervention for children at risk of developing conduct disorder *British Journal of Psychiatry 195 318-324*

Karoly, L.A., Kilburn, M.R., *et al*. (2003) *Early childhood interventions: proven results, future promises*. California: Rand Labor and Population. Available at: http://rand.org/pubs/monographs/2005/RAND_MG341.pdf)

Melhuish, E., Belsky, J., *et al*. (2008) Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study, *The Lancet*, 372 (9650), pp. 1641-1647.

Richards, M. and Abbotts, R. *et al*. (2009) *Childhood mental health and life chances in post-war Britain. Insights from three national birth cohort studies: summary of evidence on effectiveness and cost effectiveness of early interventions*. London: SCMH/Smith Institute. *Longitudinal study of long-term consequences of childhood and adolescent mental health problems for adult mental health and a wide range of economic and social outcomes.*

Sylva, K. *et al*. (2007) *Effective pre-school and primary education 3-11 project (EPPE 3-11) a longitudinal study funded by the DfES (2003-2008) Promoting Equality in the Early Years: report to the Equalities Review*. London: Institute of Education. Available at: http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/promoting_equality_in_the_early_years.pdf) *The EPPE study found that the strongest effect on children's resilience at age 5 and 10 is their level of self-regulation (independence and concentration) at the start of school. The effects associated with a high quality home learning environment (HLE – providing structure, extensive educational stimulus and activities, a high level of parent/child interaction and the family's sense of efficacy in supporting their children's learning) on children's development were stronger than for other traditional measures of disadvantage such as parental SES, education or income. EPPE found that being female, higher parental education and income, quality of "home learning environment", quality of pre-school and amount of time in pre-school are all associated with increases in self-regulation, whilst lower birth weight, eligibility for free school meals, developmental and behavioural problems are associated with decreases in self-regulation.*

A wide range of studies show that interventions aimed at reducing risk factors and enhancing protective factors in the family are of great importance; there is now a strong body of evidence to suggest that well-designed pre-school programmes which seek to improve parenting skills show a high level of effectiveness and cost-effectiveness :

Waddell, C., Hua, J., *et al*. (2007) Preventing mental disorders in childhood. *Canadian Journal of Public Health*, 98(3), 166-173.

Age: Young people and adolescence

Fagg, J., Curtis, S., *et al*. (2006) Psychological distress among adolescents, and its relationship to individual, family and area characteristics in East London. *Social Science & Medicine*, 63(3), pp.636-648. *Two studies showing that in young adulthood through to later life there is a persistent relationship between low levels of mental well-being and poorer outcomes; a number of studies demonstrate that both individual psychological resilience and family support protect against material disadvantage.*

Fergusson, D., Horwood, J. *et al*. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology and Psychiatry*, 46(8), pp. 837-849. *Influential longitudinal study demonstrating the long term impact of early behavioural problems in young children*

Hagel, A. (2004) *Time Trends in Adolescent Well-being*. London: Nuffield Foundation. Available at: http://www.nuffieldfoundation.org/fileLibrary/pdf/2004_seminars_childern_families_adolescents_and_wellbeing001.pdf

Meltzer, H., Corbin, T., *et al*. (2002) *The mental health of young people looked after by local authorities in England*. London: Office of National Statistics. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060671.pdf

Place2be (2009) *An economic evaluation of The Place2Be's school based early mental health service for children* London: Place2be

Sacker, A. and Schoon, I. (2007) Educational resilience in later life: resources and assets in adolescence and return to education after leaving school at age 16. *Social Science Research*, 36(3), pp.873-896

Age: Later life

Evans, O. *et al*. (2003) *The mental health of older people: report based on the analysis of the ONS Survey of Psychiatric Morbidity among Adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the Welsh Assembly Government*. London: HMSO. Available at: http://www.statistics.gov.uk/downloads/theme_health/PMA-MentalOlder.pdf).

Godfrey, M. and Denby, T. (2004) *Depression and Older People: towards securing well-being in later life*. Bristol: Help the Aged/ Policy Press. Available at: http://policy.helptheaged.org.uk/NR/rdonlyres/0F8B94C5-D940-4134-9DE8-BC460BE759E3/0/hs_depression_briefing_02_05.pdf

Mental Health Foundation/Age Concern (2006) *Promoting Mental Health and Well-Being in Later Life: A first report from the UK Inquiry into Mental Health and Well-Being in Later Life*. London: Age Concern. Available at: http://www.ageconcern.org.uk/AgeConcern/Documents/Inquiry_report_Promoting_mental_health_and_well-being_in_later_life_-_FINAL.pdf
This major inquiry found the key areas that influence mental health in later life are age discrimination, participation, relationships, physical health and poverty. Fear of crime and lack of transport are also consistent themes, with "daily hassles" contributing more significantly to psychological distress than major life events. Scottish data is included in: NHS Health Scotland (2004) Mental health and well-being in later life: older people's perceptions. Edinburgh: NHS Health Scotland

Netuveli, G., Wiggins, R.D. et al (2008) Mental health and resilience at older ages: bouncing back after adversity. British Household Panel Survey. *Journal of Epidemiology and Community Health*, 62, pp. 987-99.

Netuveli, G., Wiggins, R.D., et al. (2006) Quality of life at older ages: evidence from the English longitudinal study of aging (wave 1). *Journal of Epidemiology and Community Health*, 60, pp. 357-363.

Social Exclusion Unit (2005) *Excluded older people: social exclusion unit interim report*. London: Office of the Deputy Prime Minister.

See also series of helpful overheads and summaries of the SEU's findings:

Shaping Our Future: Rethinking Older People's Services: Excluded Older People. Susan Acland-Hood. Social Exclusion Unit. Available at: http://www.lga.gov.uk/lga/aio/36569

Summary diagram 'Excluded Older People' – Social Exclusion Unit Interim Report. (2005) Better Government for Older People. Available at: http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/better_gov_old.pdf

Gender

Department of Health (2002) *Women's mental heath: into the mainstream – strategic development of mental health care for women*. London: Department of Health.

Department of Health (2003) *Mainstreaming Gender and Women's Mental Health Implementation Guidance*. London: Mental Health, Health & Social Care Standards & Quality Group. Available at: http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4002408)

Living with violence or the fear of violence is a significant risk factor for poor mental health. This includes domestic violence, child abuse and community violence. Women are at much greater risk of intimate partner violence and abuse than men: women's experience of partner violence is a significant factor for subsequent mental health problems and mental ill health also makes a substantial contribution to offending behaviour in women, creating a cycle of extreme distress and deprivation, while young men, aged 16 to 24, are most at risk of being a victim of non partner violent crime.

Home Office (2005) *Domestic violence: a national report*. London: Home Office. Available at: http://www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence51.htm)

Victorian Health Promotion Foundation (2004) *The health costs of violence: measuring the burden of disease caused by intimate partner violence*. Victoria, Australia: VicHealth. Available at: http://www.rch.org.au/emplibrary/wellwomens/LOTL_DeeBasinski.pdf
This Australian study estimating the disease burden resulting from intimate partner violence, found that such violence is responsible for more ill health and premature death in women under the age of 45 than any other well-known risk factors including high blood pressure, obesity and smoking.

Ethnicity

Chakraborty, A. and McKenzie, K. (2002) Does racism cause mental illness? *British Journal of Psychiatry*, 180, pp. 475-477.

Christopher, J.C. and Hickinbottom, S. (2008) Positive psychology, ethnocentrism, and the disguised ideology of individualism. Theory and Psychology, 18(5), pp. 563-589 *Helpful international and multi-cultural perspectives on well-being*.

Department of Health (2004) *Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Ethnic Communities* Leeds: NIMHE/CSIP. Available at: http://www.nmhdu.org.uk/silo/files/cultures-black-minority.pdf)

Equalities Review (2007) *Fairness and Freedom: the final report of the equalities review* London, Cabinet Office. Available at: http://www.theequalitiesreview.org.uk) *An independent review of all forms of inequality and discrimination in Britain*

Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) Reports (2002) Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/ListOfSurveySince1990/Surveylistmentalhealth/DH_4001578)
Includes two reports drawn from research carried out in 2000: a quantitative survey of rates of mental illness among different ethnic groups in England and a qualitative study investigating ethnic and cultural differences in the context, experience and expression of mental distress.

Krueger, P.M., Bond Huie, S.A., *et al* (2004) Neighbourhoods and homicide mortality: an analysis of race/ethnic differences. *Journal of Epidemiology and Community Health*, 58, pp. 223-230.

McKenzie, K. (2003) Authors' reply. *British Journal of Psychiatry* 182(1), pp. 458. *Both the experience of racial harassment and perceptions of racial discrimination contribute independently to health outcomes.*

Newbigging, K., Bola, M. and Shah, A. (2008) *Scoping exercise with Black and minority ethnic groups on perceptions of mental well-being in Scotland*. Edinburgh: NHS Health Scotland. Available at: http://www.healthscotland.com/documents/2803.aspx) *Report on perceptions of mental well-being among Scottish Pakistani and Chinese communities, including a brief literature review and interviews with around 40 key informants from these communities.*

Samman, E. (2007) *Psychological and subjective well-being: a proposal for internationally comparable indicators* Oxford: University of Oxford: Oxford Poverty and Human Development Initiative. Available at: http://ophi.qeh.ox.ac.uk/pubs/Samman_Psych_Subj_Wellbeing_Final.pdf

Stansfeld, S.A., *et al*. (2004) Ethnicity and social deprivation and psychological distress in adolescents. *British Journal of Psychiatry*, 185, pp. 233–238.

Class/socio-economic position (see also wider determinants of health)

Series of papers analyzing the dramatic inequalities in health both within and between countries, the social gradient in health, and new evidence on the social causes of health inequities. The Commission on Social Determinants of Health is concerned with the link between health and position in the social hierarchy and the role of stratification.

Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

A wide range of studies demonstrating a relationship between socio-economic position and mental health outcomes and between inequalities and mental health.

Graham, H. (2004) Social determinants and their unequal distribution: clarifying policy understandings. *Millbank Quarterly*, 82(1), pp. 101-24.

Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review Available at: http://www.marmot-review.org.uk

Melzer, D., Fryers, T. *et al* (2004) *Social inequalities and the distribution of common mental disorders*. Maudsley Monographs 44. Hove: Psychology Press.

Rogers, A. and Pilgrim, D. (2003) *Mental health and inequality*. London: Palgrave Macmillan.

Weyer, S., Dragano, N., *et al*. (2008) Low socio-economic position is associated with poor social networks and social support: results from the Heinz Nixdorf Recall Study. *International Journal for Equity in Health*, 7(13).

Wilkinson, R.G. and Pickett, K.E. (2006) Income inequality and population health: a review and explanation of the evidence. *Social Science and Medicine*, 62, pp.1768-1784

Socio-economic position and childhood

Pickett, K.E. and Wilkinson, R.G. (2007) Child well-being and income inequality in rich societies: ecological cross sectional study. *British Medical Journal*, 335, p.1080. Available at: http://www.bmj.com/cgi/content/full/335/7629/1080) *A useful analysis from a children's perspective, drawing on the Unicef report*

UNICEF Innocenti Research Centre (2007) Child poverty in perspective: an overview of child well-being in rich countries. Florence: Innocenti Report Card.Two recent reports on the extent to which socio-economic position in childhood determines outcomes in life:

Blanden, J., Gregg, P. *et al* (2005) *Intergenerational Mobility in Europe and North America: A Report Supported by the Sutton Trust*. London: London School of Economics. Available at: http://cep.lse.ac.uk/about/news/IntergenerationalMobility.pdf)

Report from Independent Commission on Social Mobility (2009). Social Mobility Commission now disbanded – report chaired by Alan Milburn commissioned by the Liberal Democrats.

Sexuality

The quality of research in this area varies considerably; many studies do not take account of gender, class and ethnicity when looking at sexuality.

King, M., McKeown, E., *et al*. (2003) Mental health and quality of life of gay men and lesbians in England and Wales: controlled, cross-sectional study. *British Journal of Psychiatry*, 183, pp. 552-558.

Myers, F., McCollam, A., *et al*. (2005) *Equal Minds: Addressing Mental Health Inequalities in Scotland*. Edinburgh: Scottish Development Centre for Mental Health.

Warner, J., McKeown, E., *et al*. (2004) Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: results from a survey based in England and Wales. *British Journal of Psychiatry*, 185, pp. 479-485.

Disability

Department of Health (2001) *Valuing people: a new strategy for learning disability for the 21st century*. London: Department of Health. (availability http://valuingpeople.gov.uk/dynamic/valuingpeople4.jsp)

Exceptionally helpful White Paper on the rights, needs and experiences of people with learning disabilities in England.

Inequalities and Unfair Access Issues Emerging from the DHSSPS (2004) *Equality and Inequalities in Health and Social Care: A Statistical Overview Report*. (available: http://www.dhsspsni.gov.uk/disabilitymentalhealth.pdf) *Overview of health and social care issues around mental health and disability from Northern Ireland*

Sayce, L. (2008) Thinking big: mental health at the heart of the equalities agenda. *A Life in the Day, 12(1), pp*. 21-23. (availability: https://commerce.metapress.com/content/116031611430v247/resource-secured/?target=fulltext.pdf&sid=tuekuo2kpckhbe45fjokt145&sh=pierprofessional.metapress.com – asks you to pay £20.00 to view article, or athens password) *Putting mental health at the heart of the equalities, human rights and disabilities agenda.*

Physical health

Chandola, T., Brunner, E., (2006) Chronic stress at work and the metabolic syndrome: prospective study. *British Medical Journal*, 332, pp. 521 -5. *Evidence on systemic physiological responses to stress, via neuro-endocrine, cardiovascular and immunological pathways, which can be identified through changes in 'risk markers' for disease e.g. levels of cortisol, cholesterol, C-reactive protein and blood pressure. This can also be seen in "metabolic syndrome" – a combination of risk factors for cardiovascular disease, type two diabetes and liver disease that is linked to blood pressure, weight distribution, lipid levels, cholesterol levels and the way in which glucose is metabolised. Metabolic syndrome is strongly associated with chronic stress.*

Harris, E.C. and Barraclough, B. (1998) Excess mortality of mental disorder. *The British Journal of Psychiatry*, 173(11), pp.11-53.

Ostir, G.V., *et al*. (2000) Emotional well-being predicts subsequent functional independence and survival. *Journal of the American Geriatrics Society*, 48, pp.473–478.

Phelan, M., Stradins, L., *et al*. (2001) Physical health of people with severe mental illness. *British Medical Journal*, 322, pp. 443-444. *Series of papers on the impact of mental well-being and mental illness on physical health.*

Pressman, S. and Cohen, S. (2005) Does positive affect influence health? *Psychological Bulletin*, 131(6), pp. 925-971.

Steptoe, A. (2005) *How stress gets under your skin: psychobiological studies of social status, stress and health*. Glasgow Centre for Population Health Seminar Series 2: Paper 1. (available: http://www.gcph.co.uk/content/view/41/57)

Bibliography with some annotations: Wider determinants overview and well-being debates

The following reports from the Office for Economic Cooperation and Development (OECD), HM Treasury, as well as an influential paper commissioned by the French President, provide a helpful perspective on current debates about the failings of the money economy and the need for wider measures of social progress. They are invaluable in providing a strong policy rationale for the MWIA focus on well-being:

Dolan, P., Peasgood. T. et al. (2006) *Review of research on the influences on personal well-being and application to policy making*. London, Department for the Environment, Food and Rural Affairs.

Galobardes, G., Lynch, J. and Smith, G.D. (2007) Measuring socioeconomic position in health research. *British Medical Bulletin*, 81-82, pp.21-37.

Graham, H. (2004) Social determinants and their unequal distribution: clarifying policy understandings. *Millbank Quarterly*, 82(1), pp.101-24

HM Treasury (2008) *Developments in the economics of well-being*. London: HM Treasury. (available: http://www.hm-treasury.gov.uk/treasury_economic_workingpaper4.htm

Organisation for Economic Cooperation and Development . Measuring the progress of societies. (available: http://www.oecd.org/pages/0,3417,en_40033426_40033828_1_1_1_1_1,00.html

Stiglitz, J.E., Sen, A. *et al*. (2009) *Report by the Commission on the measurement of economic performance and social progress*. Paris:Commission on the Measurement of Economic Performance and Social Progress. (available: http://www.stiglitz-sen-fitoussi.fr

Two papers making a crucial contribution to the debates on social determinants of health:

Marmot, M., Friel, S., *et al*. on behalf of the Commission on Social Determinants of Health (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Lancet, 372, pp.1661-1669.

Accessible summary of the findings of the WHO Commission on the social determinants of health.

Marmot, M. and Wilkinson, R. (2006) *Social determinants of health*. Oxford: Oxford University Press.

Samman, E. (2007) *Psychological and subjective well-being: a proposal for internationally comparable indicators* . Oxford: University of Oxford, Oxford Poverty and Human Development Initiative. (available: http://ophi.qeh.ox.ac.uk/pubs/Samman_Psych_Subj_Wellbeing_Final.pdf

A series from the Oxford Poverty and Human Development Initiative provides a helpful international and multi-cultural perspective on well-being.

Physical security – housing, safety at home, neighbourhood safety

Dorling, D., Rigby, J., *et al.* (2007) *Poverty, wealth and place in Britain 1968-2005*. Bristol: the Policy Press.

Feinstein, L., Lupton, R., et al. (2008) *The public value of social housing: a longitudinal analysis of the relationship between housing and life chances*. London: The Smith Institute.

Green, A. and White, R.J. (2007) *Attachment to place: social networks, mobility and prospects of young people*. York: Joseph Rowntree Foundation.

Krug, E.G. *et al*. (2002) World report on violence and health. Geneva: World Health Organization.

Livingston, M., Bailey, N. *et al* (2008) *People's attachment to place: the influence of neighbourhood deprivation*. Coventry: Chartered Institute of Housing.

Taylor, M. (2008) *Transforming disadvantaged places: effective strategies for places and people*. York: Joseph Rowntree Foundation.

Worpole, K. and Knox, K. (2007) *The social value of public spaces*. York: Joseph Rowntree Foundation.

Series of papers commissioned by JRF on the influence of neighbourhood environments.

Environment – public space, green space, children's space, wild space, stress free space

Mitchell, R. and Shaw, R. (2008) Health impacts of the John Muir Award. Glasgow: University of Glasgow. http://www.gcph.co.uk/content/view/165/68/

Green space and the natural environment

Alves, S. and Sugiyama, T. (2006) *Literature review on the benefits of access to outdoor environments for older people*. Edinburgh: OPENspace Research Centre, Edinburgh College of Art. (available: http://www.idgo.ac.uk/useful_resources/for_other_researchers.htm#references

Countryside Recreation Network (2005) *A Countryside for Health and Well-being: The Physical and Mental Health Benefits of Green Exercise*. Sheffield: Countryside Recreation Network. (available: http://www.countrysiderecreation.org.uk/pdf/CRN%20exec%20summary.pdf

Health Scotland, Greenspace Scotland, Scottish Natural Heritage, Institute of Occupational Medicine (2008) *Health Impact Assessment of Greenspace: A Guide*. Stirling: Greenspace Scotland. (available: http://www.greenspacescotland.org.uk/upload/File/Greenspace%20HIA.pdf)

Pretty, J., Peacock, J., *et al* (2005) The mental and physical health outcomes of green exercise. *International Journal of Environmental Health Research* 15(5), pp.319 – 337.

Maas J, Verheij RA, de Vries S *et al* (2009) Morbidity is related to a green living environment *Journal of Epidemiology and Community Health* 63 pp 967-973 (available: http://jech.bmj.com/cgi/content/abstract/63/12/967?etoc

Mind (2007) "*Ecotherapy: The green agenda for mental health*". London: Mind. (available: *http://www.mind.org.uk/assets/0000/2138/ecotherapy_report.pdf*

Mitchell, R. and Popham, F. (2008) Effect of exposure to natural environment on health inequalities: an observational population study. The Lancet, 372(9650), pp.1655 – 1660. (available: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61689-X/abstract

Traffic Control

Hart, J. (2008) *Driven to excess: impacts of motor vehicle traffic on residential quality of life in Bristol*. Bristol: University of West of England. (available: http://www.stockportlivingstreets.com/pdfs/PDF/DrivenExcess.pdf

Leyden, K. (2003) Social capital and the built environment: The Importance of Walkable Neighbourhoods. *American Journal of Public Health*, 93(9)

Built environment

Chu, A., Thorne, A. *et al* (2004) The impact on mental well-being of the urban and physical environment: an assessment of the evidence. *Journal of Mental Health Promotion*, 3(2), pp.17-32.

Clarke, C., Myron, R., Stansfeld, S.A. and Candy, B. (2007) A systematic review on the effect of the built and physical environment on mental health. *Journal of Public Mental Health*, 6(2)

Guite, H.F., Clark, C. and Ackrill, G. (2006) The impact of the physical and urban environment on mental well-being *Public Health* 120, pp.1117-1126.

Meaningful activity: employment, volunteering, spirituality

Bartley, M., Sacker, A., Schoon, I. et al. (2005) *Work, non-work, job satisfaction and psychological health*. Evidence review. London: Health Development Agency.

Ferrie, J.E. (2007) (ed.) *Work, stress and health: Findings from the Whitehall II study* London: Cabinet Office/University College London.

Lum, T. and Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Ageing*, 27, pp. 31-55.

Public Service Management Wales (2008) *Sowing the Seeds Time Banking: Public Service delivery with Time Credits* Cardiff: Welsh Assembly Government (available: http://www.justaddspice.org/docs/Timebanking%20SS.pdf

Russell Commission (2005) *A national framework for youth action and engagement* London: Cabinet Office (available: http://archive.cabinetoffice.gov.uk/russellcommission/report/index.html

Ryan-Collins J, Stephens L *et al*. (2008) *The new wealth of time: how timebanking helps people build better public services* London: New Economics Foundation (availability: http://www.timebanking.org/documents/Publications/New_Wealth_of_Time.pdf

Thoits, P.A. and Hewitt, L.N. (2001) Volunteer work and well-being *Journal of Health and Social Behavior*, 42, pp.115–131.

Wheeler, F.A., Gore, K.M. *et al*. (1998) The beneficial effects of volunteering for older volunteers and the people they service: a meta-analysis. *International Journal of Ageing and Human Development*, 47, pp. 91.

Good quality food: affordable, accessible, healthy

Mental Health Foundation (2006) *Feeding Minds - The impact of food on mental health*. London: Mental Health Foundation.

Van de Weyer, C. (2006) *Changing diets, changing minds: how food affects mental well being and behaviour*. London: Sustain. (available: www.mentalhealth.org.uk/EasySiteWeb/getresource.axd?AssetID=39441&type=full&servicetype=Attachment

Leisure: arts and creativity, culture, sports

Evans, G. and Shaw, P. (2004) *The contribution of culture to regeneration in the UK: a review of the evidence*. London Metropolitan University. London: Department for Culture, Media and Sport (availability: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.120.4961&rep=rep1&type=pdf

Hughes, J. (2005) *Doing the arts justice: a review of research literature, practice and theory*. London: Arts Council England. (available: http://webarchive.nationalarchives.gov.uk/+/

http://www.culture.gov.uk/NR/rdonlyres/D4B445EE-4BCC-4F6C-A87A-C55A0D45D205/0/Doingartsjusticefinal.pdf)

Ruiz, J. (2004) *A literature review of the evidence base for culture, the arts and sport policy*. Edinburgh: Scottish Executive.

Longitudinal evidence from the British Cohort Study shows that involvement in cultural activities during childhood and adolescence has statistically significant and positive effect on economic capital at age 29 years. Four cultural activities were shown to produce the most benefit: participation in the arts or music, theatre, reading and writing for pleasure.

Participation in the arts: mental health benefits

Friedli, L., Oliver, C., *et al*. (2007) Mental health improvement: evidence based messages to promote mental well-being - A report for NHS Health Scotland. Edinburgh: NHS Health Scotland.(available: http://www.healthscotland.com/documents/2188.aspx

Education

Aldridge, F. and Lavender, P. (2000) *The Impact of Learning on Health: Key Findings*. Leicester: National Institute of Adult Continuing Education.

Chevalier, A. and Feinstein, L. (2006) *Sheepskin or Prozac: The Causal Effect of Education on Mental Health*. London: Centre for Economics of Education. (available: http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf

Dench, S. and Regan, J. (2000) *Learning in later life: motivation and impact*. London: Department for Education and Skills.

Dugdale, G. and Clark, C. (2008) *Literacy changes lives: An advocacy resource*. London: National Literacy Trust. (available: http://www.literacytrust.org.uk/research/Literacy_changes_lives.pdf

Feinstein, L., Hammond, C., *et al*. (2003) *The contribution of adult learning to health and social capital* London: Centre for Research on the Wider Benefits of Learning.

Financial security – income, credit, wealth, debt

Burchardt, T.(2008) *Time and income poverty*. York: Joseph Rowntree Foundation. (available: http://sticerd.lse.ac.uk/dps/case/cr/CASEreport57.pdf

Citizens Advice Bureau (2004) *Out of the picture: CAB evidence on mental health and social exclusion*. London: Citizens Advice Bureau. (available: http://www.citizensadvice.org.uk/out-of-the-picture

The Poverty Site. The UK site for statistics on poverty and social exclusion. York: Joseph Rowntree Foundation. (available: http://www.poverty.org.uk/summary/contact.htm

You can sign up to this website to receive regular updates on new data on many aspects of poverty, inequality and social exclusion, with UK wide data, plus data for England, Scotland, Wales and Northern Ireland. An invaluable resource.

Financial capability

Melhuish, E., Belsky, J. et al (2008) *An investigation of the relationship between financial capability and psychological well-being in mothers of young children in poor areas in England*. London: Financial Services Authority.

Pickett, K.E., James, O.W. *et al*. (2006) Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis. *Journal of Epidemiology and Community Health*, 60, pp.646-647.

Taylor, M., Jenkins, S. *et al*. (2009) *Financial capability and well-being: evidence from the BHPS*. London: Financial Services Authority.

Two papers from the FSA suggesting that financial capability has a relatively large and statistically significant impact on psychological well-being.

Thiel, V. and Nissan, S. (2008) *UK CDFIs – from surviving to thriving: realising the potential of community development finance*. London: New Economics Foundation/Hadley Trust. (available: http://www.neweconomics.org/sites/neweconomics.org/files/UK_CDFIs_1.pdf

Transport – affordable, accessible, sustainable

Douglas, M., *et al*. (2007) (eds.) *Health Impact Assessment of Transport Initiatives: A Guide*. Edinburgh: NHS Health Scotland.

Marshall, E. and Thomas, N. (2005). *Traffic calming: The reality of 'road rage'. Home Office Briefing Note 12/00 2005*. London: Home Office. (available: http://www.homeoffice.gov.uk/rds/prgpdfs/brf1200.pdf

Mutrie, N., Carney, C., et al. (2002) 'Walk in to Work Out': a randomised controlled trial of a self help intervention to promote active commuting. *Journal of Epidemiology and Community Health*, 56(6), pp. 407-412.

Study assessing the effects on general health for those who switched from driving to walking or cycling to work found there were also significant improvements in mental health.

Social Exclusion Unit (2002). *Making the connections: Final report on transport and social exclusion*. London: Social Exclusion Unit. (available: http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/making_transport_2003.pdf

Thomson, H., Jepson, R. *et al*. (2008) Assessing the unintended health impacts of road transport policies and interventions: translating research evidence for use in policy and practice. *BMC Public Health*, 8(339). (available: http://www.biomedcentral.com/1471-2458/8/339

The possible impacts cover physical activity and obesity, mental health, air quality and cardio-respiratory health, social exclusion and inequalities, and environmental impacts related to fuel emissions and climate change.

Bibliography: Social relationships and Core economy (see also core protective factors)

Alkire, S. (2007) *Concepts and Measures of Agency*. Oxford: Oxford University Press Oxford Poverty and Human Development Initiative. (available: http://www.ophi.org.uk

Bauman, Z. (2007) Has the future a left? *Soundings: a journal of politics and culture*. (available: http://www.lwbooks.co.uk/journals/articles/bauman07.html

Friedli, L . with Carlin, M. (2009) Resilient relationships in the North West: what can the public sector contribute? Manchester: Department of Health/NHS North West.

Ryan-Collins, J., Stephens, L. *et al* (2008) *The new wealth of time: how timebanking helps people build better public services*. London: New Economics Foundation. (available: http://www.neweconomics.org/gen/uploads/u4o0dteqqt15ydu0gzphnuf011112008183530.pdf

Stephens, L., Ryan-Collins, J. *et al* (2008) *Co production: a manifesto for growing the core economy*. London: New Economics Foundation. (available: http://www.neweconomics.org/gen/z_sys_publicationdetail.aspx?pid=257

Vale, D., Watts, B. et al (2009) *The receding tide: understanding unmet needs in a harsher economic climate*. London: The Young Foundation.

Watts, B. (2008) *What are today's social evils: the results of a web consultation*. York: Joseph Rowntree Foundation. (available: http://www.socialevils.org.uk/documents/social-evils-report.pdf

Woodcraft, S. (2009) *Neighbourhood working: where do we go from here? Towards a new research agenda*. London: The Young Foundation. (available: http://www.youngfoundation.org.uk/neighbourhood-working-where-do-we-go-here-towards-a-new-research-agenda-saffron-woodcraft-2009

Bibliography and some annotations: Equity and social justice

Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization. (available: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Dorling, D., Mitchell, R., *et al*. (2007) The global impact of income inequality on health by age: an observational study. *BMJ Research*, 335(873). (available: http://www.bmj.com/cgi/reprint/335/7625/873

Friedli, L. (2009) *Mental health, resilience and inequalities – a report for WHO Europe and the Mental Health Foundation*. London/Copenhagen: Mental Health Foundation and WHO Europe. (available: http://www.who.it/document/e92227.pdf

Lynch, J.W. *et al*. (2000) Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal*, 320, pp.1200-1204.

Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review (available: http://www.marmot-review.org.uk/

Melzer, D., Fryers, T. *et al*. (2004) *Social inequalities and the distribution of common mental disorders*. Maudsley Monographs 44. Hove: Psychology Press.

Pickett, K.E., James, O.W. *et al* (2006) Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis. *Journal of Epidemiology and Community Health*, 60, pp.646-647.

Pickett, K.E. and Wilkinson, R.G. (2007) Child well-being and income inequality in rich societies: ecological cross sectional study. *British Medical Journal*, 335(7629), p. 1080 (available: http://www.bmj.com/cgi/content/full/335/7629/1080

Wilkinson, R.J. and Pickett, K.E. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: The Equality Trust. (available: http://www.equalitytrust.org.uk/resource/the-spirit-level

Zaveleta, R.D. (2007) *The ability to go about without shame: a proposal for internationally comparable indicators of shame and humiliation*. Working Paper 3. Oxford: University of Oxford. (available: http://www3.qeh.ox.ac.uk/pdf/ophiwp/OPHIwp03.pdf

Stress biology

Steptoe, A. (2005) *How stress gets under your skin: psychobiological studies of social status, stress and health*. Seminar Series 2: Paper 1. Glasgow: Glasgow Centre for Population Health.

Steptoe, A. *et al*. (2007) *Neuroendocrine and cardiovascular correlates of positive affect measured by ecological momentary assessment and by questionnaire*. Psychoneuroendocrinology, 32(1), pp.56-64.

Steptoe, A. and Feldman, P. (2001) Neighbourhood problems as sources of chronic stress: development of a measure of neighbourhood problems and associations with socioeconomic status and health. *Annals of Behavioural Medicine*, 23(3), pp.177-185.

Steptoe, A. and Wardle, J. (2005) Positive affect and biological function in everyday life. *Neurobiology of Aging*, 26(S1), pp.108-112.

Series of studies on stress biology, demonstrating that psychological responses are an important pathway through which the stress associated with coping with deprivation and disadvantage influences physical health. A key finding is an increasingly sophisticated understanding of the consequences of triggering 'fight/flight' responses too often and for too long: "the accumulation of small hits". Relatively low levels of stress that recur and endure over many years result in persistent low level activation of biological systems. Both the magnitude and the duration of the response to stress may be important in understanding the social gradient in stress related disease. One study found a significant socio-economic difference in recovery time, with blood pressure failing to return to normal very much increased in people with a lower socio economic position

Bibliography with some annotations: Effective and cost effective interventions

Barry, M. M., & Jenkins, R. (2007) *Implementing Mental Health Promotion*. Oxford: Churchill Livingstone, Elsevier.

Friedli, L. and Parsonage, M. (2007) *Mental health promotion: building an economic case*. Belfast: Northern Ireland Association for Mental Health. (available: http://www.chex.org.uk/uploads/mhpeconomiccase.pdf?sess_scdc=ee4428ebde41914abac0e0535f55861c Friedli L and Parsonage M (in press) *Promoting mental health and preventing mental illness: the economic case for investment in Wales* Cardiff: Welsh Assembly Government

Jané-Llopis, E., Barry, *et al*. (2005) (eds.) The evidence of mental health promotion effectiveness: strategies for action. *Promotion and Education*, suppl. 2, pp. 9-25.

World Health Organization (2004a) *Prevention of mental disorders: effective interventions and policy options*. Summary Report. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: World Health Organization. (available: http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

World Health Organization (2004b) *Promoting mental health: concepts, emerging evidence, practice: summary report*. A Report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and The University of Melbourne. Geneva: World Health Organization. (available: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

Mental Well-being Impact Assessment (MWIA) Screening Toolkit

This section of the MWIA Toolkit is designed to be used as a 'stand alone' process for making an initial assessment of a proposal. It does not constitute an MWIA in its own right.

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Figure 3.1: Overview of MWIA process

Screening – Deciding should you carry out an MWIA?
Making an initial assessment of your proposal and deciding if further investigation is required

↓

Scoping – How you will carry out the MWIA
Initial policy appraisal, community profile, options for geographical boundaries and assessment of impacts.

↓

Appraisal process – gathering and assessing the evidence
- Community profiling
- Stakeholder and key informant – MWIA workshop
- Research such as Literature Review

↓

Identification of potential positive or negative impacts

↓

Identification of indicators
for monitoring impacts of your proposal on mental well-being and implementation of recommendations

↓

Identification of recommendations and report

Top tips for screening

1. *Involve other people, including a service user if possible, who know details about and are familiar with various aspects of the proposal – maximum of five*
2. *Bring information to the screening meeting e.g. proposal specification*
3. *Appoint a lead for asking the questions and chairing the process, and someone to scribe*
4. *Keep a written record of your discussion*

3.1 SCREENING – Initial assessment and helping you decide if you need to do a Mental Well-being Impact Assessment

Introduction

This desktop MWIA screening toolkit has been designed to help people who are planning or providing policies, services, programmes or projects (collectively referred to hereafter as proposals), to begin to find out how they might make a difference through using Mental Well-being Impact Assessment (MWIA). The process is also designed to help people decide whether it is worth doing a more intensive MWIA involving a much wider range of people; screening is the *first* stage in MWIA but can also be valuable as a stand-alone short assessment. It is designed to be user-friendly and should take approximately an hour to complete. Whilst completing the form, users may identify points that they would wish to follow up or find out more about. A space for such comments has been allowed after each section.

This screening process can be used on a wide range of proposals such as:

- Strategies - Government Policies, Community Plans, Housing or Transport Policies
- Services such as Mental Health Day Services, Older People's support
- Programmes such as Healthy Schools, Healthy Weight Management, Expert Patients
- Projects such as Timebanks, Community Arts

It is best done before the proposal has been finalised so that there is maximum opportunity for improvements to be made. It can be done on existing proposals if there is an opportunity or willingness to make changes to improve the rest of the delivery, or learn lessons. See appendix 1 for screening case studies.

Before you begin to undertake the MWIA screening process you will need to identify the following:

- Input from a range of key stakeholders, up to 5 people, representing a diversity of knowledge and experience of the proposal. These might include a service user, a funder, and an operational manager. Arrange for this group to meet for an hour to undertake the screening process. This shared working has proved beneficial in building a more complete picture and understanding of mental well-being needs and responses in relation to the proposal, as well as strengthening networking and ownership of the recommendations of the exercise. One person needs to take the lead for asking the questions
- Information regarding the proposal(s) you wish to screen. This could relate to who the key stakeholders are, known information regarding the target groups' demographic profile, knowledge of what is involved with the proposal
- Clarity of the scope to influence decisions and the timescale. If there is no scope or time to influence, it might be worth re-thinking whether the proposal you have chosen is the right one!
- It is worth appointing one person as the 'scribe' to ensure records are kept of the discussion and key decisions. This role can be shared at the various stages of the process.

3.2 MWIA SCREENING TOOLKIT – helping to decide if you need to do a Mental Well-being Impact Assessment

Name of policy, service, programme or project (proposal):

At what stage is your proposal?

- Not yet started?
- Short way into delivery?
- Half way through?
- On-going?
- Coming to an end?
- Other?

Name and title of person completing:

Are you the lead for this proposal - or what is your role?

Names and roles of other people involved:

Date of completing screening toolkit:

Whilst completing the form, you may identify points to follow up or find out more about. A space for such comments has been allowed after each section.

1. Why do you want to look at the possible impact on mental well-being of this proposal? This is just to help you understand why you are doing this screening.

Please tick as many as are relevant to you:

To find out what impact we are likely to have or are already having ☐

To find out if we should do a more developed MWIA ☐

To see if there is a way we can improve the proposal ☐

Other – please say what

2. Is there an opportunity to influence or change the ways in which the proposal is being delivered? This will be important in helping to decide whether it is worth going on to do a Rapid MWIA, as you will need to be able to influence planning or delivery.

Yes ☐

Some ☐

No ☐

Unclear ☐

If you feel clear about why you are doing the screening MWIA, then please continue, if not, then work out what, if anything, you need to do!

3. Population characteristics

Age, gender, class, race/ethnicity, disability, sexuality and physical health influence risk and protective factors for mental health and the ways in which mental health is expressed. The relative impact of population characteristics is in turn affected by wider factors. The experiences of childhood, old age, coming from a working class family, belonging to a Black or Minority Ethnic community, being gay or lesbian, living with a physical or learning disability or suffering from chronic illness vary considerably. For example, financial policy, welfare benefits, housing, education, legislation on age, racial and sexual discrimination all contribute to the mental health impact of growing old.

Please look at Table 1. Think about your proposal and the populations/ communities you are targeting and consider the ones that you think are most important (although remember this is a brief assessment so you don't need to be too detailed). One specific MWIA question is included, but you might want to think of other relevant points in relation to positive, negative or indirect impacts – please add these in.

Table 1 Population Characteristics: Risk and Protective factors for mental well-being

Population characteristics	MWIA Key question	Likely impact? Positive,negative or is it an indirect impact?
Age		
Early Years: Foundations for good mental health lie in pregnancy, infancy and early childhood. Parenting style and attachment are the key factors. The quality of the 'home learning environment', quality of pre-school and the amount of time in pre-school are all associated with greater 'self regulation', an attribute strongly linked to improved educational outcomes.	Will this proposal enhance or diminish support for parents and families through pregnancy, childbirth and first years of life?	
Adolescence: Protective factors include: attachment to school, family and community; positive peer influence; opportunities to succeed and problem solving skills. 'Social capital' indicators (e.g. friends, support networks, valued social roles and positive views on neighbourhood) are closely related to risk and severity of emotional and behavioural disorders.	Will this proposal enhance or diminish feelings of security, significance, belonging and connection in young people?	
Later Life: The key areas that influence mental health in later life are age discrimination, participation, relationships, physical health and poverty. Fear of crime and lack of transport are also consistent themes, with 'daily hassles' contributing more significantly to psychological distress than major life events.	Will this proposal impact positively or adversely on the five key areas known to influence mental health in later life?	

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Gender		
Gender has a significant impact on risk and protective factors for mental health and the way in which the experience of mental distress is expressed. Depression, anxiety, attempted suicide and self harm are more prevalent in women, while completed suicide, drug and alcohol abuse, crime and violence are much more prevalent among men. Women are much more vulnerable to poverty and unemployment, and are more likely to suffer domestic violence, rape and child abuse.	Will the proposal impact differently on men and on women?	
Race and ethnicity		
Race and ethnic differences in the levels of mental well-being and prevalence of mental disorders are due to a complex combination of socio-economic factors, racism, diagnostic bias and cultural and ethnic differences and are reflected in how mental health and mental distress are presented, perceived and interpreted. Different cultures may also develop different responses for coping with psychological stressors. However a major qualitative study found that expressions of distress bore great similarity across ethnic groups, although some specific symptoms were different.	Will the proposal impact differentially on different ethnic groups, including refugees, asylum seekers and newly arrived communities?	
Socio-economic position and class		
Socioeconomic position (SEP) refers to the position of individuals and families, relative to others, measured by differences in educational qualifications, income, occupation, housing tenure or wealth. Socioeconomic position is generally analysed by quintile, for example comparing health or other outcomes of those in the poorest fifth of the population with those in the richest fifth. Socioeconomic position shapes access to material resources, to every aspect of experience in the home, neighbourhood, and workplace and is a major determinant of health inequalities. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation, support and inclusion. Social position also influences areas like identity and social status, which impact on well-being, for example through the effects of low-self esteem, shame, and disrespect .	How will the proposal impact on people in different social positions? Will it reinforce or reduce inequalities?	
Physical health		
Poor physical health is a significant risk factor for poor mental health; conversely, mental well-being protects physical health and improves health outcomes and recovery rates, notably for coronary heart disease, stroke and diabetes. Poor mental health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet. Stress epidemiology demonstrates the link between feelings of despair, anger, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. For heart disease, psychosocial factors are on a par with smoking, high blood pressure, obesity, and cholesterol problems.	Will the proposal have an impact on or take into consideration the physical health of the communities likely to be affected? Does the proposal recognise the relationship between mental health and physical health?	

Disability		
Life chances (notably education, employment and housing), social inclusion, support, choice, control and opportunities to be independent are the key factors influencing the mental health of people with disabilities.	Will the proposal reinforce or reduce inequalities and discrimination experienced by people with disabilities?	
Sexuality and transgender		
Some studies suggest that gay, lesbian, bisexual and transgender peoples are at increased risk for some mental health problems – notably anxiety, depression, self-harm and substance misuse – and more likely to report psychological distress than their heterosexual counterparts, while being more vulnerable to certain factors that increase risk, e.g. being bullied, discrimination and verbal assault.	Will the proposal impact positively or adversely on gay men, lesbians, bisexuals and transgender peoples?	
Other population groups *Tick where appropriate*		
Looked after children People with long term conditions People in residential settings Carers People experiencing violence or abuse People in the criminal justice system Ex-offenders Others	Will the proposal have an impact or take into consideration any of the groups mentioned?	
Settings		
Schools Workplace Neighbourhoods Prisons Hospitals Primary Care Others	Will the proposal have an impact on or take into consideration any of the settings mentioned?	

4. Protective factors and wider determinants that have a particular impact on mental health and well-being

There are three main factors that are thought to promote and protect mental well-being distilled from the evidence base presented in section 2 of this MWIA Toolkit:

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

Wider determinants such as our physical health and more broadly employment, housing, poverty also affect our well-being.

Please look at Tables 2a-d. The first table covers the wider determinants at the socio-economic/environmental level. The remaining tables cover the above three protective factors at both the individual and community/social level. Thinking about your proposal and the populations/communities it affects – consider the factors that you think are most important (although remember this is a brief assessment so you don't need to be too detailed). One specific MWIA question is included, but you might want to think of other relevant points in relation to positive or negative impacts – please add these in. Then note down any comments or recommendations that occur to you.

You are unlikely to have an impact on every protective factor – please be selective and concentrate on those that appear to be most important for your proposal and client group, and mark those that seem to be a priority impact.

2a Wider determinants at a socio-economic/environmental level

MWIA uses a framework for assessing the three protective factors *in the context of the wider determinants of mental well-being.*

The wider determinants are the factors that are determined at a structural level and impact on a population or the whole of society. There is a dynamic relationship between the wider determinants, the three protective factors and mental well-being. Mental well-being is an outcome of the circumstances and experiences of our lives: individual psychological resources, for example, confidence, self efficacy, optimism and connectedness are embedded within social structures such as our position in relation to others at work, at home, and in public spaces. Mental well-being also influences a very wide range of outcomes – health behaviour, physical health and improved recovery rates, educational attainment, employment and productivity, relationships, crime, community cohesion, quality of life and, fewer limitations in daily living. Mental well-being may also be a factor in helping to explain why socio-economic disadvantage does not always correlate with health damaging behaviours.

Table 2a Wider determinants at a socio-economic and environmental level

MWIA question: How does the proposed development impact on the wider determinants?

WIDER DETERMINANTS (often at a socio-economic/environmental level)	**Likely impact?** Positive, negative or is it an indirect impact? Select those most important	**Comments or recommendations**
• **Access to quality Housing** e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate • **Physical Environment** e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment • **Economic security** e.g. access to secure employment (paid and unpaid), access to an adequate income, good working conditions, meaningful work and volunteering opportunities • **Good quality food** e.g. affordable, accessible • **Leisure opportunities** e.g. participate in arts, creativity, sport, culture • **Tackling inequalities** e.g. addressing relative deprivation and poverty • **Transport access and** options e.g. providing choice, affordability and accessibility • **Local democracy** e.g. devolved power, voting, community panels • **Ease of access to high quality public services** e.g. housing support, health and social care • **Access to Education** e.g. schooling, training, adult literacy, hobbies • **Challenging discrimination** e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith • **Other?**		

Table 2b Protective factor - Enhancing control

MWIA question: How does the proposed development impact on people's control?

PROTECTIVE FACTORS FOR ENHANCING CONTROL	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **A sense of control** e.g. setting and pursuit of goals, ability to shape own circumstances • **Belief in own capabilities and self determination** e.g. sense of purpose and meaning • **Knowledge skills and resources to make healthy choices** e.g. understanding what makes us healthy and being able to make choices • **Maintaining independence** e.g. support to live at home, care for self and family		
Community/organisation • **Self-help** provision e.g. information advocacy, groups, advice, support • **Opportunities to influence decisions** e.g. at home, at work or in the community • **Opportunities for expressing views and being heard** e.g. tenants groups, public meetings • **Workplace job control** e.g. participation in decision making, work-life balance • **Collective organisation and action** e.g. social enterprise, community-led action, local involvement, trades unions • **Resources for financial control and capability** e.g. adequate income, access to credit union, welfare rights, debt management		
Other?		

Table 2c Protective factor - Increasing resilience and community assets

MWIA question: How does the proposed development impact on resilience and community assets?

PROTECTIVE FACTORS FOR INCREASING RESILIENCE AND COMMUNITY ASSETS	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **Emotional well-being** e.g. self esteem, self worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun • **Ability to understand, think clearly and function socially** e.g. problem solving, decision making, relationships with others, communication skills • **Have beliefs and values** e.g. spirituality, religious beliefs, cultural identity • **Learning and development** e.g. formal and informal education and hobbies • **Healthy lifestyle** e.g. taking steps towards this by healthy eating, regular physical activity and sensible drinking		
Community/organisation • **Trust and safety** e.g. belief in reliability of others and services, feeling safe where you live or work • **Social networks and relationships** e.g. contact with others through family, groups, friendships, neighbours, shared interests, work • **Emotional support** e.g. confiding relationships, provision of counselling support • **Shared public spaces** e.g. community centre, library, faith settings, café, parks, playgrounds, places to stop and chat • **Sustainable local economy** e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks • **Arts and creativity** e.g. expression, fun, laughter and play		
Other?		

1 2 3 4 5 6

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Table 2d Protective factor - Facilitating participation and promoting inclusion

MWIA question: How does the proposed development impact on participation and inclusion?

PROTECTIVE FACTORS FOR PARTICIPATION AND INCLUSION	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **Having a valued role** e.g. volunteer, governor, carer • **Sense of belonging** e.g. connectedness to community, neighbourhood, family group, work team • **Feeling involved** e.g. in the family, community, at work		
Community/organisation • **Activities that bring people together** e.g. connecting with others through groups, clubs, events, shared interests • **Practical support** e.g. childcare, employment, on discharge from services • **Ways to get involved** e.g. volunteering, Time Banks, advocacy • **Accessible and acceptable services or goods** e.g. easily understood, affordable, user friendly, non-stigmatising, non-humiliating • **Cost of participating** e.g. affordable, accessible • **Conflict resolution** e.g. mediation, restorative justice • **Cohesive communities** e.g. mutual respect, bringing communities together		
Other?		

5. Scale of impact and population

There are two more aspects to consider before determining if you will go on to do further MWIA assessment on your proposal.

a) Scale of the impact on mental well-being

If known (or suspected) at this stage, what is the duration of the likely mental health and well-being impacts of your proposal?

Please tick (this could be more than one period of time)

Brief ☐

Weeks ☐

Months ☐

Years ☐

Entire Life (of the proposal) ☐

Sustained beyond the proposal ☐

Unclear ☐

b) Scale of the population whose mental well-being is impacted

What is the scale of the population that your proposal will impact upon?

A few people ☐

A small part of the population ☐

A majority of the population ☐

The entire population ☐

6. Having completed the screening assessment process the following sections will help you determine what to do next.

For each question in the central column, circle the appropriate answer

Favouring further appraisal	Question	Not favouring further appraisal
Yes/Don't know	Does your proposal affect in a negative way any of your population groups in Table 1?	*No*
Yes/Don't know	Does your proposal affect in a negative way any of the wider determinants and protective factors in Tables 2a-d	*No*
Yes/Don't know	For some of the wider determinants and protective factors of mental well-being, are some of the impacts of your proposal unknown?	*No*
Yes/Don't know	Are the impacts likely to be over a long period of time (one year or more)	*No*
Yes/Don't know	Is there an opportunity to influence the delivery of the proposal you are screening?	*No*

If you have answered 'yes' or 'don't know' to at least two or more questions under the above question, then you are advised to consider further appraisal under the MWIA process. Use section four of this toolkit to plan and undertake your MWIA.

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7. Actions to think about if you don't favour further appraisal under the MWIA process

If you have answered No to at least three or more questions under the above question, then you are not in favour of further appraisal under the MWIA process and may wish to consider doing one or some of the following actions listed below.

Throughout the screening process you will have made a list of comments or action points which may relate to one or two of the other stages of MWIA. It may be useful to use one of the methods/ stages to better inform your highlighted action points. For example:

- Find out more about the project activities in relation to the mental well-being determinants – consider holding a stakeholder workshop see Section 4 of this toolkit
- Find out more about the characteristics of the population targeted by the project – consider completing a community profile see Section 4 of this toolkit
- Find out how to target population groups not using the project, and who may benefit in terms of mental well-being – consider completing a community profile and redoing the population table screening toolkit see Section 4 of this toolkit
- Develop an action plan based on your screening findings, in order to refine your project to maximise potential mental well-being and/or to reduce potential negative impacts
- Find out if there are any further opportunities to influence the proposal and / or who may be in a position to influence the proposal and seek their support for undertaking an MWIA
- Find out if you have any existing evidence of your impact on any of the components of mental well-being identified as a priority for your proposal. For example: existing monitoring data, surveys or evaluation reports. See Section 5 of this toolkit for further ideas
- Find out if you could integrate an indicator into your existing data collection to measure your impact on any of the components of mental well-being identified as a priority for your proposal? See Section 5 of this toolkit for further ideas

Appendix 1: Screening Case Studies

Policy level – the Lancashire Local Area Agreement (LAA)

The full report for this is available on www.hiagateway.org.uk

The purpose of the MWIA was to ensure that mental health is recognised as a cross-thematic issue within the whole LAA – not just a health and social care or well-being issue, and to increase mental health awareness across the whole range of policy makers in the county. The aim was to develop a cross-thematic action plan to address community well-being with commitment and ownership across the whole LAA.

The desk top screening tool was used with each LAA thematic group which also helped to identify priority mental well-being indicators for each theme for mental well-being. We then completed the community profiling and collation of the evidence base – linking into the Joint Strategic Needs Assessment process - and organised a multi-agency stakeholder event for each indicator. The screening process helped to prioritise which themes and indicators to work on. The first workshops were for NI 153 (working age people claiming out of work benefits) and this identified priority actions such as addressing personal development, confidence and self-esteem rather than just focusing on vocational skills when supporting people back to work; working with employers to increase their mental health awareness, skills, and how to support the mental health of employees.

Service level – Warwickshire Resource Cafés

The full report for this is available on www.hiagateway.org.uk

Warwickshire's seven resource cafés offer a service to those individuals in the community who have identified mental health problems (including common mental health problems and dual diagnosis) who are over 18 years of age. The aim is to work with service users (many of whom have been in long term institutions) to enable them to live healthily and make life changes that would both improve their mental health and their quality of life. New contracts require a move from a dependency model towards adopting a well-being focus using a self help model as well as encouraging use of Individual Budgets and

Direct Payments for beneficiaries to purchase and manage their own support care.

An hour and a half meeting was organised with the resource café leads and commissioner of the services to screen all seven cafés for their potential impact on mental well-being, and to ascertain whether further appraisal of the evidence was justified. One café did not participate further. Use of the Screening Toolkit enabled each targeted population group to be systematically assessed. It was possible for each of the six cafés to identify those groups who were not currently being targeted but who could benefit from the services. These included women, some black and minority ethnic communities and young adults.

Exploring the impact of the protective factors highlighted positive benefits such as promoting access to information and services, and social activities and networks. Areas that needed further work were the support needs for client groups that were in transition from dependency to self-help. All the resource cafés agreed that further investigation and understanding of their impacts was needed. A community profile and literature review were undertaken, and a successful stakeholder event was held.

Programme Level – Liverpool '08 European Capital of Culture

The full report for this is available on www.hiagateway.org.uk

The Liverpool 08 European Capital of Culture Company was developing a wide range of programmes designed to promote culture as well as regenerate areas of Liverpool as 08 European Capital of Culture. The Company committed to commissioning the first Comprehensive MWIA as well as assisting with piloting the evolving MWIA toolkit in 2007.

Sixteen projects and policies were screened to assess the effects of the programme on mental well-being. The screening toolkit was also used to decide whether a more intensive assessment should be carried out. The screening was undertaken during a short meeting with each project and policy team.

After the screening it was agreed that an intensive assessment should be done and include:

- Comprehensive profiling of the communities involved and affected
- A review of the published literature with reference to the potential impacts of the arts and culture on health and well-being
- A series of workshops for those projects identified through the screening process as having the greatest potential to impact on mental well-being. Funders, managers, people with a creative/ artistic role, and communities would be invited to join to bring a wide perspective on impacts and to pool ideas.

Eight project and policy teams participated in workshops: the Grants Programme, G-litter, Four Corners of the City, Mersey Boroughs Programme, 08 Volunteers, Chinese New Year, Commercial Partners, and the 08 Vision Document.

Project Level – Well London – Be Creative Be Well

Well London is a three year Big Lottery funded well-being programme delivered by seven partner organisations across 20 Super Output Areas (SOA) in London. One of the target areas is Broadgreen in Croydon. A project commissioned by the Arts Council (a partner in Well London) aimed to refurbish and redesign the interior of the local community resource centre to enhance and transform how the centre was used and the impact it had on community well-being.

With the design and refurbishment already underway, the MWIA screening tool helped identify the potential impacts of the refurbished centre on the mental well-being of the community and helped identify what was needed to ensure maximum impact from the investment once the refurbishment was complete. The screening highlighted key ideas and issues, for example, increasing access to the building, how decisions are made about activities, identifying organisations who may like to host activities / outreach sessions at the centre.

Appendix 2: Lambeth Expert Patients (available: www.hiagateway.org.uk)

An example of how to fill in the screening table:

Enhancing control

MWIA question: How does the Expert Patients Programme project impact on people's control?

Protective factors for the Expert Patients Project (A six week programme for people with chronic long term conditions to enable them to maintain independent living)	Likely impacts (e.g. positive or negative) * those most important	Comments or recommendations
Individual/lifestyle • Maintaining independence	*Positive & negative*	Positive – helps to develop patients' knowledge of support services and grants available, and how to access them. Negative – not all patients who could benefit from the programme are using it. Recommendation – need to do more work to promote the programme.
Community/organisation • Opportunities for expressing views/being heard	*Positive*	Views encouraged from all participants to enable people to learn from each other. Recommendation – encourage more opportunities for expressing views e.g. with GPs.

The Mental Well-being Impact Assessment Assessment Process

Section 4 describes how to do a complete MWIA:

- **screening** – deciding whether to do an MWIA
- **scoping** – planning your MWIA
- **appraisal** – gathering and assessing the evidence
- **indicators** – to measure impact on mental well-being (covered in detail in section 5)
- **formulating** – recommendations, monitoring and evaluating your MWIA

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Figure 4.1: Overview of MWIA process

Screening – Deciding should you carry out an MWIA?
Making an initial assessment of your proposal and deciding if further investigation is required

↓

Scoping – How you will carry out the MWIA
Initial policy appraisal, community profile, options for geographical boundaries and assessment of impacts.

↓

Appraisal process – gathering and assessing the evidence
- Community profiling
- Stakeholder and key informant – MWIA workshop
- Research such as Literature Review

↓

Identification of potential positive or negative impacts

↓

Identification of indicators
for monitoring impacts of your proposal on mental well-being and implementation of recommendations

↓

Identification of recommendations and report

Top tips for MWIA

- *Good knowledge of mental well-being isn't essential as all the information is in Sections 2 and 6 (Resource A).*
- *Keep your first MWIA small and manageable*
- *Have something clear to assess*
- *Time – is it the right time for the MWIA to take place? Do you have enough time committed to do the MWIA?*
- *Work as a team and use the different strengths and skills of team members*
- *Have a small budget to carry out the MWIA to pay for things like venues and refreshments*

4.1 Introduction

This part of the toolkit presents an overview of the theory and methods behind all the stages of the MWIA process and offers guidance on how to undertake each stage.

4.2 What are these stages about?

MWIA follows a series of stages that have been adapted from The Merseyside Guidelines on Health Impact Assessment (HIA)[1].They have been adapted over time after applying in around 500 MWIAs which included feedback from the people involved and those who have been trained in MWIA. By following the entire process (see Figure 4.1) it is reasonable to conclude that a robust MWIA process has been undertaken. However, by undertaking part of the process, such as the Screening stage only, it will be possible to gain sufficient understanding of the potential impact of MWIA and develop an action plan. It is important to acknowledge that this does not constitute an MWIA. In section 6 of this toolkit you will find a range of tools such as sample invitations, programmes, facilitators' notes, exercises and a sample evaluation form to assist you with holding MWIA workshops.

Having undertaken the **Screening** process (section 3 of this MWIA toolkit) and decided that further investigation of potential impacts is needed or desirable, the next stage is to **Scope** the MWIA. Having Scoped the MWIA the next stage is to **Appraise** all the evidence that will be used, to make a more thorough investigation of the potential impacts and to produce recommendations on how to maximise positive and reduce negative impacts. Having appraised the proposal, the next stage is to identify and/or develop **Indicators** to monitor the impacts of the proposal on mental well-being (section 5 of this MWIA toolkit). Finally, to formulate a set of evidence-based **Recommendations** designed to inform the decision makers. Running throughout the MWIA process should be monitoring and **Evaluation** of the process and eventually monitoring and evaluation of the impact.

4.3 HOW TO UNDERTAKE THE MWIA PROCESS

Screening Stage

Screening is a crucial first stage in the MWIA process. It is a systematic short desktop process and can be undertaken by a small number of people (depending on the scale of the proposal being assessed). It is designed to:

- Make an initial assessment of the potential impact of a proposal on mental well-being. In some cases this has provided enough information and no further assessment action is required
- Assist with deciding if further investigation of the impacts is required i.e. the rest of the MWIA process. This enables the best use of available resources and should ensure there is a willingness to respond to the findings of the subsequent MWIA

Section three of this MWIA toolkit provides a 'Screening Toolkit' that provides instructions and a systematic assessment process which should be undertaken as early as is possible in thinking about undertaking MWIA – to allow for sufficient time to do the rest of the MWIA process.

If you have already undertaken the screening process and identified a need to undertake a complete MWIA process please move onto the next stages.

Scoping Stage

Scoping is the next stage and is about identifying and establishing the practical foundations for the MWIA.

Table 4.1: Scoping

Key Scoping tasks include: Scoping the proposal

- **What scale of MWIA** are you planning to do? Is it a relatively manageable one or will you need to investigate many strands in some detail?
- What are the **boundaries for the MWIA** in terms of time, place, relevant population groups and/or geographical area?
- Which **decision makers** need to be involved? How will you link to the decision making process for making changes to the proposal based on the recommendations of this MWIAl?
- When are the proposal's **key decision points?** What time is available to undertake the MWIA? It is best to start the MWIA as early as possible to have the best chance to influence the decision making process
- How are you going to ensure an **open and transparent process** which allows all stakeholders to express a view and manage potential controversy or confidentiality concerns?

Scoping the MWIA Process

- **How and by whom** will the MWIA process be overseen? If you are planning a small scale MWIA you would need to bring a small number of people together to help you undertake the process. If you decide to undertake a larger scale MWIA you may need a Steering Group. It is best to keep this group limited in number (max 8). A list of who needs to be recruited is included below. This group will also oversee and monitor the MWIA through to the end of the process, including presenting and lobbying for the recommendations to be accepted
- Which **specialists, practitioners and skills** could usefully be involved? What skills are you going to need, and how will you access them? (see discussion below about the Steering Group)
- How will **responsibility** be divided up for the different MWIA tasks? Who is doing what?
- What **financial resources** are required and available? Will you need to pay for venues, refreshments, crèche, translation etc.?
- What **range of methods** will be used, given the resources available, to gather the evidence base needed to undertake the MWIA? E.g. for the community profiling, literature review, stakeholder workshop
- How can a **wide range of people affected** by the proposal be enabled to give their views and experiences on the likely impacts?
- How will the process be **monitored and evaluated**?

Setting up a Steering Group

It is important to recognise that people have differing views about what mental well-being means for them. Also, that those in a policy-making, a service/project delivery role and community members may all have different priorities and perspectives. If undertaking a larger scale MWIA, it is advisable to set up a Steering Group to advise, oversee and monitor the MWIA.

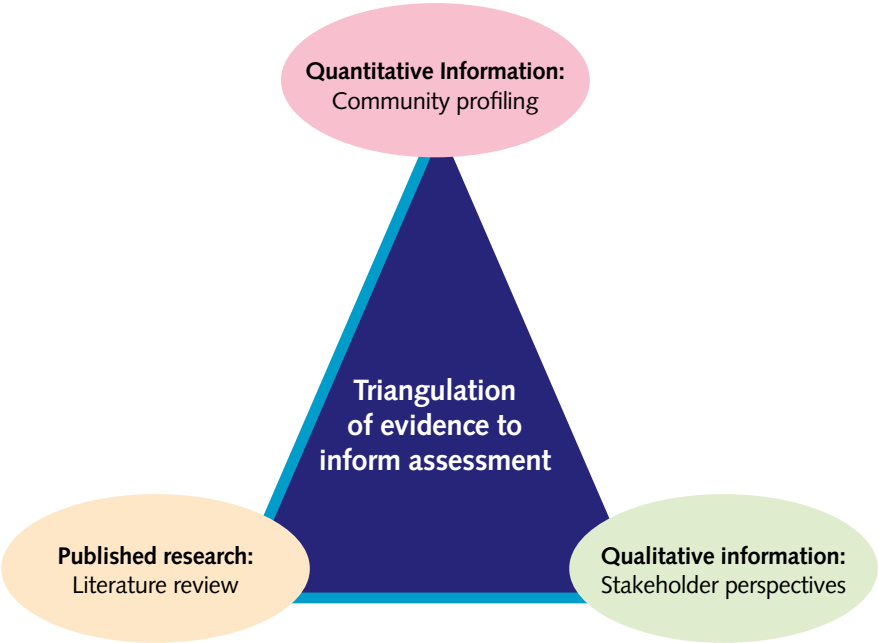
This could include:

- A chair person who can keep the Steering Group focused and linked to the decision makers
- The lead for the proposal – this person needs to be familiar with the proposal
- Someone who can project-manage the MWIA process
- Someone who has knowledge of the demography of the affected population/community, such as an Information Analyst
- People who are able to access relevant 'stakeholders' to your proposal such as planners, elected members, trade unions, health and local authority staff etc
- More than one person who can bring views and experiences from the affected population/community and who can advise on how to access these (this enables community representatives/advocates to be involved with the MWIA from the start)

Appraisal Stage

This stage is often referred to as the 'engine room' of the impact assessment process. It involves collecting a range of 'evidence' to inform the development of recommendations that should influence the policy, programme or project, (hereafter referred to as proposal) which is subject to the MWIA. It is important when making an assessment to have relevant and credible information/evidence to use – the type and quantity varies with the level of assessment. There are generally three forms of evidence used as depicted in figure 4.2:

Figure 4.2: Forms of evidence used in MWIA



- **Quantitative information: Community profiling** – collecting demographic and health and well-being status information about the population likely to be affected
- **Published research: Literature review** – published or 'grey' literature on potential impacts of the interventions under investigation on mental well-being, and on protective factors, reviewing previous MWIAs or other forms of impact assessments such as HIAs on similar interventions. If you have the resources and are undertaking a larger scale MWIA you might interview 'expert witnesses' and / or key informants
- **Qualitative information: Stakeholder perspectives** – collecting information from original field work, such as workshops, one-to-one interviews, site visits or other participatory techniques as well as previous consultations or MWIAs.

Appraisal Task 1:
CLARIFYING THE PROPOSAL

Before collecting the 'evidence' it is important to have a clear understanding of the proposal that is subject to the MWIA. Answering the following questions may help:

- What is the rationale, context and strategies or themes for the proposal under consideration
- Which populations or communities likely to be affected by the proposal
- Who are the relevant stakeholder and key informants
- What is the relationship of the proposal to other relevant policies, services, programmes or projects
- Are there any results from previous assessments or evaluations of similar proposals
- Are there any results from previous stakeholder consultations on the proposal

How to do it

This could consist of an analysis of three types of documents:

- The proposal plan and supporting documents
- Other policies and official documents that relate to the proposal under investigation
- Evidence of the social, economic, political, cultural and scientific context for the proposal

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Appraisal Task 2:
Quantitative Information: COMMUNITY PROFILING

Top tips

- *Be specific and focused on community profile research*
- *Draw on local expertise such as the Public Health Department of your Primary Care Trust (PCT) or Information Unit in the Local Authority*
- *Draw on easily available data such as local authority profiles and information from Public Health Observatories such as Health Profiles developed on specific areas*
- *Identify and make clear any information that you could not obtain such as equality/minority target population groups*

Compile a brief profile of the areas and population groups and/or communities likely to be affected by the proposal. If you are undertaking a small scale MWIA this should be no more than two sides of A4, and in more detail if a larger scale MWIA is undertaken. This should draw on socio-demographic, health and well-being data and community knowledge to ensure a robust understanding of current health and mental well-being status of the population groups that you might need to consider some of which will have been highlighted and prioritised in your screening process.

The emphasis should be on mental well-being of the population groups you have identified together with their experience of the wider determinants of health relevant to the proposal being assessed, using the list below:

1. Physical security e.g. housing, safety at home and in the neighbourhood
2. Environment e.g. green space, safe play space, quality of the built environment
3. Meaningful activity e.g. employment, volunteering
4. Good quality food e.g. affordable, accessible
5. Leisure e.g. arts and creativity, sport, culture
6. Education e.g. lifelong learning, pre-school
7. Financial security e.g. income, credit, assets, economic environment
8. Transport e.g. affordable, accessible, sustainable

This information will be used to inform the appraisal, and then contribute to a baseline to monitor impacts.

How to do it

Top tips

- *Use the population groups table in the screening toolkit (section three of this MWIA Toolkit) as a guide to gathering information on your target community*
- *Look on organisational websites for data and information such as the local Joint Strategic Needs Assessment, Annual Public Health Report or on the regional Public Health Observatory website*
- *Draw on data you already have on your target community*
- *Keep this work within your resource limits e.g. spend no more than two days on it*

Section 2 of this MWIA Toolkit, The Evidence Base, discusses how particular population groups are differentially at risk of poorer mental well-being. During the screening process you should have considered which of your population groups are likely to be affected, either positively or negatively, by your proposal. In your Screening exercise you will have identified the population groups that you will now collect data on. Check what data you have on these groups or what other organisations have and identify any gaps in the information. Other population groups may become identified as you work through the process.

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From the profiling identify:

- Particular target groups that are of interest or concern to you
- Other groups who will be affected by the proposal
- Groups that may be (unexpectedly or indirectly) negatively affected by the proposal.

If you are running a MWIA workshop, you should have prepared this work in advance and be able to present a brief summary of the findings, while ensuring that people who can represent the population groups of greatest interest or concern attend the workshop wherever possible. It is then helpful to check out this information with the stakeholders and key informants before the workshop. An exercise is provided in the facilitators' notes in Section 6 of this MWIA Toolkit, Resource E on how to run a MWIA workshop.

Appraisal Task 3:
Published research: LITERATURE REVIEW

Top tips

- *Work as a team and use the different strengths and skills – there might be someone who prefers to do desktop research rather than facilitation*
- *"Prepare the evidence base – put time and effort into this"*
- *Keep the research focused to the main interventions in your proposal – it's too easy to generate too much information for the time available*
- *Look at existing MWIAs and use our reference lists such as those in Section Two and Six, Resource K*
- *Identify if other Impact Assessments such as HIAs or Equality Impact Assessments have considered similar proposals and used evidence or formed conclusions relevant to mental well-being*

This forms part of the evidence base for the appraisal. It can include:

- Evidence which includes published work such as scientific (research) literature published in peer-reviewed journals and grey (unpublished) literature such as local project reports. In addition, Section Two of this MWIA Toolkit is based on a comprehensive review of the published literature on mental well-being and can be used in your MWIA
- Other MWIAs, HIAs or other Impact Assessments that might have been undertaken on similar proposals
- Information from previous consultations or evidence gathered on the proposal, or other relevant proposals

There are useful guidelines compiled by Mindell *et al* [2] '*A Guide to Reviewing Evidence for use in Health Impact Assessment*' to support good practice.

How to do it

In producing this toolkit there has been a comprehensive search of the literature (Section Two) identifying what affects mental well-being and what helps to improve it, including the protective factors that constitute the MWIA criteria. This information has been discussed and piloted with a wide variety of communities and specialist workers. This, in turn, has informed the MWIA Population groups and Protective Factors in Section 6 of this MWIA Toolkit, in Resource A.

In undertaking a small scale MWIA, there should be a short review of the literature (recommended time is three days on this) and there should be no need to undertake primary research. However, if undertaking a larger scale MWIA, there might be a need to do further reviews of published research with relevance to your proposal. There is a useful list of sources of evidence in Sections 2 and 6 of this MWIA toolkit that should assist you with this, as well as many published MWIAs on a wide variety of subjects available on www.hiagateway.org.uk

Appraisal Task 4:
Qualitative Information: STAKEHOLDER EXPERIENCE
(Holding an MWIA Workshop)

Top tips

- *MWIA is an effective way of increasing stakeholder awareness and aspiration for promoting mental well-being*
- *MWIA is active participation rather than passive consultation*
- *Preparation is the key, make time for planning, have a rehearsal, visit the venue beforehand, assess wall space availability, review health and safety considerations*
- *Facilitators need to know the process and material, adapt the material/language to meet your needs – but don't stray from the evidence base*
- *Good facilitation skills are required*
- *Trust and be positive about the amount of time involved*
- *Prioritise which protective factors you really need to focus on – use the information from your screening activity*
- *Offer an open invitation to anyone with an interest or likely to be affected by the proposal. Try to include all stakeholders identified from the screening and scoping assessment – offer an incentive to attend*
- *Make it as interactive as possible*

The process of MWIA requires broad participation, as people have different perspectives and experiences of mental well-being, as well as bringing local knowledge to the process.

The benefits of including community members/stakeholders and key informants (expert witnesses) in the MWIA are that it:

- Provides information about the proposal to those affected
- Improves quality of assessment, by ensuring that the potential health impacts identified will match local experience
- Provides opportunities for stakeholders to express and consider concerns, and to submit their own evidence or suggestions to maximise positive or reduce potential negative impacts
- Can help manage expectations and misconceptions
- Improves the quality of the final decision, as local needs can be reflected and tailor made responses and recommendations developed
- Affirms transparency of the process by opening to public scrutiny and helps to inform indicators

Other benefits we have found[3] in developing MWIA workshops is that when a range of people have had the opportunity to get together and assess a proposal that partnerships and networks have been strengthened. Ownership, networks and actions to improve proposal delivery are also more likely to take place when people responsible are involved.

How to do it

The collection of data on potential mental well-being impacts involves qualitative research with the stakeholders and key informants. Balancing an open invitation to all with an interest or likely to be affected by the proposal with ensuring those who are less likely to attend and whom might be negatively affected can be a challenge. Selecting those who should be included, and how many people, is dependent on the nature of the MWIA. The MWIA Screening process should have started to identify these groups. Stakeholders who have knowledge and a particular interest in the proposal can be identified from the Community Profile and appraisal of the proposal, by the steering group and local community workers. You should also consider how to include views and experiences from those who are likely to be affected, but who are less likely to be heard or to give their views.

Before the evidence is gathered it is important to ensure that you have tried to get a 'representative' sample based on priorities identified through the Community Profile and that you use a consistent method of collating the information.

Methods for collecting stakeholder evidence does not have to be only through a workshop and could include one-to-one interviews, focus groups, video diaries, questionnaires, site visits and secondary research such as reviewing previous consultation exercises. This should have been considered as part of the Scoping process.

We recommend running one or a series of workshops. Guidance and materials on how to hold a **'stakeholder' workshop** is given in Section 6 of this MWIA Toolkit. Table 4.3 below will help you identify the resources you may need:

Table 4.3:
Resources in Section 6 of this MWIA Toolkit to assist with an MWIA Workshop

- **Resource A** Population group, wider determinants and protective factor tables
- **Resource B** Preparation check list for holding a workshop
- **Resource C** Sample invitation letter
- **Resource D** Sample programme
- **Resource E** Facilitators notes
- **Resource F** Flipchart templates
- **Resource G** Sample evaluation form
- **Resource H** Statements and definitions of Mental Health, Well-being and Mental Well-being.

These resources are intended as guidance and not to be prescriptive – please adapt to your own use but stay within the evidence base framework. The more interactive you can make the process the better, including encouraging stakeholders to explore their own understanding of mental well-being, while at the same time balancing this with an input of research evidence.

Who might your 'stakeholders' be?
Your stakeholders should include:

- The lead for the proposal – this person needs to be familiar with the proposal
- Someone who has knowledge of the demography of the affected population/community (or if you cannot secure this – access to this type of information)
- Someone who is involved with delivering the proposal
- People who can bring views and experiences from the affected population/community
- Experts whose knowledge is relevant to the proposal (or particular aspects of it), and who may or may not be from the locality concerned
- Relevant health (or related) professionals
- Workers from relevant voluntary organisations
- Key decision makers
- Any other partners involved with the proposal

Appraisal Task 5:
IDENTIFICATION OF POTENTIAL POSITIVE OR NEGATIVE IMPACTS ON SOCIAL DETERMINANTS AND PROTECTIVE FACTORS OF MENTAL WELL-BEING

Top tips:

- *Use the set of evidence based tables, Resource A in Section 6*
- *Use Resource E (Section 6) to explore different understandings of mental wellbeing*

As discussed in Section 2 of this MWIA toolkit, understanding and using the evidence base for mental health and well-being are the foundation of the MWIA criteria. Resource A in Section Six presents the wider social determinants and protective factors for mental well-being. The evidence base for the impact on mental well-being of the socio-environmental model has been appraised and factors relevant to mental well-being have been incorporated into the protective factors. The factors have been based on reviewing the evidence and in piloting the toolkit. These are included to act as a guide to your assessment.

It is also important that, at a local level, there is a discussion as to what the understanding of mental well-being is, and if the model in this toolkit is the most appropriate model to use. There are a variety of websites, some of which are listed in Sections 2 and 6 of this MWIA toolkit, that can help to access background reading on mental health and well-being to support this understanding.

How to do it

In bringing stakeholders and key informants into the MWIA, it is important to establish a common understanding about mental well-being. In Section 6 of this MWIA Toolkit, Resource E offers two suggested exercises that can be used or adapted to support this process. In Section 6, Resource H gives a list of facts and statements on mental health, well-being and mental well-being that can be used.

The tables that are presented in Section 6, Resource A are there to act as a guide to the stakeholders and provide a list of topics you will need to collect evidence on. They can be used in workshops, adapted for one to one interviews, focus groups or desktop appraisals. These tables are the population groups, wider determinants and three protective factors with their respective components against which you will assess your proposal.

We recommend a stakeholder workshop and the outline and exercises for undertaking the steps are in Section 6 of this MWIA toolkit, Resources A to H.

Appraisal Task 6:
ANALYSIS OF MENTAL WELL-BEING IMPACTS

Top tips

- *Don't panic at the amount of information you have collected!*
- *Be systematic in collecting and using the information based on the MWIA assessment criteria*

As described earlier, the MWIA process should include bringing together different forms of evidence. It is important to be clear about the status of this evidence:

- How representative were your stakeholders? What are the gaps? Be clear about those who were not included
- How extensive was your literature search?
- What is the status of the published research? Was it one study, or were the findings consistent from several?
- How comprehensive was your community profile, and where are the gaps?
- Is the language used to describe the evidence appropriate for the target audience?
- What is the weighting of qualitative evidence to quantitative evidence?

- What are the limitations of your evidence – what was it not possible to collect?
- Who are you trying to influence? What form of evidence will be seen to be credible? (i.e. if you are trying to influence clinicians you will need to have some quantitative type evidence; however, if it is a regeneration programme stakeholder evidence will be important)

How to do it

It is best to document your MWIA process and findings as you go along, and use a consistent format. The templates presented for use in the stakeholder exercises can form the basic framework. The task is then to compile all your findings to identify the degree of consensus from the various forms of evidence, and to be clear where there are discrepancies or gaps in the evidence base.

So for example the likely consistency of 'expert' and 'community' perceptions of probability (i.e. risk), frequency and severity of important impacts could be described via a simple matrix (completed example below in Table 4.4). The greater the likely consistency (i.e. the greater the likely agreement between expert and lay perceptions of important impacts), the more emphasis on the findings is warranted. The 'precautionary' principle should also be used: if there is a likelihood of negative impact – even though the evidence is not substantial – the risk should still be given priority attention, even if the recommendation is only to do further research into the risk.

Table 4.4: Risk assessment matrix (example)

Expert/lay Consistency	Aspect of potential impact		
	Probability	Frequency	Severity
High		X	X
Low	X		

(Source: Scott-Samuel 2006, personal communication)

Ranking and researching the most important impacts

Top tip:

- *Don't lose sight of all three sources of evidence*

As in most impact assessment investigation, many potential positive and negative impacts will be found. It will not be possible to explore all in great detail; hence impacts will need to be prioritised. This should be an iterative process, whereby all stakeholders who contribute evidence should be encouraged to prioritise as part of the process during the workshops and with others, when undertaking the final appraisal of all evidence collected if undertaking a Comprehensive MWIA.

How to do it

The prioritisation can be undertaken at a number of levels:

- By the Steering Group in the 'Scoping' stage, by identifying the criteria for selecting the impacts such as those most likely to have significant negative impacts on communities, those for which there is a realistic solution, those offering value for money
- By stakeholders: the criteria identified by the Steering Group can then be used to inform questions posed during the stakeholder interviews or workshops
- At the Workshops: using the prioritisation exercise described in the facilitators' notes in Section 6 of this MWIA toolkit, Resource E
- During Evidence Collection: using criteria based on the Measurability and Degree of risk identified in the evidence
- At 'Consensus Workshops' in larger scale MWIAs: it might be worth considering holding a 'consensus workshop' for stakeholders to consider the findings and comment on the conclusions

The following tasks follow on from a completed appraisal process.

FORMULATING INDICATORS TO MONITOR IMPACT ON MENTAL WELL-BEING

It important to consider monitoring the impact the proposal will have on the community's mental well-being. To produce a set of indicators to assist with monitoring see Section 6 of this MWIA toolkit. This can be undertaken as a follow on desktop exercise following the appraisal of the proposal.

The development and use of the indicators to monitor subsequent impacts on community mental well-being would then form part of the recommendations of the MWIA, and be evaluated as discussed below.

Section 5 of this MWIA toolkit presents information and a framework for identifying and developing appropriate indicators for measuring mental well-being.

FORMULATING RECOMMENDATIONS AND PRODUCING A REPORT

This stage follows on from the appraisal tasks.

Top tips:

- *Prioritise!*
- *See examples of MWIA reports on www.hiagateway.org.uk*

One outcome of undertaking the MWIA process will be the raising of awareness and understanding of mental well-being which is highly valued by participants. In addition the principal outcome of an HIA is a set of evidence based recommendations. Hence, it is also important that having appraised the evidence a set of recommendations designed to influence decision makers or proposal delivery are also produced. These recommendations should be aimed at 'maximising potential positive and mitigating against potential negative' impacts on mental well-being. Occasionally one main recommendation emerges that can be substantiated by all the evidence. More usually, long lists of possible recommendations emerge.

How to do it

As with ranking impacts, there should be a prioritisation process. The following characteristics are likely to require consideration:

- The stage(s) of proposal development – how much time or space is there for negotiating changes to the delivery? Be realistic about this!
- The mental well-being determinants that are likely to be affected. Which ones are of greater concern?
- The nature of these effects and the probability that they will occur. How certain are you of the evidence base? If not totally certain, do you have enough to justify a recommendation? If the concern is significant about a potential negative impact, then it might be better to make a recommendation (precautionary principle) – but be honest about the status of the evidence
- The organisations and political willingness available to implement the recommendations
- The social equity and acceptability of the recommendations
- The resources including costs of the recommendations being implemented
- How the implementation of the recommendations will be monitored.

The final product from the MWIA should be a report that sets out the process you undertook, the findings in summary form (place the detail into Appendices) and the recommendations you have identified. The format and language used should be appropriate for the decision makers who will be responding to the findings. There are many examples of MWIA reports on and a template for writing the report are available at www.hiagateway.org.uk.

EVALUATION OF THE MWIA

This is generally an underdeveloped area in HIA, as currently efforts are focused on undertaking the process of the impact assessment and influencing decision makers, rather than spending the time to identify how and why the process may or may not have worked well. Nevertheless, it is important that lessons are learned from undertaking MWIA and then disseminated for those who follow, and to improve practice. Clarity is especially required around evaluation; monitoring processes will follow more or less automatically once appropriate evaluation formats are agreed.

Evaluation in MWIA consists essentially of the elements shown in table 4.5

Table 4.5: Evaluation elements for MWIA

What to evaluate	Type of evaluation	Type of evaluation data	Nature of evaluation data	How to do it
Achievement of Terms of Reference of MWIA	Input/process/ output	Qualitative	Descriptive and/or checklist	This can be in the form of simple evaluation forms (a sample form is presented in Section 6 of this MWIA toolkit, Resource G), use of pre and post interviews with stakeholders, and/or observing the MWIA process.
Impact of MWIA on decision-making process	Impact	Qualitative	Descriptive	Monitor whether recommendations were accepted, and in the longer term, whether MWIA indicators were helpful in identifying a change in mental well-being
Impact of MWIA on the public health	Outcome	Qualitative and/or quantitative	Descriptive and / or numerical	Monitor the MWIA indicators in identifying a change in mental well-being.

(Source: Scott-Samuel 2006, personal communication)

It is helpful to think about the type of questions that could help with identifying process and impact data. These could include:

Table 4.5: Evaluation questions

Process: Questions to ask	Impact and outcome: Questions to ask
1. How was the MWIA undertaken? Did it follow best practice?	1. Did the MWIA change participants' awareness and understanding of mental well-being, and if so, how?
2. Did it make best use of available resources?	2. Did the MWIA process help to identify impact on mental well-being in a way that could be built upon by the proposal and participants?
3. What evidence was used, and did it help inform the conclusions of the MWIA?	3. Did the MWIA process identify indicators to measure mental well-being? Were these adopted? If not why not?
4. How were health inequalities assessed in relation to mental well-being?	4. Did the MWIA process identify recommendations that were adopted? 5. Yes/No 6. If not, why weren't they?
5. How were recommendations formed and presented to decision makers?	7. Were the aims and objectives of the MWIA met?
6. What did those involved think of the process?	8. Were there any unexpected outcomes from the MWIA?
7. Others?	9. Others?

Source: Taylor *et al*. 2003[4]

4.4 Summary

Once all these stages of an MWIA have been followed through to a completed assessment the following should have been achieved:

- An increased understanding and awareness of mental well-being across the range of your stakeholders
- An increased understanding of which population groups are impacted upon by your proposal and the distribution of those impacts
- An increased understanding of how your proposal impacts on mental well-being for your target audience – both positive and negative
- Recommendations agreed that seek to maximise positive and minimize negative impacts

Section 5 of this MWIA Toolkit will enable a detailed exploration of how those impacts are or could subsequently be measured.

References for section 4 of MWIA Toolkit

[1] Scott-Samuel,A., Birley,M., Ardern,K (2001). *The Merseyside Guidelines for Health Impact Assessment.* Second Edition, May 2001. Liverpool,UK: International Health Impact Assessment Consortium. (available: http://www.lho.org.uk/Download/Public/10846/1/Reviewing%20Evidence-Final%20v6.4_230806.pdf)

[2] Mindell J, Biddulph JP, *et al*. *A Guide to Reviewing Evidence for use in Health Impact Assessment.* London: London Health Observatory, 2006 (available: : http://www.lho.org.uk/viewResource.aspx?id=10845)

[3] Cooke A, Stansfield J (2009) *Improving Mental Well-being through Impact Assessment: A summary of the development and application of a Mental Well-being Impact Assessment Tool.* London: National Mental Health Development Unit

[4] Taylor,L.,Gowman,N.,Quigley,R. (2003) *Evaluating health impact assessment* London,UK: Health Development Agency (available: http://www.apho.org.uk/resource/item.aspx?RID=83401)

Measuring Mental Well-being

Section 5 provides an overview of the policy context and benefits of monitoring the subsequent impact of a proposal on mental well-being following the MWIA process. It contains detailed guidance on **identifying and developing indicators** to complete the MWIA process.

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Top tips for mental well-being indicators

1. *Establish what you, partners and other organisations are already measuring and how these might relate to mental well-being – don't re-invent the wheel*
2. *Be realistic in determining how many indicators to use – prioritise using the findings from the MWIA and what your reporting requirements are*
3. *Involve performance management staff at the scoping, appraisal and indicator stages to ensure ownership and alignment with their systems*

This section of the MWIA Toolkit looks at monitoring mental well-being. It explores what is meant by mental well-being with regard to its measurement, considers the current policy context to measuring mental well-being, explains why measuring mental well-being is useful and provides guidance on choosing and developing indicators for monitoring mental well-being as the final stage of your MWIA.

5.1 Policy context to measuring mental well-being

This is the right time to be building measures of well-being into a service or project. The policy context for measuring well-being has increased significantly over recent years and momentum continues to grow around the importance of measuring well-being outcomes.

The most recent, and perhaps most significant, policy announcement in this area came from Prime Minister David Cameron in November 2010. He asked the Office for National Statistics (ONS) to lead a programme of work exploring how best to measure national well-being, and announced the inclusion of subjective questions measuring well-being in one of the largest government surveys, the Integrated Household Survey, from April 2011.

This development comes after a growing number of calls for this sort of approach: for the development of an 'over-arching mental capital and wellbeing measure akin to the Communities and Local Government's (CLG) Index of Multiple Deprivation' (Foresight 2008)[1] and for governments to introduce and systematically measure National Accounts of Well-being (New Economics Foundation 2009)[2]. Sir Michael Marmot's Strategic Review of Health Inequalities in the England post 2010[3] also called for a national wellbeing indicator to be developed and implemented as a national target on health inequality.

In fact, central government and the wider public sector have been producing and using measures of well-being for some time. In 2007 the government published national indicators associated with well-being as part of its sustainable development indicator set, drawing together a cluster of existing measures and new survey data on subjective well-being. This included constructs such as positive and negative feelings, life satisfaction, and engagement in positive activities (Defra 2007)[4].

NHS Health Scotland also pioneered a programme of work to develop a set of standard measures (indicators) that can be used to gauge changes in the mental health and well-being of Scotland's population[5]. This led in part to the introduction of the Warwick Edinburgh Mental Well-being Scale (WEMWBS)[6], which is now being included in a number of major surveys, such as the Health Survey for England.

The Public Health White Paper *Healthy Lives Healthy People*[7] outlined a specific public health outcomes framework, linked to outcomes within social care and health care. The five proposed public health outcome domains are:

1. Health protection and resilience
2. Tackling wider determinants of health
3. Health improvement
4. Prevention of ill-health
5. Healthy life expectancy and preventable mortality

The National Mental Health Development Unit in its special briefing (January 2011)[8] recognised each of these domains as being highly relevant to public mental health. Each domain contains indicators similar to the factors included in the MWIA tables. The third domain specifically includes an indicator on self reported wellbeing.

5.2 Background to measuring mental well-being

There has been no single, agreed definition of mental well-being or well-being currently in use across central or local government, among health authorities, the voluntary and community sectors. In fact, there are many different theoretical approaches as to what constitutes well-being and how to measure it (Dolan *et al*. 2006; Thompson and Marks 2008)[9, 10]. Definitions commonly refer to well-being as feeling good and functioning effectively.

The Government Office for Science's Foresight Review on Mental Capital and Well-being (2008)[11] cemented cross government commitment to addressing well-being. It defined well-being as "a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community". The Foresight Review also highlights the distinction between measuring mental illness and measuring the positive aspects of well-being, including positive emotions (e.g. happiness, contentment, interest), positive attitudes towards oneself and others (e.g. optimism, autonomy) and positive behaviours (e.g. pursuing valued goals, healthy lifestyle, pro-social behaviour). It suggests well-being can be most usefully thought of as a dynamic process that gives people a sense of how their lives are going through the interaction between:

- **their circumstances**
- **their activities**
- **their psychological resources or 'mental capital'**

Measuring well-being should ideally encompass each of these dimensions and assess the extent to which they combine together to provide an overall sense of how a person feels about their life and how well they function in life.

For the purposes of developing indicators within an MWIA we draw on a range of approaches, resources and tools in order to measure mental well-being and well-being. For example:

- A social model of health which emphasises the social determinants of mental well-being (protective factors and components) e.g. employment
- Methodologies that measure specific psychological attributes relevant to mental well-being such as self esteem, optimism
- Other subjective well-being measures such as life satisfaction or feelings about the local area

The Office of National Statistics (ONS) has announced the four subjective questions measuring well-being which are being included in the Integrated Household Survey from April 2011. They cover evaluation of life as a whole, emotional well-being and a question which starts to address functioning in life, about valuable activities. These questions do not cover all aspects of well-being and still have 'experimental' status. However, including them within a set of well-being indicators allow the levels of well-being of the specific group of interest to be compared with those of the UK population as a whole.

The four questions are:

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

5.3 Why develop indicators of mental well-being?

Developing indicators to enable the measurement and monitoring of the impacts of the proposal on mental well-being is an important next step for a number of reasons:

- It encourages stakeholders to monitor the effectiveness of proposals
- It helps demonstrate to commissioners and funders the impact and outcomes that a proposal is having
- It helps identify links for proposals to local and national agendas and policy
- It helps to develop the evidence base for what makes a difference to mental well-being
- It enables all stakeholders to identify what might be an appropriate measure to use and to assess whether the proposal does go on to have the predicted positive impacts that were identified by the MWIA
- It enables stakeholders to monitor whether any improvements to the proposal are making any difference in reducing potential negative impacts i.e. have your recommendations made a difference

5.4 The outcome framework for MWIA

The outcome framework in table 5.1 sets out the indicators that can be used to measure mental well-being arising from undertaking an MWIA. The ultimate outcome is improved mental wellbeing of the target population. This is not impossible to measure but it is resource intensive. Using a logical approach, other indicators can be measured at each stage leading to this outcome. A process, or input, indicator measures what activity has taken place such as conducting an MWIA with stakeholders. The next stage is to measure what immediately arose from that activity, the outputs, such as a set of evidence based recommendations were agreed. Both of these indicators are easily measured and recorded. The next stage is to measure what impact both of those had. An indicator of the impact of undertaking an MWIA is that the recommendations are implemented and improvements are then made to the proposal so that it has a positive impact on mental wellbeing. This is the immediate purpose of undertaking MWIA and therefore crucial throughout the process – ensuring from the beginning (screening) that it is possible to make changes and at the end to follow up that changes have been made. It may take a while to see the changes happen, depending on the planning cycle of your proposal.

Table 5.1: The outcome framework for MWIA

Process	Output	Impact	Outcome
Mental Wellbeing Impact Assessment undertaken with stakeholders	Set of evidence based recommendations agreed	Improvements made to proposal (which maximise the positive impacts it has on mental wellbeing and minimise the negative)	Improved mental well-being (and/or its determinants)

5.5 Some useful considerations before you start to measure well-being

Efforts to measure well-being will be most useful when you are clear about what it is you want to find out, why you want to know this information, and what you might do with the findings. The specific well-being dimensions you select for measurement should therefore be shaped by the particular aims and objectives of your service or project.

In most cases, measuring well-being effectively will require:

- Asking people about their feelings, experiences and perceptions (often referred to as their 'subjective' or 'mental' well-being)
- Obtaining information about the external conditions and circumstances of people's lives (typically drawn from 'objective' quality of life or well-being indicators)

Most measurement and evaluation processes include at least some objective indicators but in some cases there may be a need for new surveys or research to be introduced to better measure people's own reflections on their well-being and how they feel about the wider circumstances of their lives and ability to function within it. Measuring well-being in this way can be both useful and robust. It can be done by selecting questions from existing surveys on well-being or by drawing on validated well-being measurement scales.

If you have undertaken a MWIA you will need to consider if you need to develop new indicators or use existing indicators.

This will depend on what you want to use your indicators for and whether there is an existing indicator that is fit for your purpose.

Why develop a new indicator?

- You want to measure the impact of recommendations from the MWIA on local service delivery and improvement
- You want to monitor if the proposal actually has the impact identified in the MWIA on specific subjective aspects of mental well-being e.g. optimism
- You want to engage project participants/service users in deciding how the success of your proposal is measured
- There is no regional or national indicator that measures the impact of the proposal you are assessing

Why use a national or locality indicator?

- You want to compare your impact with other similar projects and programmes
- You want or need to evidence your impact to local commissioners
- You want to link your work into local or regional strategies
- You want to evidence how the proposal contributes to local or regional strategies e.g. community safety
- You don't want to reinvent the wheel if appropriate and relevant indicators are already being collected

A mapping of indicators to MWIA factors and components is presented in Section 6, Resource J of this MWIA Toolkit to assist with identifying relevant indicators for mental well-being.

5.6 Identifying and choosing mental well-being indicators from your MWIA

This section of the MWIA toolkit follows directly on from the work that was undertaken in Section 4 of this toolkit, the Appraisal Process. From this, you should have identified the main impacts of your proposal (as it currently stands) on mental well-being. It is important to now consider identifying existing measures or perhaps new ones to monitor the progress of these impacts.

Having identified the need to develop indicators to measure impacts of your proposal it is firstly important that all stakeholders are clear about:

- Why it is important to come up with some indicators
- How they might use them
- Who they are for

The Steps are:

1. Arrange a meeting with the proposal lead, a person who is involved with collecting data on the proposal and the person who led the MWIA. Resources required are:
- A copy of the table of priority positive and negative impacts identified from the MWIA process
- Copy of the blank Developing Indicators template (section 6, Resource I)
- Copy of Table 5.2: an example of a completed template
- Selected publications from the reference list at the end of this section that could be relevant

2. Use the indicator checklist to go through the process of identifying indicators for each priority impact and record in the indicator template.

Indicator checklist:

- What factor are you looking at (e.g. control)?
- What was the primary component (e.g. decision making)?
- How do you know it is having an impact?
- How could you measure it?
- Is there an existing scale or measure that would be fit for purpose, e.g. something the proposal already collects, a regional indicator (see section 6 resource J) or an existing validated measure (see selected publications from the reference list at the end of this section)
- What will the data be used for?
- Who are the target group you want to measure the impact upon?
- Is this method appropriate or acceptable to the target groups?
- How often will you need to collect the data?
- Who will collect it?
- Who will analyse the data?
- How will the data be stored (data protection)?
- How will the data be reported on or used?

An example: The Changing Minds Programme

Changing Minds is a nine month part time course to train service users with long term mental health problems to deliver training in their communities from their perspective. The course enables service users to become trainers and to use their skills in service user involvement programmes and challenging discrimination through the training and education of professionals and people in the community. The course includes the development of training and facilitation skills; learning theory; working with others and self awareness. The Changing Minds programme used the MWIA to develop indicators of mental well-being for participants. These measures have now been integrated into the course which has been rolled out across London. An analysis of the measures can be found in a report entitled 'Changing Minds: Tackling discrimination and promoting the mental well-being of people with experience of mental health problems'[12] published on www.hiagateway.org.uk, see Table 5.4 for examples of indicators developed for the Changing Minds course.

Figure 5.2: An example completed indicator template

Factor	Priority component your MWIA has identified	How would you know that you are having an impact on this component?	How could you measure it?	Is the there an existing scale or measure: That the proposal already collects An existing regional indicator or target Other existing validated measure	Data collection What will the data be used for? Who do you want to measure the impact on? What measure could you use for the indicator?	Frequency
Increasing control	Decisions and choices Discussion by participants at the MWIA workshop revealed that attending the course had increased confidence and motivation to take difficult personal decisions	Through the process of completing the MWIA people gave a number of different examples where, as a direct result of participating on Changing Minds, they had been able to make decisions that before the course they found hard to address	To measure this impact people suggested that at the beginning of the course participants should identify things in their life that they were finding it hard to make decisions over or that they felt they had no control over. They should then review this at the end of the course to see if the situation had changed and if they felt that that change could be attributed to the course.	No No No	The data will be used to measure the impact of course on a sense of control and decision making and will form part of the overall measure of the impact on mental well-being that will go to funders. Course participants Measure: Participants to list decisions that they are struggling with in their lives at the start of course as a baseline. The list is then reviewed at the end of the course to see if any decisions have been taken or if there is other significant change attributable to the course. Data collection can be integrated into baseline and end of course data collection processes	Beginning and end of the course

Factor	Priority component your MWIA has identified	How would you know that you are having an impact on this component?	How could you measure it?	Is the there an existing scale or measure: That the proposal already collects An existing regional indicator or target Other existing validated measure	Data collection What will the data be used for? Who do you want to measure the impact on? What measure could you use for the indicator?	Frequency
Resilience and community assets	Self esteem Discussion highlighted that the course increased self esteem	People have an increased sense of self worth and belief in their own abilities	By asking people to consider their levels of self esteem before and after the project	Not currently collected but there are a range of existing validated scales of self esteem.	The data will be used to identify if the course is increasing people levels of self-esteem. It will be used by course facilitators to reflect on whether they are delivering the course in a way that promotes self-esteem On course participants Participants are asked to complete self esteem surveys at the beginning, middle and end of the course	Beginning middle and end of the course

Factor	Priority component your MWIA has identified	How would you know that you are having an impact on this component?	How could you measure it?	Is the there an existing scale or measure: That the proposal already collects An existing regional indicator or target Other existing validated measure	Data collection What will the data be used for? Who do you want to measure the impact on? What measure could you use for the indicator?	Frequency
Participation and Inclusion	Valued Role Past participants identified that going on to undertake a range of valued roles after the course had had a major impact on their well-being	After completing the course people go on to take up valued roles such as training, employment volunteering etc	By recording the valued roles that people take up after the course	This is already collected. The link should be made to the evidence that undertaking valued roles increases people levels of mental well-being	The data will be used to demonstrate recovery and inclusion outcomes for funders and also for facilitators to reflect on the success of the course in moving participants on On course participants Follow up of all participants to identify valued roles	Follow up at 6 months and 1 year

Table 5.3: Summary table of MWIA indicators developed for Changing Minds

Please note: The components listed are from the earlier MWIA toolkit – the comparable ones from this updated version are in brackets)

Factor	Component	Data collection	Frequency
Increasing Control	Decisions and choices (Control: Sense of control)	Participants list decisions that they are struggling with in their lives.	List at beginning, review at the end
Resilience	Self-esteem (Resilience: Emotional well-being)	Self-assessment scale	Beginning and end of course
	Optimism and aspirations (Resilience: Emotional well-being)	Subjective well-being questionnaire	Start and finish of each course
Participation and Inclusion	Social contacts/support networks (Resilience: Social networks and relationships)	Draw support networks at the beginning	Baseline at the beginning of the course. Redraw again at end of the course
	Valued Role (Participation & Inclusion: Having a valued role)	Collection of objective information around volunteering, training, consultancy and employment	On-going through course and 6 month or 1 year follow up

5.7 Data collection

Having developed a series of indicators, you will need to consider how you will make arrangements for collecting and collating the information, and at what intervals you will need to do this. Being able align and build your MWIA indicators in to existing data collection processes e.g. adding additional questions to an existing customer satisfaction survey, is very helpful. Involving people who are, or will be, responsible for collecting data on your proposal in the MWIA process (and in particular the indicator development) is key to ensuring that you come up with indicators that are likely to be collected.

You will also need to consider how the information is then used to inform the project on an on-going basis about its performance in terms of promoting mental well-being and how the information that you generate can support continuous service improvement.

5.8 Resources for measuring well-being

Health Scotland have a series of very useful **Mental Health Improvement Evaluation Guides**, which aim to encourage, support and improve standards in the evaluation of mental health improvement initiatives. Guides 2, 3 and 5 provide particularly useful guidance on identifying indicators of mental well-being designing how to measure the impact and outcomes of your proposal and mental well-being scales. Available at: http://www.healthscotland.com/mental-health-publications.aspx

Measuring Well-being In Lambeth by the New Economics Foundation. A practical, introductory guide on how to measure well-being for local projects and services. Contains a range of examples of validated well-being measures and how to use them. Available at: http://www.lambethwellbeing.co.uk/Lambeth%20well-being%20handbook.pdf

The ONS have published a paper exploring the potential measures of subjective well-being in relation to public policy making. It sets out measures that can be used for 1) Monitoring progress; 2) Informing policy design; and 3) Policy appraisal. It also makes recommendations of questions for inclusion in ONS surveys. Available at: http://www.statistics.gov.uk/articles/social_trends/measuring-subjective-wellbeing-for-public-policy.pdf

ONS (2011) Press release: People asked to rate life satisfaction as new well-being question revealed

Measuring Progress: Sustainable development indicators 2010 presents further well-being indicators from a national sample. Available at: http://sd.defra.gov.uk/2010/07/measuring-progress-sustainable-development-indicators-2010/

The European Social Survey (ESS) 2006 included a well-being module covering 50 questions designed by a consortium led by Felicia Huppert at the University of Cambridge and involving the new economics foundation (nef). Available at: http://www.europeansocialsurvey.org/

Warwick Edinburgh Mental Well-being Scale (WEMWBS), a 14-item validated well-being survey tool. Available at: http://www.healthscotland.com/documents/1467.aspx

5.9 References for Indicators

[1] Foresight (2009) Foresight Mental Capital and Wellbeing Project (2008). Final Project report. London: The Government Office for Science. Available from: http://www.foresight.gov.uk/Mental%20Capital/Mental_capital_&_wellbeing_Exec_Sum.pdf

[2] Michaelson J *et al* (2009) National Accounts of Well-being: bringing real wealth onto the balance sheet. nef, London, UK. Available from: http://cdn.media70.com/national-accounts-of-well-being-report.pdf)

[3] Marmot M. (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010, London: The Marmot Review

[4] Department for Environment, Food and Rural Affairs (2007) Sustainable development indicators in your pocket, 2007. London: Department for Environment, Food and Rural Affairs. Available from: http://www.defra.gov.uk/sustainable/government/progress/documents/SDIYP2009_a9.pdf

[5] Parkinson, J (2006) Establishing national mental health and well-being indicators for Scotland, Scotland: Health Scotland. Available from: http://www.healthscotland.com/uploads/documents/EstablishingNationalMHI.pdf

[6] Warwick Edinburgh Mental Well-being Scale (WEMWBS), a 14-item validated well-being survey tool. Available from: http://www.healthscotland.com/documents/1467.aspx

[7] Department of Health (2010) *Healthy lives healthy people*: Our strategy for public health in England. London: HMG

[8] NMHDU (2011) NMHDU Briefing, January 2011, London: NMHDU

[9] Dolan P, Peasgood T, White M (2006) Review of research on the influences on personal well-being and application to policy making. London: DEFRA

[10] Thompson S and Marks N (2008) Measuring well-being in policy: issues and applications London, UK. Available from: http://www.neweconomics.org/sites/neweconomics.org/files/Measuring_well-being_in_policy.pdf

[11] Foresight (2009) Foresight Mental Capital and Wellbeing Project (2008). Final Project report. London: The Government Office for Science. Available from: http://www.foresight.gov.uk/Mental%20Capital/Mental_capital_&_wellbeing_Exec_Sum.pdf

[12] McKinley, S., Edmonds, N., Coggins, T. (2009) Changing Minds: Tackling discrimination and promoting the mental well-being of people with experience of mental health problems. London, UK: SLaM

Resources to Support the MWIA Process

Section 6 is a **set of resources** to support the MWIA process, links with national Indicators and a master reference list

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The following resources are designed to assist you with your MWIA. They have been developed and adapted from applying them in countless MWIAs. However, you may want to adapt them to suit your target audience, for example adapting the Invitation letter to use language familiar to your target audience. The resources in Resource F are available to purchase as re-useable tools on www.hiagateway.org.uk

- **Resource A** Population group, wider determinants and protective factor tables
- **Resource B** Preparation checklist for holding a workshop
- **Resource C** Sample invitation
- **Resource D** Sample programme
- **Resource E** Facilitators notes for MWIA workshop
- **Resource F** Flipchart templates for MWIA workshop
- **Resource G** Sample MWIA workshop evaluation form
- **Resource H** Statements and definitions of Mental Health, Well-being and Mental Well-being
- **Resource I** Developing an Indicator template
- **Resource J** Mapping indicators to MWIA factors and components
- **Resource K** Useful resources and websites for MWIA
- **Resource L** Master list of References and Bibliography

Resource A – Population group, wider determinants and protective factor tables

Table 1 Population Characteristics: Risk and Protective factors for mental well-being

Population characteristics	MWIA Key question	Likely impact? Positive, negative or is it an indirect impact?
Age		
Early Years: Foundations for good mental health lie in pregnancy, infancy and early childhood. Parenting style and attachment are the key factors. The quality of the 'home learning environment', quality of pre-school and the amount of time in pre-school are all associated with greater 'self regulation', an attribute strongly linked to improved educational outcomes.	Will this proposal enhance or diminish support for parents and families through pregnancy, childbirth and first years of life?	
Adolescence: Protective factors include: attachment to school, family and community; positive peer influence; opportunities to succeed and problem solving skills. 'Social capital' indicators (e.g. friends, support networks, valued social roles and positive views on neighbourhood) are closely related to risk and severity of emotional and behavioural disorders.	Will this proposal enhance or diminish feelings of security, significance, belonging and connection in young people?	

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Later Life: The key areas that influence mental health in later life are age discrimination, participation, relationships, physical health and poverty. Fear of crime and lack of transport are also consistent themes, with 'daily hassles' contributing more significantly to psychological distress than major life events.	Will this proposal impact positively or adversely on the five key areas known to influence mental health in later life?	
Gender		
Gender has a significant impact on risk and protective factors for mental health and the way in which the experience of mental distress is expressed. Depression, anxiety, attempted suicide and self harm are more prevalent in women, while completed suicide, drug and alcohol abuse, crime and violence are much more prevalent among men. Women are much more vulnerable to poverty and unemployment, and are more likely to suffer domestic violence, rape and child abuse.	Will the proposal impact differently on men and on women?	
Race and ethnicity		
Race and ethnic differences in the levels of mental well-being and prevalence of mental disorders are due to a complex combination of socio-economic factors, racism, diagnostic bias and cultural and ethnic differences and are reflected in how mental health and mental distress are presented, perceived and interpreted. Different cultures may also develop different responses for coping with psychological stressors. However a major qualitative study found that expressions of distress bore great similarity across ethnic groups, although some specific symptoms were different.	Will the proposal impact differentially on different ethnic groups, including refugees, asylum seekers and newly arrived communities?	
Socio-economic position and class		
Socio-economic position (SEP) refers to the position of individuals in the hierarchy and is inherently unequal for different groups of people, shaping access to resources and every aspect of experience in the home, neighbourhood, and workplace. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation support and inclusion. Social position also influences areas like identity and social status, which impact on well-being, for example through the effects of low-self esteem, shame, and disrespect.	How will the proposal impact on people in different social positions? Will it reinforce or reduce inequalities?	

Physical health		
Poor physical health is a significant risk factor for poor mental health; conversely, mental well-being protects physical health and improves health outcomes and recovery rates, notably for coronary heart disease, stroke and diabetes. Poor mental health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet. Stress epidemiology demonstrates the link between feelings of despair, anger, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. For heart disease, psychosocial factors are on a par with smoking, high blood pressure, obesity, and cholesterol problems.	Will the proposal have an impact on or take into consideration the physical health of the communities likely to be affected? Does the proposal recognise the relationship between mental health and physical health?	
Disability		
Life chances (notably education, employment and housing), social inclusion, support, choice, control and opportunities to be independent are the key factors influencing the mental health of people with disabilities.	Will the proposal reinforce or reduce inequalities and discrimination experienced by people with disabilities?	
Sexuality		
Some studies suggest that gay, lesbian, bisexual and transgender peoples are at increased risk for some mental health problems – notably anxiety, depression, self-harm and substance misuse – and more likely to report psychological distress than their heterosexual counterparts, while being more vulnerable to certain factors that increase risk, e.g. being bullied, discrimination and verbal assault.	Will the proposal impact differently on gay men, lesbians, bisexuals and transgender peoples?	
Other population groups *Tick where appropriate*		
Looked after children ☐ People with long term conditions ☐ People in residential settings ☐ Carers ☐ People experiencing violence or abuse ☐ People in the criminal justice system ☐ Ex-offenders ☐ Others ☐	Will the proposal have an impact or take into consideration any of the groups mentioned?	
Settings		
Schools Workplace Neighbourhoods Prisons Hospitals Primary Care Others	Will the proposal have an impact on or take into consideration any of the settings mentioned?	

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Table 2a Wider determinants at a socio-economic and environmental level

MWIA question: How does the proposed development impact on the wider determinants?

WIDER DETERMINANTS (often at a socio-economic/environmental level)	**Likely impact? Positive, negative or is it an indirect impact? Select those most important**	**Comments or recommendations**
• **Access to quality Housing** e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate • **Physical Environment** e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment • **Economic security** e.g. access to secure employment (paid and unpaid), good working conditions, meaningful work and volunteering opportunities • **Good quality food** e.g. affordable, accessible • **Leisure opportunities** e.g. participate in arts, creativity, sport, culture • **Tackling inequalities** e.g. addressing poverty, deprivation • **Transport access and** options e.g. providing choice, affordability and accessibility • **Local democracy** e.g. devolved power, voting, community panels • **Ease of access to high quality public services** e.g. housing support, health and social care • **Access to Education** e.g. schooling, training, adult literacy, hobbies • **Challenging discrimination** e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith • **Other?**		

Table 2b Protective factor – Enhancing control

MWIA question: How does the proposed development impact on people's control?

PROTECTIVE FACTORS FOR ENHANCING CONTROL	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **A sense of control** e.g. setting and pursuit of goals, ability to shape own circumstances • **Belief in own capabilities and self determination** e.g. sense of purpose and meaning • **Knowledge skills and resources to make healthy choices** e.g. understanding what makes us healthy and being able to make choices • **Maintaining independence** e.g. support to live at home, care for self and family		
Community/organisation • **Self-help** provision e.g. information advocacy, groups, advice, support • **Opportunities to influence decisions** e.g. at home, at work or in the community • **Opportunities for expressing views and being heard** e.g. tenants groups, public meetings • **Workplace job control** e.g. participation in decision making, work-life balance • **Collective organisation and action** e.g. social enterprise, community-led action, local involvement • **Resources for financial control** e.g. access to credit union, welfare rights, debt management		
Other?		

Table 2c Protective factor – Increasing resilience and community assets

MWIA question: How does the proposed development impact on resilience and community assets?

PROTECTIVE FACTORS FOR INCREASING RESILIENCE AND COMMUNITY ASSETS	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **Emotional well-being** e.g. self esteem, self worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun • **Ability to understand, think clearly and function socially** e.g. problem solving, decision making, relationships with others, communication skills • **Have beliefs and values** e.g. spirituality, religious beliefs, cultural identity • **Learning and development** e.g. formal and informal education and hobbies • **Healthy lifestyle** e.g. taking steps towards this by healthy eating, regular physical activity and sensible drinking		
Community/organisation • **Trust and safety** e.g. belief in reliability of others and services, feeling safe where you live or work • **Social networks and relationships** e.g. contact with others through family, groups, friendships, neighbours, shared interests, work • **Emotional support** e.g. confiding relationships, provision of counselling support • **Shared public spaces** e.g. community centre, library, faith settings, café, parks, playgrounds, places to stop and chat • **Sustainable local economy** e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks • **Arts and creativity** e.g. expression, fun, laughter and play		
Other?		

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Table 2d Protective factor - Facilitating participation and promoting inclusion

MWIA question: How does the proposed development impact on participation and inclusion?

PROTECTIVE FACTORS FOR PARTICIPATION AND INCLUSION	Likely impact? Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual • **Having a valued role** e.g. volunteer, governor, carer • **Sense of belonging** e.g. connectedness to community, neighbourhood, family group, work team • **Feeling involved** e.g. in the family, community, at work		
Community/organisation • **Activities that bring people together** e.g. connecting with others through groups, clubs, events, shared interests • **Practical support** e.g. childcare, employment, on discharge from services • **Ways to get involved** e.g. volunteering, Time Banks, advocacy • **Accessible and acceptable services or goods** e.g. easily understood, affordable, user friendly, non-stigmatising, non-humiliating • **Cost of participating** e.g. affordable, accessible • **Conflict resolution** e.g. mediation, restorative justice • **Cohesive communities** e.g. mutual respect, bringing communities together		
Other?		

Resource B – Preparation checklist for holding a workshop

Planning your MWIA – Task List

Tasks	Details/Resources needed	Lead person	When to do this?
Inform and engage decision makers and project managers of intention to undertake MWIA			
Decide on who will take the lead on the community profile?			
Decide who will take a lead on the literature review?			
Decide who will take the lead on the report writing?			
Agree the focus of the MWIA e.g. the scope and boundaries. You need to make your assessment as specific as possible. Things to consider: • Will you focus on a particular aspect of a project or service? • Which population group and/or geographical area are you focusing on?			
Identify stakeholders to engage in the process and invite to the workshop: • Agree which decision makers need to be involved • To what extent can those affected by or using the proposal/project be involved? • Which specialist practitioners could be involved?			
Agree a date for the stakeholder workshop			
Identify and book venue and catering			
Agree how you will promote the event and communicate its purpose			
Design invitation (Resource C)			
Send out invites and take bookings			
Make other arrangements necessary for participation e.g. childcare, interpreters, large print			
Agree a date for a planning meeting prior to the workshop			

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Tasks to cover at your planning meeting			
Use the MWIA workshop planning guide (Resource E) and decide who will deliver which part of the session and key roles and responsibilities for the day e.g. • Who will ensure that participants sign in? • Who will do the introduction? • Who will do the "what is mental well-being exercise?" • Who will provide information about the project/proposal? • Who will do the population groups and wider determinants exercises? • Allocate scribes and facilitators for protective factor grid exercise			
Prepare presentations and other materials as required e.g. definitions of mental well-being (Resources F & H) and sticky coloured dots			
Prepare participants programme (Resource D)			
Organise materials needed on the day: MWIA toolkit/materials/ post it notes/flipchart and pens, blue tack			
Who will bring a camera to take photos of grids and workshop?			
Agree who will collect the flip chart notes, evaluation forms (Resource G) and other materials from the workshop			
Ensure you have an attendance sign in sheet, with spaces to record contact details, and the evaluation forms			
After the workshop			
Type up notes and actions within one week			
Send draft report to participants asking for feedback ideally within one week			
Agree deadline for final report			
You will probably need another meeting with your MWIA team and key stakeholders and the lead for the proposal to agree and finalise recommendations and indicators			
Collate any feedback from participants and complete report You may want to share out the allocation of responsibility for report sections between your MWIA team			
Send out report to workshop participants and key stakeholders			

Resource C – Sample invitation

This is a sample invitation that you might wish to adapt to suit the language or needs for your target audience.

Logo space

(Project Name)

Invites you to an event to explore how we can benefit the well-being of (local people/members)

This is an opportunity to learn more about well-being and for you to express your views and ideas as to how *(project name)* can make a positive impact on well-being.

(Date and Time)

(Insert Address)

The event is free and Lunch will be provided

Limited spaces – so book now!

What is 'Well-being'?

Well-being is about being emotionally healthy, feeling able to cope with normal stresses, and living a fulfilled life. It can be affected by things like worries about money, work, your home, the people around you and the environment you live in. Your well-being is also affected by whether or not you feel in control of your life, feeling involved with people and communities, and feelings of anxiety and isolation.

What will this event involve?

We are inviting members, local organisations, local residents, and other people involved in the local community. We want you to help us with the project and think about what we do now and whether it could be improved. We will have discussions in small groups about what well-being means and there will be opportunity to give your views and experiences of (the project) and how it might impact on well-being.

What is a Mental Well-being Impact Assessment (MWIA) ?

Mental Well-being Impact Assessment is a way for us to assess how projects and services affect well-being and how we can maximise the positive impact and reduce any negative impacts on well-being. At the workshop we will discuss how important the different aspects of well-being are to people participating in or who are affected by (the project/proposal) such as:

- Having your say and influencing decisions
- (Add in those components that are particularly relevant to your project)

After the event you will understand more about well-being and how yours and others' solutions can improve the (project/proposal).

Lunch, tea and coffee will be provided

Please confirm your attendance by completing and returning the form below in the envelope provided *(date)* to

(contact person)

or telephone *(contact person)*

- ☐ I shall be attending the well-being workshop
- ☐ I have specific dietary requirements of *(please specify)*
- ☐ I have specific physical needs such as a hearing loop *(please specify)*
- ☐ I need a crèche space / interpreter / other

Name _____

Address _____

Telephone/email address _____

Organisation & Job title (if applicable) _____

If you require transport please contact *(contact person)*

Resource D – Sample programme

We have found that most people are happy with a very brief programme. We tend to put in the times for the refreshment and lunch breaks and leave the rest as headings with no timings. This enables the programme to be flexible and meet the needs of the group.

- Welcome, Introductions and Housekeeping (insert name of who is doing this)
- What this 'workshop' is all about (insert name of who is doing this)
- What does mental well-being mean for you? Small group exercise
- Who are the people this (insert name of project or service being assessed) is serving, are there others who might benefit? Whole group exercise
- Range of influences on our health. Whole group exercise
- Specific factors that affect our mental well-being. Small group exercises
- Action planning to improve (insert name of project or service being assessed)
- Feedback and what happens now? (insert name of who is doing this)
- Evaluation. All
- Ends – state ending time and stick to it!!

NOTE: *You may want to shorten this or use your own words – please feel free!*

Resource E – Facilitators notes for MWIA workshop

Workshop Facilitator's Script

PLEASE NOTE: *These notes are intended to provide a guide to the facilitation of the MWIA – they can be adapted to meet your own needs including timings. The relevant resource/s to use or adapt are highlighted where appropriate and can be found in section 6 of this MWIA toolkit.*

Time	Activity
Allow 20 minutes	**Welcome and purpose of workshop** • To increase our understanding of what we mean by mental well-being • To identify those population groups that are relevant to the proposal to be assessed • To identify the main factors that affect our mental well-being and those, which this proposal is likely to be having an impact upon • To develop an action plan to improve the proposal – to make the most of positive impacts, and lessen possible negative impacts. Briefly explain how the workshop will be run. **Group introductions**: invite people to introduce themselves in whatever way you feel is most appropriate. In small groups, we've invited people to say who they are, why they are there and one thing they have done that week to make themselves feel better – starting with one of the facilitators first. From this, you can reasonably conclude that we all have different ways of relaxing or looking after ourselves – mental well-being means different things to different people!
Allow 30 minutes	**What do we mean by Mental Well-being?** *Use either of the following exercises:* **Exercise 1** You could ask the group to **come up with words they see as relevant to mental well-being**, perhaps using post-it notes to write them on. They could then work in small groups to first **put the words into a couple of sentences to make up a definition**, and then share these so the whole group has a chance to form their own views. Then, as facilitator, you will need to summarise the discussion and, maybe talk briefly about other definitions such as some of those in Resource K). **Exercise 2** Place previously prepared statements and facts (Resource K) that give various definitions of mental health, well-being and explanations of happiness all around the room. *We have included lots of statements, so you might want to select some and use others that you know of.* Draw participants' attention to the statements on the wall, and invite them to circulate and look at them. Encourage people to chat to each other about what they understand, like and dislike about them. Give each participant three green and three red dots, and – working in pairs – encourage people to place the **green dots on those statements they like the most**, and **red on those they like the least**. Then, select those that have the most of each, and invite people to talk briefly about why they chose these. *Going through this process helps people engage with the language, the understanding and to 'own' that understanding. It will also help the facilitator get a feel about where participants are coming from in their understanding.* Summarise the collective understanding, and feedback to main group.

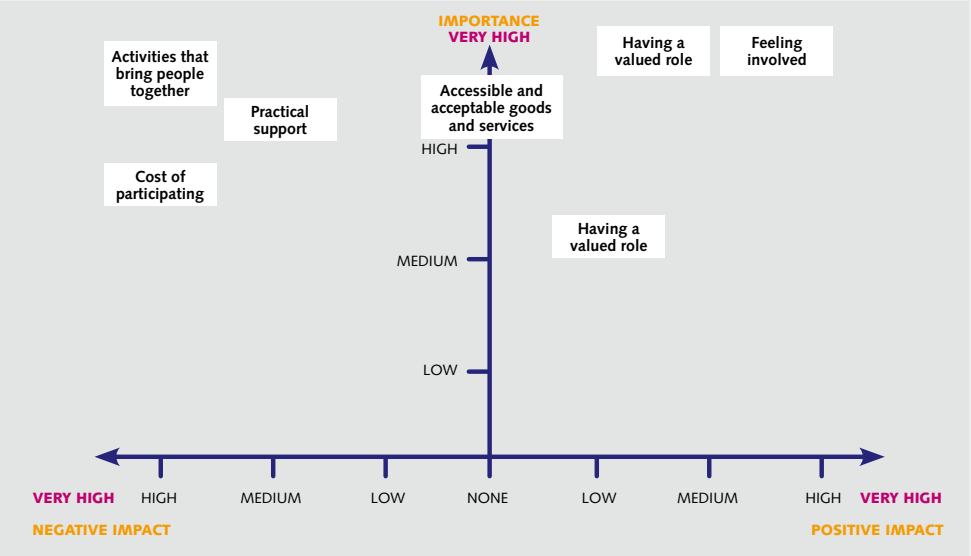
Allow 10 minutes	**Introduction to the Population, Wider Determinants and Mental Well-being Protective Factors** It is important that the facilitator is clear about their understanding of these protective factors and is able to give examples for each. It is not necessary to memorise every component or evidence quote – just enough to feel able to help people understand the concepts and turn this into tangible examples related to their likely needs and experiences of the project. Maybe draw out examples from when you screened your proposal?
Allow 15 minutes	**Brief introduction of the Service or Project that you will be working on.** *We have found this an important part of the process. Time spent clarifying what the proposal is and what is being assessed is time well spent.* Invite the lead person for the proposal you will be assessing to give a **short explanation of what the proposal aims to achieve**, who it is targeted at (hence the population group you are assessing), and the main aspects of the proposal. **Ask if they have any questions?**
Allow 15 minutes	**REFRESHMENT BREAK**
Allow 10 minutes	**POPULATION CHARACTERISTICS** This exercise is more robust if you have previously collected information on the population groups most likely to be affected by the proposal. This information should be available from the local Annual Public Health Report, and if possible, try to have someone with this knowledge contributing to the discussion. All the population groups in this section are potentially at an increased risk of experiencing low levels of mental well-being – and they may be priority target groups for your proposal. **In small groups** **Say to the group:** We'll be going through each section of the rapid appraisal, and taking notes on the flipchart. **SECTION 1 – Population characteristics** Ask the group to **identify the groups who they think will be particularly affected by the Service or project**. They could draw on the findings from the Screening process, and/or whatever information you have previously identified, or it might be contained in the proposal you are working upon. You can also use the MWIA questions listed in Table 1 (Resource A). **Identify:** • Particular target groups that are of interest or concern to you • Other groups who will be affected by the plan • Groups that may be (inadvertently) negatively affected by the plan If lots of groups are identified, ask the group to prioritise the first three. **FACILITATOR:** This discussion should be kept brief. **SCRIBE:** Capture as much of this as possible on the flipchart prepared earlier – see flipchart 1 in Resource F.

Allow 15 minutes	**WIDER DETERMINANTS** MWIA uses a framework for assessing the three protective factors *in the context of the wider determinants of mental well-being.* These are listed in the table in Flipchart 2 in Resource F, which you should on a flipchart or use the MWIA Resource Kit available on www.hiagateway.org.uk. **Say to the group:** On the flipchart is a list of areas that research suggests have a **major impact on mental well-being.** For example: Housing. We know that people living in rented accommodation tend to have a greater rate of anxiety and depression: research suggests that people who live in areas with easy access to green natural spaces tend to have better well-being. Because these areas are so important for mental well-being we are just going to spend 5-10 minutes thinking about how the project/proposal might impact on them. **FACILTATOR:** Work though each determinant asking the group: 1. "How important is… say determinant e.g. housing) for the mental well-being of… (the population group that the project is working with e.g. older people in Waltham Forest) 2. "Does the… (project name) have any impact positively or negatively on… (say determinant e.g. housing)". If it does not ask, "Could the project do anything to have an impact on… to improve mental well being? 3. "Is there anything that could be done to respond to the negative impacts?" **SCRIBE:** Capture as much of this as possible on the flipchart prepared earlier using Flipchart 2 in Resource F. **Note:** projects/proposals will not necessarily have an impact on these wider determinants, but it is useful to highlight those which are particularly relevant to the target population and any areas where the project is already having an impact or could in the future. Once you have worked through the whole table, summarise the discussion and move onto the protective factors exercise.
Allow 35 minutes	**SECTION 3 – Protective factors** Use the grid previously prepared earlier using Flipchart 4, one for each Protective Factor, with the components printed onto post-it notes or use the MWIA Resource Kit available on www.hiagateway.org.uk. **Say to the group:** The evidence shows that there are a number of *protective factors* that are important in protecting and promoting mental well-being. The most important ones we are looking at today are: *only refer to the ones that you are going to focus on in the workshop from the screening exercise.* • Enhancing people's sense of **control** over their lives • Building their **resilience/assets** • Facilitating greater **participation** and promoting greater **social inclusion.** **In this section, we'll look at these in more detail. First, (using Enhancing Control as an example)…** **ENHANCING CONTROL** Begin by asking the group what they understand by this, *particularly for the population groups they listed in section 1.* **FACILITATOR:** Ask each member of the group to pick one of the 'components' placed on the bottom of the MWIA grid. In turn ask each person to talk a little about the component they have, what it means to them and ask everyone else for any further brief comment.

Then invite them to come forwards and say how important it is to them (in the context of the Service or Project you are assessing) – is it high, medium or low? Others in the group may also comment at this point. Then ask them if their experience of the Service or Project is likely to or has had a positive or negative impact on the component. As they and the group discuss this try to record the discussion (having a scribe is very important to get a good record). Encourage them to place it in the most appropriate spot. If there is a big discrepancy in opinion then invite the others to write the component on one of the blank stickers and place it where they want and share the reasons.

Continue this process until all the factors that relate to the proposal have been placed. There may be factors that the group does not think are relevant. These can be put aside.

Your grid might look like this:



NEXT STEP

Invite the group to choose a maximum of three components which they would like to discuss in more detail in order to find ways to improve the impact. Try to 'steer' the group to select those that are important to them but which the Service or Project is NOT having as big a positive impact as it could, or which is having a negative impact as this offers the greatest scope to make recommendations to improve the proposal.

Pick **one** of the these factors to look at in more detail and list all the ways your

proposal has a **positive impact** on this factor.

SCRIBE: Capture as much of this using Flipchart 3 in Resource F. Use a biro rather than flipchart pen, so you can write detail. If group is unclear whether some impacts are positive, write this in the 'unclear' box, checking the group are OK with this.

	STEP 3 Identify ways your proposal has a **negative impact** on this factor – and probe any **inadvertent** negative impacts. **STEP 4** Identify what **actions/recommendations** the group could make for improving the proposal in the light of their discussions, and **record these**. **REPEAT THIS PROCESS FOR EACH OF THE PRIORITY COMPONENTS**
Allow 45 minutes	**LUNCH**
Allow at least one hour minutes	**GROUPWORK CONTINUED** **Try to complete all the Protective Factors and follow through to formulating recommendations.** If you have a large group we suggest you split participants up and facilitate them undertaking one factor each. If you have a small group we suggest you prioritise the protective factor that seems the most important or relevant to the group and proposal (your Screening of the proposal should help you to identify this) and complete this one.
Allow 20 minutes	**PLENARY SESSION** Recall all the groups and invite brief feedback from each: • Main impacts identified • Recommendations and suggestions of how these can be taken forward • Is there interest in doing further work on developing Indicators? **Summarise** and agree how the MWIA findings will be disseminated. **Invite participants to complete Evaluation forms before leaving.** **Thank everyone and close the session.**
Allow 10 minutes	**Evaluation**

NOTES

- You may have less time and therefore may want to prioritise two of the factors from screening and work on these during the workshop
- If you have very little time (approximately 2 ½ hours) you may want to divide the group into two and have each group do one factor.
- You may want to split the group into two groups if you have more than 8-10 people
- Small groups work best if they have a variety of stakeholders and if there are at least five members (excluding the facilitator and scribe)
- At the end take digital photos of the grids as these can be used in the report

Resource F – Flipchart templates for MWIA workshop.

FLIPCHART 1 POPULATION GROUPS

PRIORITY POPULATION GROUP AFFECTED OR TARGETED BY YOUR PROPOSAL

FLIPCHART 2 WIDER DETERMINANTS OF MENTAL WELL-BEING

WIDER DETERMINANTS OF MENTAL WELL-BEING (often at a socio-economic level as well as affecting individuals and communities)	**Likely impact (e.g. positive or negative)** *those most important	**Comments or recommendations**
• Access to quality Housing e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate • Living Environment e.g. green space/trees, safe play space, quality of built environment • Nature and access to the natural environment e.g. woodlands, parks, open spaces • Economic security e.g. access to secure employment (paid and unpaid), good working conditions, meaningful work/volunteering opportunities; • Good quality food e.g. affordable, accessible • Leisure e.g. arts, creativity, sport, culture • Tackling inequalities e.g. housing, occupation, socio-economic position, status • Transport access and options e.g. choice, affordability and accessibility • Local democracy e.g. devolved power, voting, community panels • Ease of access to high quality public services e.g. Housing, Health and social care • Access to Education e.g. schooling, training, adult literacy • Challenging discrimination e.g. racism, sexism, homophobia and discrimination related to disability, mental illness or faith • Other?		

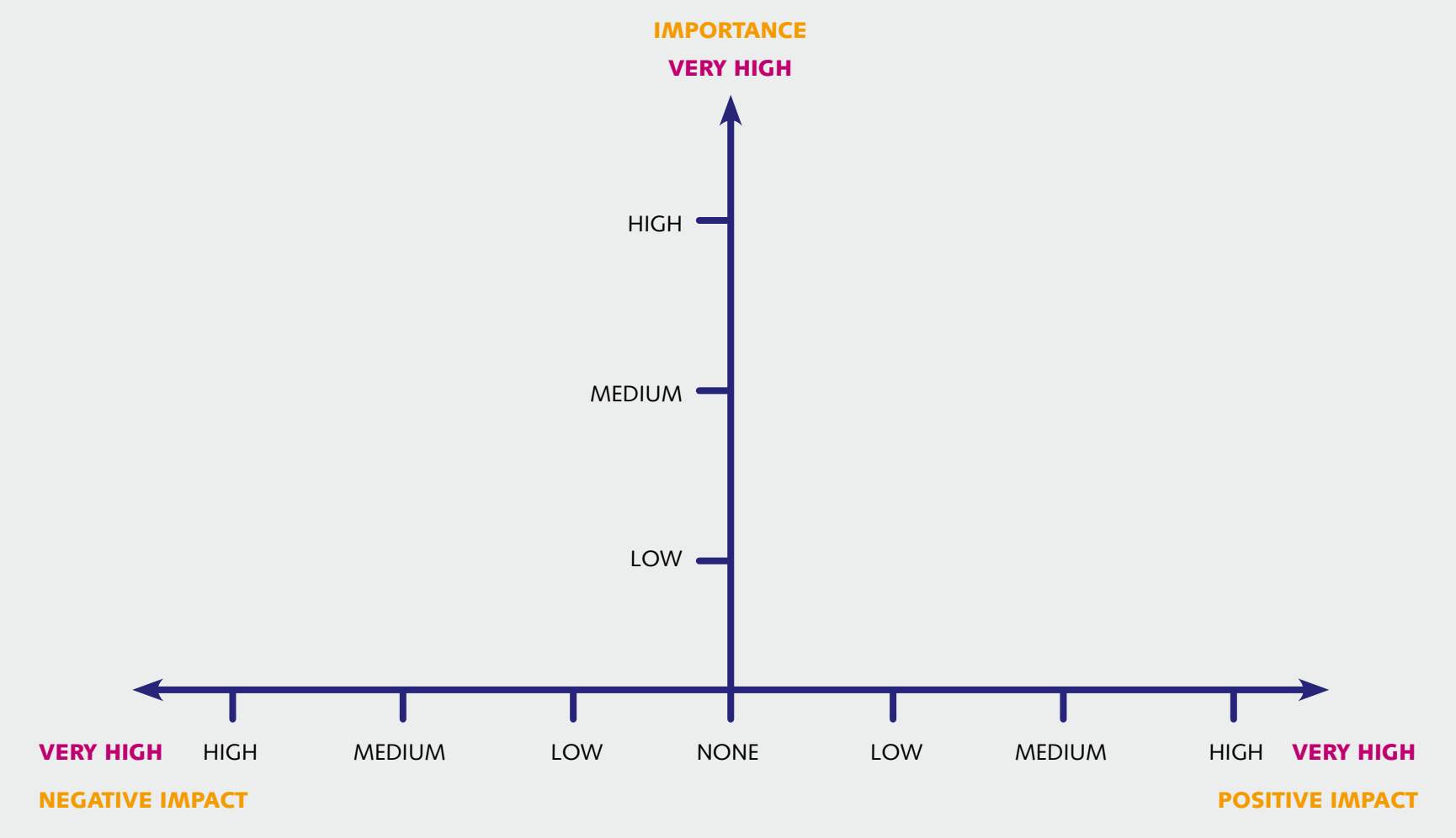
FLIPCHART 3 PROTECTIVE FACTORS FOR MENTAL WELL-BEING: ENHANCING CONTROL

Adapt this chart for the other two protective factors of resilience and community assets, and participation and social inclusion.

Protective factor: CONTROL Three top priorities	Impact of your proposal on this protective factor			Comments Actions identified
	Positive	Negative	Unclear	
1.				
2.				
3.				

FLIPCHART 4 PRIORITISATION GRID FOR PROTECTIVE FACTORS

Enhancing Control



Having drawn this grid onto flipchart you will need to write up or print labels post-it notes with all the components for the respective protective factors. These can then be used by your participants to place where they feel is most appropriate onto the prioritisation grid.

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Resource G – Sample MWIA workshop evaluation form

Mental Well-being Impact Assessment Workshop Evaluation Form and Next Steps

Instructions
The evaluation sheet should be given out when participants arrive. The pre-workshop question should be answered by participants at the beginning of the workshop. The rest of the evaluation questions need to be answered at the end of the session. This will ensure that each participant's pre and post answers can be compared to see if there has been a change as a result of the workshop. It would also be useful if the forms could be numbered (top right hand corner) to ensure that you are able to get them all back at the end of the session.

Please tell us what you thought about the workshop today by answering the questions below.

DATE OF WORKSHOP:

YOUR NAME *(Optional):*

Pre-workshop question – Please answer this question before the workshop starts

1. How confident are you in discussing mental well-being with others?

(*Please tick* the answer that describes how you feel on the scale below)

☐ Not at all ☐ Not very much ☐ A fair amount ☐ A great deal

Please comment

PLEASE ANSWER THE QUESTIONS BELOW AT THE END OF THE WORKSHOP.

2. How relevant was today's workshop to you and your role? (*Please tick* your choice)

☐ Very relevant ☐ fairly relevant ☐ slightly relevant ☐ not relevant

3. Did the workshop increase your understanding of mental well-being? *(Please tick)*

☐ YES ☐ NO

Please comment

4. How confident are you now in discussing mental well-being with others? (*Please tick* the answer that describes how you feel)

☐ Not at all ☐ Not very much ☐ A fair amount ☐ A great deal

Please Comment or give an example

5. Was the workshop
(Please tick)

Useful?	☐ YES	☐ NO	Interesting?	☐ YES	☐ NO
Understandable?	☐ YES	☐ NO	Enjoyable?	☐ YES	☐ NO

Please Comment

6. How do you think the MWIA will contribute to your local project? Please comment

7. Would you recommend this workshop to others?

(Please circle)

YES / NO

8. Any other comments?

NEXT STEPS
We would like to give you the chance to read and comment on the draft report and recommendations that will be created from your work today. If you would like to receive a copy of the draft report this please put your name and an email address or postal address below:

Name:

Email Address:

Postal Address:

Thank you

Resource H – Statements and definitions of Mental Health, Well-being and Mental Well-being.

The following list of statements and definitions are not exhaustive, we encourage you to select a few that represent a range of perspectives and to include any that you use at a locality level.

Mental wellbeing "…is a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community.

It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society."

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

Well-being is "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and wider environment."

Cross-government strategy: Mental Health Division (2009) *New Horizons: A Shared Vision for Mental Health* England: Department of Health (Available: http://www.newhorizons.dh.gov.uk/Resources/reports/New-Horizons/index.aspx)

"Mental health is the emotional and spiritual resilience, which enables us to enjoylife and survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth."

Health Education Authority (1997) Mental Health Promotion: A Quality Framework. London: HEA

"Mental health status is a key consideration to changing the health status of a community."

WHO. (2001a) *Promoting mental health – concepts-emerging evidence-practice* WHO
http://www.who.int/mental_health/evidence/MH_Promotion

Mental health is described as "…a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

WHO. (2001a) *Promoting mental health – concepts-emerging evidence-practice* WHO
http://www.who.int/mental_health/evidence/MH_Promotion

"… mental health is the foundation of well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures."

WHO. (2001b) *Promoting mental health – concepts-emerging evidence-practice* WHO
http://www.who.int/mental_health/evidence/MH_Promotion

"Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity."

Friedli,L. (2009) *Mental Health, Resilience & Inequalities*. Denmark: World Health Organization. (p.III)
http://www.euro.who.int/document/e92227.pdf

"Being HAPPY is seriously good for you and others around you."

Attributable to **nef** in an early mini version of 'A well-being manifesto for a flourishing society'

"...levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing."

Friedli,L. (2009) *Mental Health, Resilience & Inequalities*. Denmark: World Health Organization. (p.III)
http://www.euro.who.int/document/e92227.pdf

"Well-being is more than just happiness. As well as feeling satisfied and happy, well-being means developing as a person, being fulfilled, and making a contribution to the community."

Shah H and Marks N (2004) 'A well-being manifesto for a flourishing society' London: **nef**

"Salutogenesis asks, 'what are the causes and distribution of health and wellbeing in this group, community or country population'. Epidemiology asks 'what are the causes and distribution of disease and early death in this group, community or population'".

Harrison D et al. (2004) *Assets for Health and Development (AHDP) Developing a Conceptual Framework.* Copenhagen, WHO Regional Office for Europe. p.9

"Well-being is about being emotionally healthy, feeling able to cope with normal stresses, and living a fulfilled life. It can be affected by things like worries about money, work, your home, the people around you and the environment you live in. Your well-being is also affected by whether or not you feel in control of your life, feeling involved with people and communities, and feelings of anxiety and isolation."

Coggins,T., Cooke,A. (2003) *Mental Health Impact Assessment: A two part toolkit.* Lewisham, UK: SLaM

"How society works at every level influences the way people feel about themselves. And how people feel influences how well society functions."

Public Mental Health project, Scottish Development Centre for Mental Health Services, 1999

"Mental health is characterised by the ability to love and to create… by a sense of identity based on one's experience of self as the subject and agent of one's powers, by the grasp of reality inside and outside of us, that is, by the development of objectivity and reason."

Fromm,E. (1956), *The Art of Loving*. America: Harper and Row

"Mental health promotion involves any action to enhance the mental well-being of individuals, families, organizations or communities. … It is essentially concerned with:

- How individuals, families, organizations and communities think and feel
- The factors which influence how we think and feel, individually and collectively
- The impact that this has on overall health and well-being.

Friedli,L. (2000) Making it Happen – A guide to delivering mental health promotion England: Department of Health (available: http://www.publications.doh.gov.uk/pdfs/makingithappen.pdf)

"A positive sense of well-being; individual resources including self-esteem, optimism, sense of mastery and coherence; the ability to initiate, develop and sustain mutually satisfying personal relationships; the ability to cope with adversities (resilience); these will enhance the person's capacity to contribute to family and other social networks, local community and society."

European Green Paper and Consultation (2006) Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union. Brussels: European Union. (available: http://ec.europe.eu/health/ph_determinants/life style/mental/mental health.en.htm)

"Mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential. The Prime Minister and the Deputy Prime Minister have made it clear that success for the Coalition Government will be assessed not just on bringing about a healthy economy but also on the wellbeing of the whole population. Moreover, good mental health and wellbeing also bring wider social and economic benefits." Department of Health (Feb.2011) *No health without mental health* [page 5] London: HMG

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf

Resource I – Developing an Indicator template

Developing Indicators

Adapt this template for the other two Protective Factors

Factor	**Priority component your MWIA has identified**	**How would you know that you are having an impact on this component?**	**How could you measure it?**	**Is there an existing scale or measure?** That the proposal already collects An existing regional indicator or target Other existing validated measure	**Data collection** What will the data be used for? Who do you want to measure the impact on? What measure could you use for the indicator?	**Frequency**
Control						

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Resource J – Indicators to MWIA factors and components

Mapping indicators to MWIA factors and components:
to assist with matching impacts on the MWIA factors and components other indicators that might be collected on your proposal might act as proxy indicators. Here are some suggestions:

MWIA Factor and Components	Specific indicators
ENHANCING CONTROL	
Individual level	
A sense of control e.g. setting and pursuit of goals, ability to shape own circumstances	• **Young people's participation in positive activities** • **% of people who feel they can influence decisions in their locality**
Belief in own capabilities and self determination e.g. sense of purpose and meaning	• **Emotional health of children** • **Emotional and behavioural health of children in care** • **Self-reported measure of people's overall health and wellbeing**
Knowledge, skills and resources to make healthy choices e.g. understanding what makes us healthy and being able to make choices	• **Use of public libraries** • **Migrants English language skills and knowledge** • **Alcohol-harm related hospital admission rates** • **Drug users in effective treatment** • **Prevalence of Chlamydia in under 20 year olds** • **Substance misuse by young people**
Maintaining independence e.g. support to live at home, care for self and family	• **People with a long-term condition supported to be independent and in control of their condition** • **People supported to live independently through social services (all ages)** • **People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently** • **Number of vulnerable people achieving independent living** • **Number of vulnerable people who are supported to maintain independent living** • **Health related quality of life for Older people. This is one of the proposed public health outcomes**

MWIA Factor and Components	Specific indicators
Community / organisation level	
Self help provision e.g. information advocacy, groups, advice, support	
Opportunities to influence decisions e.g. at home, at work or in the community	• **% of people who feel they can influence decisions in their locality**
Opportunities for expressing views and being heard e.g. tenants groups, public meetings	• **% of people who feel they can influence decisions in their locality**
Workplace job control e.g. participation in decision making, work-life balance	• **Work sickness absence This is one of the proposed public health outcomes**
Collective organisation and action e.g. social enterprise, community-led action, local involvement	• **Residual household waste per head** • **Improved street and environmental cleanliness (levels of graffiti, litter, detritus and fly posting)** • **Improved street and environmental cleanliness – fly tipping**
Resources for financial control e.g. access to credit union, welfare rights, debt management	• **Children in Poverty. This is one of the proposed public health outcomes**

MWIA Factor and Components	Specific indicators
RESILIENCE AND COMMUNITY ASSETS	
Individual level	
Emotional well-being e.g. self esteem, self worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun	• Emotional health of children • Emotional and behavioural health of children in care • Obesity among primary school age children in Reception Year • Obesity among primary school age children in Year 6 • Children and young people's participation in high-quality PE and sport • Secondary schools judged as having good or outstanding standards of behaviour? • Self-reported measure of people's overall health and wellbeing • Self reported experience of social care users
Ability to understand, think clearly and function socially e.g. problem solving, decision making, relationships with others, communication skills	• Emotional health of children • Emotional and behavioural health of children in care • Secondary schools judged as having good or outstanding standards of behaviour
Have beliefs and values e.g. spirituality, religious beliefs, cultural identity	
Learning and development e.g. formal and informal education and hobbies	• Use of public libraries • Visits to museums or galleries • Engagement in the arts • Young offenders engagement in suitable education, employment or training • Achievement of various qualifications • Various education targets
Healthy lifestyle e.g. taking steps towards this by healthy eating, regular physical activity, and sensible drinking	• Adult participation in sport • Young people's participation in positive activities • All-age all cause mortality rate • % of adults meeting the recommended guidelines on physical activity (% x 30 minutes a week

MWIA Factor and Components	Specific indicators
Community level	
Trust and safety e.g. belief in reliability of others and services, feeling safe where you live or work	• **Perceptions that people in the area treat one another with respect and dignity** • **Social Connectedness. This is one of the proposed public health outcomes** • **Satisfaction with the way the police and local council dealt with antisocial behaviour** • **Satisfaction of different groups with the way the police and local council dealt with anti-social behaviour** • **Understanding of local concerns about anti-social behaviour and crime by the local council and police** • **Repeat incidents of domestic violence** • **Perceptions of drunk or rowdy behaviour as a problem** • **Perceptions of drug use or drug dealing as a problem** • **Hospital admissions caused by unintentional and deliberate injuries to children and young people** • **Children who have run away from home/care overnight** • **Children who have experienced bullying**
Social networks and relationships e.g. contact with others through family, groups, friendships, neighbours, shared interests, work	• **Perceptions that people in the area treat one another with respect and dignity**
Emotional support e.g. confiding relationships, provision of counselling support	• **Specialist support to victims of a serious sexual offence** • **Drug users in effective treatment** • **Effectiveness of child and adolescent mental health (CAMHs) services** • **Services for disabled children**
Shared public spaces e.g. community centre, library, faith settings, café, parks, playgrounds, places to stop and chat	• **Visits to museums or galleries** • **Access and utilisation of green space**
Sustainable local economy e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks	
Arts and creativity e.g. expression, fun, laughter and play	• **Visits to museums or galleries** • **Engagement in the arts**

MWIA Factor and Components	Specific indicators
PARTICIPATION AND SOCIAL INCLUSION	
Individual level	
Having a valued role e.g. volunteer, governor, carer	• Civic participation in the local area • Participation in regular volunteering
Sense of belonging e.g. connectedness to community, neighbourhood, family, group, work team	• % of people who feel that they belong to their neighbourhood • Perceptions that people in the area treat one another with respect and dignity • Social Connectedness. This is one of the proposed public health outcomes
Feeling involved e.g. in the family, community, at work	• Civic participation in the local area • Participation in regular volunteering
Community / organisation	
Activities that bring people together e.g. connecting with others through groups, clubs, events, shared interests	• Adult participation in sport • Children and young people's participation in high-quality PE and sport • Participation in regular volunteering
Practical support e.g. childcare, employment, on discharge from services	• Number of Sure Start Children Centres • Take up of formal childcare by low-income working families • Timeliness of social care packages
Ways to get involved e.g. volunteering, Time Banks, advocacy	• Civic participation in the local area • Participation in regular volunteering • Adult participation in sport • Children and young people's participation in high-quality PE and sport • Young people's participation in positive activities
Accessible and acceptable services or goods e.g. easily understood, affordable, user friendly, non-stigmatising, non-humiliating	

MWIA Factor and Components	Specific indicators
Cost of participating e.g. affordable, accessible	• Number of affordable homes delivered (gross) • Changes in Housing Benefit/ Council Tax Benefit entitlements within the year • Value for money – total net value of on-going cash-releasing value for money gains that have impacted since the start of the 2008-9 financial year
Conflict resolution e.g. mediation, restorative justice	• Perceptions of parents taking responsibility for the behaviour of their children in the area • Dealing with local concerns about anti-social behaviour and crime by the local council and police • Satisfaction with the way the police and local council dealt with antisocial behaviour • Satisfaction of different groups with the way the police and local council dealt with anti-social behaviour
Cohesive communities e.g. mutual respect, bringing communities together	• % of people who believe people from different backgrounds get on well together in their local area • Perceptions that people in the area treat one another with respect and dignity • Perceptions of parents taking responsibility for the behaviour of their children in the area • Social Connectedness. This is one of the proposed public health outcomes
PROTECTIVE FACTORS FOR WIDER DETERMINANTS	
Access to quality Housing e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate	• Overall/general satisfaction with local area • Young offenders access to suitable accommodation • Net additional homes provided • Number of affordable homes delivered (gross) • Number of households living in Temporary Accommodation • % decent council homes • Supply of ready to develop housing sites • Local Authority tenants' satisfaction with landlord services • Housing overcrowding rates

MWIA Factor and Components	Specific indicators
Physical Environment e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment	• Overall/general satisfaction with local area • Principal roads where maintenance should be considered • Non-principal roads where maintenance should be considered • Previously developed land that has been vacant or derelict for more than 5 years • Per capita CO_2 emissions in the LA area • Level of air quality – reduction in NO_x and primary PM_{10} emissions through local authority's estate and operations • Improved street and environmental cleanliness (levels of graffiti, litter, detritus and fly posting) • Improved street and environmental cleanliness – fly tipping • Access and utilisation of green space • Percentage of the population affected by environmental, neighbour and neighbourhood noise
Economic security e.g. access to secure employment (paid and unpaid), good working conditions, meaningful work and volunteering opportunities	• Participation in regular volunteering • Environment for a thriving third sector • Offenders under probation supervision in employment at the end of their order or licence • Adults with learning disabilities in employment • Care leavers in employment, education or training • Adults in contact with secondary mental health services in employment • Overall employment rate • Working age people on out of work benefits • Working age people claiming out of work benefits in the worst performing neighbourhoods
Good quality food e.g. affordable, accessible	• Food establishments in the area which are broadly compliant with food hygiene law
Leisure opportunities to participate in arts, creativity, sport, culture	• Adult participation in sport • Use of public libraries • Visits to museums or galleries • Engagement in the arts • Children and young people's participation in high-quality PE and sport • Young people's participation in positive activities

MWIA Factor and Components	Specific indicators
Tackling inequalities e.g. addressing poverty, deprivation	• **Environment for a thriving third sector**
Transport access and options e.g. providing choice, affordability and accessibility	• **Access to services and facilities by public transport, walking and cycling** • **Working age people with access to employment by public transport (and other specified modes)** • **Local bus passenger journeys originating in the authority area** • **Bus services running on time** • **Children travelling to school – mode of travel usually used**
Local democracy e.g. devolved power, voting, community panels	• **Civic participation in the local area** • **% of people who feel they can influence decisions in their locality**
Ease of access to **high quality public services** e.g. housing support, health and social care	• **Effectiveness of child and adolescent mental health (CAMHs) services** • **Specialist support to victims of a serious sexual offence** • **Drug users in effective treatment** • **Services for disabled children**
Access to Education e.g. schooling, training, adult literacy, hobbies	• **Migrants English language skills and knowledge**
Challenging discrimination e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith	

Resource K – Useful resources and websites for MWIA

Foresight Project on Mental Capital and Wellbeing (July 2006 – October 2008)
http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp

Health Impact Assessment Gateway
http://www.hiagateway.org.uk
The HIA Gateway is funded by the Department of Health (England) and provides access to documents and information for practitioners and commissioners of Health Impact Assessment (HIA), those new to HIA and those interested in other impact assessments (e.g. Integrated Impact Assessment (IIA), Mental Well-being Impact Assessment (MWIA) and Strategic Environmental Assessment (SEA). It is both a national and international resource. MWIA information and resources can be found throughout all sections of the HIA Gateway (MWIA web pages; Reports; Guides; Tools; Evidence; Policy Documents; Evaluation; Current Use; Theory; Links; and Events and Training Courses). The MWIA Toolkit can be found under "Tools" and completed MWIA reports (worth looking through before going further with your own MWIAs) are listed under "Reports" using the filter "MWIA".

IMHPA – International Mental Health Promtion and Action
http://www.gencat.net/salut/imhpa/Du32/html/en/Du32/index.html
IMHPA is the second phase of a European Network for Mental Health Promotion and Mental Disorder Prevention project. It consists of an international network of expert partners in 30 European countries and 7 international networks and professionals who share the aim of supporting the development and implementation of mental health promotion and mental disorder prevention action across Europe. The site includes a searchable database of mental health promotion programmes and an evidence base and useful description of risk and protective factors for mental health.

Journal of Public Mental Health
http://www.mentalhealth.org.uk/publications

Measuring Well-being in Lambeth
Copies can be obtained from wellbeing@lambethpct.nhs.uk
This handbook gives guidance on how to measure well-being to better understand and improve the lives of people living in Lambeth. It could be applied to people living elsewhere. It was produced by the *centre for wellbeing*, **nef** (new economics foundation), an independent think tank working on behalf of Lambeth partners and the Lambeth Mental Health Promotion steering group.

Mental Health Improvement Evaluation Guides
http://www.healthscotland.com/mental-health-publications.aspx
National Institute for Mental Health in England (2005) Making it Possible: improving mental health and well-being in England. This guidance provides good practice to support the development and delivery of action to improve mental health and wellbeing. It sets out a framework for action to raise public awareness of how to look after personal mental health and other people's, and to involve communities and organisations in taking positive steps to promote and protect mental well-being. The key areas promoted in the publication include marketing mental health, equality and inclusion, and support for parents and other carers of young children.

National Mental Health Development Unit NMHDU
http://www.nmhdu.org.uk
Launched in April 2009, consists of a small central team and a range of programmes funded by both the Department of Health and the NHS. It provides national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services.

New Economics Foundation – Centre for Well-being
http://www.neweconomics.org/gen/well_being_top.aspx?page=1038&folder=174&
Written by the New Economics Foundation this is a useful resource of measure of well-being

North east Mental Health Observatory
http://www.nepho.org.uk/mho/
The Mental Health Observatory exists to collate and make available data about mental health care in England, collected routinely or through special surveys, by health and social services.

Scottish Mental Health Indicator Set
http://www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx

Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
www.healthscotland.com/documents
Newly developed scale for assessing positive mental health (mental well-being).

Mental Wellbeing Checklist (NMHDU 2010)
http://www.nmhdu.org.uk/news/mental-wellbeing-checklist-available-to-download/

The former NMHDU developed and published a mental wellbeing checklist. It is simple and easy to use and helps the reader become more familiar with the major influences on mental well-being and provides a quick reference source to help with local improvements and actions as part of local commissioning, development, review, delivery or evaluation.

The checklist is designed for use across organisations and sectors e.g. the voluntary and community sector, private sector, education, community development and particularly for those working in Public Health and Health Improvement, Local Government, Social Care, NHS and Employment where mental well-being is a growing priority. The checklist is evidence based and provides information on what we know protects individual and community mental well-being, what the wider determinants of mental well-being are and which populations face the greatest inequalities in mental well-being.

The checklist helps to answer some familiar questions for developing local public health and health improvement work, such as: Are specific protective factors being addressed appropriately - at the individual and community level? Are the wider structural determinants being considered? Has attention been paid to particular groups - is it equitable for all people?

The role of Local Authorities in promoting population well-being (LGID/NMHDU, 2010)
http://www.idea.gov.uk/idk/core/page.do?pageId=23692693

Jointly commissioned by Local Government (LG) Improvement and Development and the former National Mental Health Development Unit and written by nef (the new economics foundation), this report examines how local government can support a better life for its citizens to help build resilient communities, both now and in the long term.

The role of local government in promoting wellbeing is a thought-provoking report which speaks to the heart of what local government is about. While local government has begun to engage with the evidence base on wellbeing, much more needs to be done. In becoming 'wellbeing aware' at every level, local government has the opportunity to think and act differently in order to realise cost savings, and at the same time build healthier, more equal and more capable communities. It will also help to enhance communities' abilities to participate in the 'big society' and in local decision making.

The Commissioning mental wellbeing for all – A toolkit for commissioners (2010, NMHDU/UCLAN)
http://www.nmhdu.org.uk/news/commissioning-wellbeing-for-all-a-toolkit-for-commissioners

This toolkit was commissioned by the former NMHDU and developed and produced by Karen Newbigging and Chris Heginbotham, The International School for Communities, Rights and Inclusion - University of Central Lancashire It provides a resource for local authority and

health commissioners to improve the mental wellbeing of people living in their areas.

Population mental wellbeing has been the focus for research and development over the last decade both in the UK and internationally. It has been shown to have real potential to improve the quality of people's lives, relationships and communities. This will only be further realised if health service and local authority commissioners think more about and act on the mental health and wellbeing of the wider population, as well as on preventing or ameliorating the effects of mental illness. Taken together these activities are not in conflict with each other, in fact they are mutually supportive and reinforcing and help achieve the wider social and economic outcomes we desire.

This toolkit will help with this real and emerging arena and provides some helpful resources and pointers to appropriate strategies and interventions. It is intended to be a helpful guide for moving this agenda forward locally and to be a step on the road to improved strategic commissioning for mental wellbeing.

The toolkit cites MWIA as a key resource to support the commissioning process, in particular for securing collaboration across sectors in promoting well-being.

'Public mental health and well-being – the local perspective'. (2011, NHS Confederation/NMHDU)
http://www.nhsconfed.org/Publications/reports/Pages/Public-mental-health-well-being-local-perspective.aspx

Government programmes, policies and national projects in the last three years have given increasing emphasis to public mental health and well-being. This has changed the focus of public service agencies towards promoting and protecting better mental health, not just among the unwell but across whole populations.

This report examines local leaders' perceptions of public mental health and well-being, the progress they have made, how they are acting on recent evidence, and the complementary nature of addressing mental illness and improving mental well-being. It aims to describe the current state of public mental health and well-being and to provide a sense of what would help to take this work forward locally and nationally.

The MWIA toolkit is noted to be a useful tool for localities to measure the impact of a public service or activity on public mental wellbeing.

Resource L – Master list of References and Bibliography

Aked J et al (2009) *Backing the Future: why investing in children is good for us all* London: New Economics Foundation (available: : http://neweconomics.org/events/2010/02/18/backing-the-future-making-the-case-for-prevention-and-co-production)

Aldridge, F. and Lavender, P. (2000) *The Impact of Learning on Health: Key Findings.* Leicester: National Institute of Adult Continuing Education.

Alkire, S. (2007) *Concepts and Measures of Agency*. Oxford: Oxford University Press Oxford Poverty and Human Development Initiative. (available: http://www.ophi.org.uk)

Alves, S. and Sugiyama, T. (2006) *Literature review on the benefits of access to outdoor environments for older people.* Edinburgh: OPENspace Research Centre, Edinburgh College of Art. (available: http://www.idgo.ac.uk/useful_resources/for_other_researchers.htm#references)

Anderson LM, Shinn C, Fullilove MT et al (2003). *The effectiveness of early childhood development programs: A systematic review*. American Journal of Preventive Medicine, 24(3S), 32-46.

Arah, O.A. (2008) Effect of voting abstention and life course socioeconomic position on self reported health. *Journal of Epidemiology and Community Health,* 62: 759-760.

Audit Commission's Library of Local Performance Indicators, which includes a mix of objective quality of life and subjective well-being indicators (often linked to particular life domains such as health, economy, neighbourhood). (available at: http://www.local-pi-library.gov.uk/index.html)

Barry, M. M., & Jenkins, R. (2007) *Implementing Mental Health Promotion.* Oxford: Churchill Livingstone, Elsevier.

Bartley, M., Sacker, A., Schoon, I. *et al*. (2005) *Work, non-work, job satisfaction and psychological health. Evidence review.* London: Health Development Agency.

Bartley, M. (2006) (ed.) *Capability and Resilience: beating the odds.* ESRC Human Capability and Resilience Research Network. London: UCL Department of Epidemiology and Public Health. (available: www.ucl.ac.uk/capabilityandresilience)

Bates, P. (2002) *Working for Inclusion: making social inclusion a reality for people with severe mental health problems.* London: Sainsbury Centre for Mental Health .

Bauman, Z. (2007) Has the future a left? *Soundings: a journal of politics and culture* (available: http://www.lwbooks.co.uk/journals/articles/bauman07.html)

Berkman, L.F., Glass, T., *et al*. (2000) From social integration to health: Durkheim in the new millennium. *Social Science & Medicine,* 51, pp. 843-857.

Blanden, J., Gregg, P. et al (2005) *Intergenerational Mobility in Europe and North America: A Report Supported by the Sutton Trust.* London: London School of Economics. (available: http://cep.lse.ac.uk/about/news/IntergenerationalMobility.pdf)

Brugha, T. S., Weich, S., et al. (2005) Primary group size, social support, gender and future mental health status in a prospective study of people living in private households throughout GB. *Psychological Medicine*, 35 (5), pp. 705-14 (available: http://wrap.warwick.ac.uk/247)

Burchardt, T.(2008) *Time and income poverty.* York: Joseph Rowntree Foundation (available: http://sticerd.lse.ac.uk/dps/case/cr/CASEreport57.pdf)

Bynner J. and Parsons S. (2001) Qualifications, Basic Skills and Accelerating Social Exclusion *Journal of Education and Work*, 14, 280-291

Bywater, T, Hutchings, J, et al. (2009) Long-term effectiveness of a parenting intervention for children at risk of developing conduct disorder *British Journal of Psychiatry 195 318-324*

Caldwell LL (2005). Leisure and health: Why is leisure therapeutic? British Journal of Guidance and Counselling, 33, 7–26.

Centre for the Wider Benefits of Learning (2007) *The wider benefits of learning: a synthesis of findings from the Centre for Research on the wider benefits of learning 1999-2006* London: DCFS (available: http://www.dcsf.gov.uk/research/data/uploadfiles/RCB05-06.pdf)

Chakraborty, A. and McKenzie, K. (2002) Does racism cause mental illness? *British Journal of Psychiatry,* 180, pp. 475-477.

Chandola, T., Brunner, E., (2006) Chronic stress at work and the metabolic syndrome: prospective study. *British Medical Journal,* 332, pp. 521 -5.

Chevalier A and Feinstein L (2006) *Sheepskin or Prozac: The Causal Effect of Education on Mental Health* London: Centre for Economics of Education (available: http://cee.lse.ac.uk/cee%20dps/ceedp71.pdf)

Christopher, J.C. and Hickinbottom, S. (2008) Positive psychology, ethnocentrism, and the disguised ideology of individualism. *Theory and Psychology,* 18(5), pp. 563-589

Chu, A., Thorne, A. et al(2004) The impact on mental well-being of the urban and physical environment: an assessment of the evidence. *Journal of Mental Health Promotion,* 3(2), pp.17-32.

Citizens Advice Bureau (2004) *Out of the picture: CAB evidence on mental health and social exclusion*. London: Citizens Advice Bureau. (available: http://www.citizensadvice.org.uk/out-of-the-picture)

Clarke, C., Myron, R., Stansfeld, S.A. and Candy, B. (2007) A systematic review on the effect of the built and physical environment on mental health. *Journal of Public Mental Health,* 6(2)

Clements, A., Fletcher, D. et al. (2008) *Three years on: survey of the emotional development and well-being of children and young people.* London: ONS (available: http://www.statistics.gov.uk/cci/article.asp?id=2063)

Coggins, T., Cooke, A., Friedli, L., Nicholls, J., Scott-Samuel, A. And Stansfield, J. (2007) *Mental Well-being Impact Assessment Toolkit.* Manchester: Care Services Improvement Partnership (available: http://www.apho.org.uk/resource/view.aspx??RID=70495)

Commission on the Social Determinants of Health. (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health* Geneva: World Health Organization (WHO) (available: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

Communities and Local Government (2009??) *Strong and prosperous communities – The Local Government White Paper. Final implementation plan*. London: The Stationery Office. (available: http://www.communities.gov.uk/documents/localgovernment/pdf/1179718.pdf)

Comprehensive Area Assessment (available: http://www.audit-commission.gov.uk/localgov/audit/caa/Pages/default.aspx)

Cooke,A., Stansfield,J. (2009) *Improving Mental Well-being through Impact Assessment. A summary of the development and application of a Mental Well-being Impact Assessment Tool.* London: National Mental Health Development Unit.

Countryside Recreation Network (2005) *A Countryside for Health and Well-being: The Physical and Mental Health Benefits of Green Exercise.* Sheffield: Countryside Recreation Network. (available: http://www.countrysiderecreation.org.uk/pdf/CRN%20exec%20summary.pdf)

Daykin N, Byrne E, Soteriou T, O'Connor S (2008) Review: The impact of art, design and environment in mental healthcare: a systematic review of the literature. Journal of the Royal Society for the Promotion of Health, 128(2), 85-94

Dench, S. and Regan, J. (2000) *Learning in later life: motivation and impact.* London: Department for Education and Skills.

Department for Communities and Local Government (2008) *Communities in Control: real people, real power.* London: The Stationary Office. (available: http://www.communities.gov.uk/publications/communities/communitiesincontrol)

Department for Education and Skills (2003) *Every Child Matters*. London: Department for Education and Skills. (available: http://publications.everychildmatters.gov.uk/eOrderingDownload/ECM-Summary.pdf)

Department for Environment, Food and Rural Affairs (2007) *Sustainable development indicators in your pocket 2007* London: Department for Environment, Food and Rural Affairs (available: http://www.defra.gov.uk)

Department for Food and Rural Affairs (2005) *Securing the future delivering UK sustainable development strategy.* London: The Stationery Office (available: http://www.defra.gov.uk/sustainable/government/publications/uk-strategy/documents/SecFut_complete.pdf)

Department of Health (2001) *Valuing people: a new strategy for learning disability for the 21st century.* London: Department of Health. (availability http://valuingpeople.gov.uk/dynamic/valuingpeople4.jsp)

Department of Health (2004) *Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Ethnic Communities* Leeds: NIMHE/CSIP (available: http://www.nmhdu.org.uk/silo/files/cultures-black-minority.pdf)

Department for Health (2004) *Choosing Health: Making healthy choices easier.* London: The Stationery Office (available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550)

Department for Health (2006) *Our health, our care, our say.* London: The Stationery Office (available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453)

Department of Health (2007) Report of the Review of Arts and Health Working Group. http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073589.pdf

Department of Health (2008) South East Public Health Observatory (2008) *Children and Young People: promoting emotional health and well-being*. London: CSIP South East (available: http://www.sepho.org.uk/Download/Public/11536/1/Information%20Series%20-%20CYP%20Emotional%20Health%20and%20Well-being24PP%20-%20Sallie%20Bacon%20-%20June%202008.pdf)

Department for Health (2009) *New Horizons: a shared vision for mental health.* London: The Stationery Office (available: http://www.newhorizons.dh.gov.uk/assets/Reports/299060_NewHorizons_acc.pdf)

Department of Health (2010) *A vision for social care: Capable communities and active citizens.* London: HMG http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

Department of Health (2010) *Healthy lives healthy people: Our strategy for public health in England.* London: HMG

Department of Health (Feb.2011) *No health without mental health.* London: HMG http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

Department for Work and Pensions (2008) *Health, work and well-being – Caring for our future A strategy for health and well-being of working age people.* London, UK (available: http://www.dwp.gov.uk/docs/health-and-wellbeing.pdf)

De Silva, M.J. *et al* (2005) Social capital and mental illness: a systematic review. *Journal of Epidemiology and Community Health, 59*, pp.619-627.

Dolan P, Peasgood T, White M (2006) Review of research on the influences on personal well-being and application to policy making. London: DEFRA

Dorling, D., Mitchell, R., et al (2007) The global impact of income inequality on health by age: an observational study. *BMJ Research*, 335(873)

Dorling, D., Rigby, J., *et al* (2007) *Poverty, wealth and place in Britain 1968-2005.* Bristol: the Policy Press.

Douglas, M., *et al* (2007) (eds.) *Health Impact Assessment of Transport Initiatives: A Guide*. Edinburgh: NHS Health Scotland.

Dugdale, G. and Clark, C (2008) *Literacy changes lives: an advocacy resource.* London: National Literacy Trust (available: http://www.literacytrust.org.uk)

Dwelly T (2001) Creative Regeneration: lessons from ten community arts projects, York: Joseph Rowntree Foundation.

Equalities Review (2007) *Fairness and Freedom: the final report of the equalities review.* London: Cabinet Office (available: http://www.theequalitiesreview.org.uk)

Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) Reports (2002) Department of Health (available: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/ListOfSurveySince1990/Surveylistmentalhealth/DH_4001578)

European Green Paper and Consultation (2006) *Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union.* Brussels: European Union (available: http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf)

European Social Survey (ESS) 2006 included a well-being module covering 50 questions designed by a consortium led by Felicia Huppert at the University of Cambridge and involving the new economics foundation (nef) (available at: http://www.europeansocialsurvey.org/)

European Union (2008) *High-level Conference.European Pact for Mental Health and Wellbeing.* Brussels: European Union (available: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf)

Evans, G. and Shaw, P. (2004) *The contribution of culture to regeneration in the UK: a review of the evidence.* London Metropolitan University. London: Department for Culture, Media and Sport

Evans, O. *et al.* (2003) *The mental health of older people: report based on the analysis of the ONS Survey of Psychiatric Morbidity among Adults in Great Britain carried out in 2000 for the Department of Health, the Scottish Executive Health Department and the Welsh Assembly Government.* London: HMSO (available: http://www.statistics.gov.uk/downloads/theme_health/PMA-MentalOlder.pdf)

Fagg, J., Curtis, S., et al. (2006) Psychological distress among adolescents, and its relationship to individual, family and area characteristics in East London. *Social Science & Medicine,* 63(3), pp.636-648.

Feinstein L, Budge D, Vorhaus J, Duckworth K (2008) The social and personal benefits of learning. A summary of key research findings. Institute of Education. University of London. http://www.learningbenefits.net/Publications/FlagshipPubs/Final%20WBL%20Synthesis%20Report.pdf

Feinstein, L. and Duckworth, K. (2006). *Development in the early years: its importance for school performance and adult outcomes.* London: Centre for Research on the Wider Benefits of Learning (available: http://www.learningbenefits.net/Publications/ResReps/ResRep20.pdf)

Feinstein, L., Hammond, C., Woods, et al. (2003). *The Contribution of adult learning to health and social capital. Wider Benefits of Learning Research Report No.8.* London: The Centre for Research on the Wider Benefits of Learning (available: http://www.learningbenefits.net/Publications/ResReps/ResRep8.pdf)

Feinstein, L., Lupton, R., *et al*. (2008) *The public value of social housing: a longitudinal analysis of the relationship between housing and life chances.* London: The Smith Institute.

Feinstein L, Sabates R (2007) The public value of adult learning: Skills and social productivity. http://archive.niace.org.uk/lifelonglearninginquiry/docs/Feinstein-Sabates12.pdf

Fergusson, D., Horwood, J. et al. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology and Psychiatry*, 46(8), pp. 837-849.

Ferrie, J.E. (2007) (ed.) *Work, stress and health: Findings from the Whitehall II study* London: Cabinet Office/University College London.

Ferrie, J.E. (2007) (ed.) *Work, stress and health: Findings from the Whitehall II study*. London: Cabinet Office/University College London.

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

Foresight Project on Mental Capital and Wellbeing (July 2006 – October 2008) http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp

Friedli, L. (2009) *Mental health, resilience and inequalities – a report for WHO Europe and the Mental Health Foundation.* London/ Copenhagen: Mental Health Foundation and WHO Europe (available: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Friedli, L. and Carlin, M. (2009) *Resilient relationships in the North West: what can the public sector contribute?* Manchester: Department of Health/NHS North West

Friedli, L., Oliver, C., et al. (2007) *Mental health improvement: evidence based messages to promote mental well-being - A report for NHS Health Scotland.* Edinburgh: NHS Health Scotland.(available: http://www.healthscotland.com/documents/2188.aspx)

Friedli, L. and Parsonage, M. (2007) *Mental health promotion: building an economic case.* Belfast: Northern Ireland Association for Mental Health (available: http://www.niamh.co.uk/)

Friedli L and Parsonage M (in press) *Promoting mental health and preventing mental illness: the economic case for investment in Wales* Cardiff: Welsh Assembly Government

Friedli L, Watson S (2004) Social prescribing for mental health Leeds and York: Northern Centre for Mental Health

Galobardes, G., Lynch, J. and Smith, G.D. (2007) Measuring socioeconomic position in health research. *British Medical Bulletin,* 81-82, pp.21-37.

Godfrey, M. and Denby, T. (2004) Depression and Older People: towards securing well-being in later life. Bristol: Help the Aged/Policy Press (available: www.policypress.org.uk)

Gordon, D., Adelman, L., et al. (2000) *Poverty and Social Exclusion in Britain.* York: Joseph Rowntree Foundation.

Government Office for Science (2008) *Foresight mental capital and well-being project: final project report.* London: Government Office for Science.

Graham, H. (2004) Social determinants and their unequal distribution: clarifying policy understandings. *Millbank Quarterly,* 82(1), pp. 101-24.

Green, H., McGinnity, A. *et al.* (2005) *Mental health of children and young people in Great Britain 2004.* London: Office of National Statistics (available: http://www.statistics.gov.uk/downloads/theme_health/GB2004.pdf)

Green, A. and White, R.J. (2007) *Attachment to place: social networks, mobility and prospects of young people.* York: Joseph Rowntree Foundation.

Guite, H.F., Clark, C. and Ackrill, G. (2006) The impact of the physical and urban environment on mental well-being *Public Health* 120, pp.1117-1126.

Hagel, A. (2004) *Time Trends in Adolescent Well-being.* London: Nuffield Foundation (available: www.nuffieldfoundation.org/fileLibrary/pdf/2004_seminars_children_families_adolescents_and_well-beingwell-being.pdf)

Hammond, C. and Feinstein, L. (2005) The effects of adult learning on self-efficacy *London Review of Education*, 3(3), pp. 265-87.

Hammond, C. and Feinstein, L. (2006) *Are those who flourished at school healthier adults? What role for adult education?* Wider Benefits of Learning Research Report No.17.

Harris, E.C. and Barraclough, B. (1998) Excess mortality of mental disorder. *The British Journal of Psychiatry,* 173(11), pp.11-53.

Harrison, D. et al. (2004) Assets for Health and Development (AHDP) Developing a Conceptual Framework. Copenhagen: World Health Organisation Regional Office for Europe.

Hart, J. (2008) *Driven to excess: impacts of motor vehicle traffic on residential quality of life in Bristol.* Bristol: University of West of England (available: http://www.2shared.com/file/3788304/f7ea0c6c/DrivenToExcess.html)

Health Impact Assessment Gateway http://www.hiagateway.org.uk

Health Scotland, Greenspace Scotland, Scottish Natural Heritage, Institute of Occupational Medicine (2008) *Health Impact Assessment of Greenspace: A Guide*. Stirling: Greenspace Scotland (available: http://www.greenspacescotland.org.uk/upload/File/Greenspace%20HIA.pdf)

Home Office (2005) *Domestic violence: a national report.* London: Home Office (available: http://www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence51.htm)

HM Treasury (2007) *The 2007 Comprehensive Spending Review:prospects and Processes. Sixth Report of Session 2006–07*. London: The Stationery Office Limited (available: http://www.hm-treasury.gov.uk/sr_csr07_index.htm)

HM Treasury (2008) *Developments in the economics of well-being*. London: HM Treasury (available: http://www.hm-treasury.gov.uk/treasury_economic_workingpaper4.htm)

Hughes, J. (2005) *Doing the arts justice: a review of research literature, practice and theory*. London: Arts Council England.(available: http://webarchive.nationalarchives.gov.uk/+/http://www.culture.gov.uk/NR/rdonlyres/D4B445EE-4BCC-4F6C-A87A-C55A0D45D205/0/Doingartsjusticefinal.pdf)

Huppert FA, Marks N, Clark A, Siegrist J, Stutzer A, Vitterso J and Wahrendorf M (2008) 'Measuring Well-being Across Europe: Description of the ESS Well-being Module and Preliminary Findings'. PSE Working Papers 2008-0, PSE (Ecole normale supérieure).

Hutchings, J., Bywater, T., et al. (2007) Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. British Medical Journal, 334,

IMHPA – International Mental Health Promtion and Action http://www.gencat.net/salut/imhpa/Du32/html/en/Du32/index.html

Inequalities and Unfair Access Issues Emerging from the DHSSPS (2004) *Equality and Inequalities in Health and Social Care: A Statistical Overview Report* (available: http://www.dhsspsni.gov.uk/disabilitymentalhealth.pdf)

Irwin, L.G., Siddiqi, A., et al. (2007) *Early Child Development : A Powerful Equalizer Final Report for the World Health Organization's Commission on the Social Determinants of Health.* Geneva: CSDH (available: http://www.who.int/social_determinants/resources/ecd_kn_report_07_2007.pdf)

Jané-Llopis, E., Barry, et al. (2005) (eds.) The evidence of mental health promotion effectiveness: strategies for action. *Promotion and Education,* suppl. 2, pp. 9-25.

Jones, C. *et al*. (2006) Studying social policy and resilience in families facing adversity in different welfare state contexts – the case of Britain and Sweden. *International Journal of Health Services,* 36 (3), pp. 425–442.

Journal of Public Mental Health http://www.mentalhealth.org.uk/publications

Karoly, L.A., Kilburn, M.R., et al. (2003) *Early childhood interventions: proven results, future promises.* California: Rand Labor and Population (available: http://rand.org/pubs/monographs/2005/RAND_MG341.pdf)

King, M., Semlyn, J., See Tai, S., Killaspy et al (2008). *Mental disorders, suicide and deliberate self-harm in lesbian, gay and bisexual people: a systematic review of the literature*. BMC, 8:70.

King, M., McKeown, E., et al. (2003) Mental health and quality of life of gay men and lesbians in England and Wales: controlled, cross-sectional study. *British Journal of Psychiatry,* 183, pp. 552-558.

Kirkwood T, Bond J, May C et al (2008) Foresight Mental Capital and Wellbeing Project. Mental capital through life: Future challenges. The Government Office for Science, London

Kretzmann, J.P. and McKnight, J.L. (1993), *Building Communities from the Inside Out: a Path Toward Finding and Mobilizing a Community's Assets.* Evanston IL: Institute for Policy Research.

Krueger, P.M., Bond Huie, S.A., et al (2004) Neighbourhoods and homicide mortality: an analysis of race/ethnic differences. *Journal of Epidemiology and Community Health,* 58, pp. 223-230.

Krug, E.G. *et al. (2002)* World report on violence and health. Geneva: World Health Organization.

Lawlor E, Neitzert E and Nicholls J (2008) *Measuring value: a guide to social return on investment* London: New Economics Foundation (available: http://www.neweconomics.org/gen/uploads/jkefez55axlzer31smpvcp4520062008134406.pdf)

Livingston, M., Bailey, N. et al (2008) *People's attachment to place: the influence of neighbourhood deprivation.* Coventry: Chartered Institute of Housing.

Leyden, K. (2003) Social capital and the built environment: The Importance of Walkable Neighbourhoods. *American Journal of Public Health,* 93(9)

Local Government Association (2004) 'Community cohesion: an action guide' London: LGA Publications

Lum, T. and Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Ageing*, 27, pp. 31-55.

Lynch, J.W. *et al*. (2000) Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal,* 320, pp.1200-1204.

Lyubomirsky S, King LA, Diener E (2005). The benefits of frequent positive affect. Psychological Bulletin, 131, 803-855.

Maas J, Verheij RA, de Vries S et al (2009) Morbidity is related to a green living environment Journal of Epidemiology and Community Health 63 pp 967-973 (available: http://jech.bmj.com/cgi/content/abstract/63/12/967?etoc)

Marmot, M., Friel, S., *et al*. on behalf of the Commission on Social Determinants of Health (2008) Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet,* 372, pp.1661-1669.

Marmot Review (2010) Fair society, healthy lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review (available: http://ucl.ac.uk/marmotreview)

Accessible summary of the findings of the WHO Commission on the social determinants of health.

Marmot, M. and Wilkinson, R. (2006) *Social determinants of health.* Oxford: Oxford University Press.

Marshall, E. and Thomas, N. (2005). *Traffic calming: The reality of 'road rage'. Home Office Briefing Note 12/00 2005.* London: Home Office (available: http://www.homeoffice.gov.uk/rds/prgpdfs/brf1200.pdf)

Matarasso F (1997) Use or ornament? The social impact of participation in the arts. Comedia. ISBN 1 873667 57 4

McKenzie, K. (2003) Authors' reply. *British Journal of Psychiatry* 182(1), pp. 458. *Both the experience of racial harassment and perceptions of racial discrimination contribute independently to health outcomes.*

McKenzie, K. and Harpham, T. (2006) *Social Capital and Mental Health.* London: Jessica Kingsley.

McKinley,S., Edmonds,N., Coggins,T. (2009) Changing Minds: Tackling discrimination and promoting the mental well-being of people with experience of mental health problems. London, UK: SLaM

McManus, S., Meltzer, H., et al. (2009) *Adult Psychiatric Morbidity in England, 2007: results of a household survey.* The NHS Information Centre (available: http://www.ic.nhs.uk/pubs/psychiatricmorbidity07)

Measuring Well-being In Lambeth by the New Economics Foundation. A practical, introductory guide on how to measure well-being for local projects and services. Contains a range of examples of validated well-being measures and how to use them (available at: http://www.lambethwellbeing.co.uk/Lambeth%20well-being%20handbook.pdf)

Melhuish, E., Belsky, J. et al (2008) *An investigation of the relationship between financial capability and psychological well-being in mothers of young children in poor areas in England.* London: Financial Services Authority.

Melhuish, E., Belsky, J., et al. (2008) Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study, *The Lancet,* 372 (9650), pp. 1641-1647.

Meltzer, H., Corbin, T., et al. (2002) *The mental health of young people looked after by local authorities in England.* London: Office of National Statistics (available: www.statistics.gov.uk)

Melzer, D., Fryers, T. et al (2004) *Social inequalities and the distribution of common mental disorders.* Maudsley Monographs 44. Hove: Psychology Press.

Mental Health Foundation (2006) *Feeding Minds - The impact of food on mental health.* London: Mental Health Foundation.

Mental Health Improvement Evaluation Guides http://www.healthscotland.com/mental-health-publications.aspx National Institute for Mental Health in England (2005)

Mentality (2003). Making it effective: a guide to evidence-based mental health promotion. Radical Mentalities Briefing Paper 1. London: Mentality.

Michaelson J et al (2009) *National Accounts of Well-being: bringing real wealth onto the balance sheet* nef London, UK (available: http://www.neweconomics.org/)

Mind (2007) "*Ecotherapy: The green agenda for mental health*". London: Mind. (available: http://www.mind.org.uk/NR/rdonlyres/D9A930D2-30D4-4E5B-BE79-1D401B804165/0/ecotherapy.pdf)

Mindell J, Biddulph JP, et al. *A Guide to Reviewing Evidence for use in Health Impact Assessment.* London: London Health Observatory, 2006 (available: http://www.apho.org.uk/resource/item.aspx?RID=44867)

Minton A (2009) *Ground Control: Fear and Happiness in the Twenty-First-Century City* London: Penguin (available: www.culturewars.org.uk/index.php/site/article/the_new_public_space)

Mitchell, R. and Popham, F. (2008) Effect of exposure to natural environment on health inequalities: an observational population study. *The Lancet*, 372(9650), pp.1655 – 1660 (available: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61689-X/abstract)

Mitchell, R. and Shaw, R. (2008) Health impacts of the John Muir Award. Glasgow: University of Glasgow. http://www.gcph.co.uk/content/view/165/68/

Morgan, A. and Swann, C. (2004) *Social capital for health: issues of definition, measurement and links to health.* London: Health Development Agency

Mutrie, N., Carney, C., *et al*. (2002) 'Walk in to Work Out': a randomised controlled trial of a self help intervention to promote active commuting. *Journal of Epidemiology and Community Health,* 56(6), pp. 407-412.

Myers, F., McCollam, A., et al. (2005) *Equal Minds: Addressing Mental Health Inequalities in Scotland.* Edinburgh: Scottish Development Centre for Mental Health.

National Indicator Set (NIS) has final definitions for the indicators and is published by Communities and Local Government in February 2008 (available at: http://www.communities.gov.uk/publications/localgovernment/nationalindicatorsupdate)

National Mental Health Development Unit NMHDU http://www.nmhdu.org.uk

NMHDU (2010) *Mental Wellbeing Checklist* London: NMHDU http://www.nmhdu.org.uk/news/mental-wellbeing-checklist-available-to-download/

New Economics Foundation – Centre for Well-being http://www.neweconomics.org/gen/well_being_top.aspx?page=1038&folder=174 & Written by the New Economics Foundation this is a useful resource of measure of well-being

New Economics Foundation (2010) *The role of Local Authorities in promoting population well-being* London: Local Government Improvement Development / NMHDU, 2010) http://www.idea.gov.uk/idk/core/page.do?pageId=23692693

Netuveli, G., Wiggins, R.D. *et al* (2008) Mental health and resilience at older ages: bouncing back after adversity. British Household Panel Survey. *Journal of Epidemiology and Community Health, 62*, pp. 987-99.

Netuveli, G., Wiggins, R.D., *et al*. (2006) Quality of life at older ages: evidence from the English longitudinal study of aging (wave 1). *Journal of Epidemiology and Community Health,* 60, pp. 357-363.

Newbigging, K., Bola, M. and Shah, A. (2008) *Scoping exercise with Black and minority ethnic groups on perceptions of mental well-being in Scotland.* Edinburgh: NHS Health Scotland (available: http://www.healthscotland.com/documents/2803.aspx)

Newbigging,K., Heginbothan,C., The International School for Communities, Rights and Inclusion – University of Central lancashire (2010) *The Commissioning mental wellbeing for all- A toolkit for commissioners* Lancashire: NMHDU/UCLAN) http://www.nmhdu.org.uk/news/commissioning-wellbeing-for-all-a-toolkit-for-commissioners

NHS Confederation (2011) '*Public mental health and well-being – the local perspective*'. London: NHS Confederation / NMHDU http://www.nhsconfed.org/Publications/reports/Pages/Public-mental-health-well-being-local-perspective.aspx

NICE (2009) Promoting mental wellbeing at work: full guidance. http://guidance. nice.org.uk/PH22/Guidance/pdf/English

North east Mental Health Observatory The Mental Health Observatory exists to collate and make available data about mental health care in England, collected routinely or through special surveys, by health and social services. http://www.nepho.org.uk/mho/

Organisation for Economic Cooperation and Development . Measuring the progress of societies.(available: http://www.oecd.org/pages/0,3417,en_40033426_40033828_1_1_1_1_1,00.html)

Ostir, G.V., *et al*. (2000) Emotional well-being predicts subsequent functional independence and survival. *Journal of the American Geriatrics Society,* 48, pp.473–478.

Parkinson, J (2006) *Establishing national mental health and well-being indicators for Scotland* Scotland: Health Scotland (available: http://www.healthscotland.com/mental-health-publications.aspx)

Pevalin, D.J. and Rose, D. (2003) *Social capital for health: investigating the links between social capital and health using the British Household Panel Survey.* Wivenhoe: Institute for Social and Economic Research, University of Essex.

Phelan, M., Stradins, L., et al. (2001) Physical health of people with severe mental illness. *British Medical Journal,* 322, pp. 443-444.

Pickett, K.E., James, O.W. et al (2006) Income Inequality and the Prevalence of Mental Illness: A Preliminary International Analysis. *Journal of Epidemiology and Community Health,* 60, pp.646-647.

Pickett, K.E. and Wilkinson, R.G. (2007) Child well-being and income inequality in rich societies: ecological cross sectional study. *British Medical Journal,* 335(7629), p. 1080 (available: http://www.bmj.com/cgi/content/full/335/7629/1080).

Place2be (2009) *An economic evaluation of The Place2Be's school based early mental health service for children* London: Place2be

Poulton, R. *et al*. (2002) Association between children's experiences of socioeconomic disadvantage and adult health: a life-course study. *British Medical Journal,* 360, pp. 1640-5.

The Poverty Site. The UK site for statistics on poverty and social exclusion. York: Joseph Rowntree Foundation (available: http://www.poverty.org.uk/summary/contact.htm)

Pressman, S. and Cohen, S. (2005) Does positive affect influence health? *Psychological Bulletin*, 131(6), pp. 925-971.

Pretty, J., Peacock, J., et al (2005) The mental and physical health outcomes of green exercise. *International Journal of Environmental Health Research* 15(5), pp.319 – 337.

Public Service Management Wales (2008) *Sowing the Seeds Time Banking: Public Service delivery with Time Credits* Cardiff: Welsh Assembly Government (available: http://www.justaddspice.org/docs/Timebanking%20SS.pdf)

The Question Bank, issued by Communities and Local Government for use alongside the NIS (available at: http://www.communities.gov.uk/publications/localgovernment/placesurveymanual0809)

Report from Independent Commission on Social Mobility (2009)

Richards, M. and Abbotts, R. *et al.* (2009) *Childhood mental health and life chances in post-war Britain. Insights from three national birth cohort studies: summary of evidence on effectiveness and cost effectiveness of early interventions.* London: SCMH/Smith Institute.

Rogers, A. and Pilgrim, D. (2003) *Mental health and inequality*. London: Palgrave Macmillan.

Ruiz, J. (2004) *A literature review of the evidence base for culture, the arts and sport policy.* Edinburgh: Scottish Executive.

Russell Commission (2005) *A national framework for youth action and engagement* London: Cabinet Office (available: http://archive.cabinetoffice.gov.uk/russellcommission/report/index.html)

Ryan-Collins J, Stephens L (2008) *The new wealth of time: how timebanking helps people build better public services* London: New Economics Foundation (available: www.neweconomics.org)

Sabates R, Feinstein L (2006). Education and the take-up of preventative health care. Social Science and Medicine 62, 2998-3010.

Sacker, A. and Schoon, I. (2007) Educational resilience in later life: resources and assets in adolescence and return to education after leaving school at age 16. *Social Science Research,* 36(3), pp.873-896.

Samman, E. (2007) *Psychological and subjective well-being: a proposal for internationally comparable indicators.* Oxford: University of Oxford/Oxford Poverty and Human Development Initiative: (available: www.ophi.org.uk/wp-content/uploads/OPHI-wp05.pdf)

Sayce, L. (2000) *From psychiatric patient to citizen: overcoming discrimination and social exclusion* Basingstoke: Macmillan

Sayce, L. (2008) Thinking big: mental health at the heart of the equalities agenda. *A Life in the Day, 12(1), pp.* 21-23 (availability: http://pavilionjournals.metapress.com/content/116031611430v247/)

Schoon, I. (2006) *Risk and Resilience. Adaptations in changing times*. Cambridge: Cambridge University Press.

Schuller, T., Preston, J., et al. 2004. *The Benefits of Learning: The impact of education on health, family life and social capital.* London: Routledge Falmer

Schuller T, Preston J, Hammond C et al (2004). The benefits of learning: The impact of education on health, family life and social capital. Routledge Falmer.

Scottish Mental Health Indicator Set http://www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx

Scott-Samuel,A., Birley,M., Ardern,K (2001). *The Merseyside Guidelines for Health Impact Assessment.* Second Edition, May 2001. Liverpool,UK: International Health Impact Assessment Consortium (available: http://www.liv.ac.uk/ihia/IMPACT%20Reports/2001_merseyside_guidelines_31.pdf)

Searle B (2008) Well-being: In search of a good life? Bristol, Policy Press

Secker J, Hacking S, Spandler H et al (2007) Mental health, social inclusion and arts: developing the evidence base. Anglia Ruskin University.

Section 5 Place Survey Question Bank (available at: (available: http://www.communities.gov.uk/publications/localgovernment/placesurveymanual0809?view=Standard)

Shah H and Marks N (2004) 'A well-being manifesto for a flourishing society' London: **nef**

Singleton, N. and Lewis, G. (2003) *Better or Worse: a longitudinal study of the mental health of adults living in private households in Great Britain*. London: Stationery Office (available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4081091)

Social Exclusion Unit (2005) *Excluded Older People: Social Exclusion Unit Interim Report*. London: Office of the Deputy Prime Minister (available: http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/better_gov_old.pdf)

Social Exclusion Unit (2002). *Making the connections: Final report on transport and social exclusion.* London: Social Exclusion Unit (available: http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications.aspx)

Social Exclusion Unit (2004) *Mental Health and Social Exclusion: Social Exclusion Unit Report*. London: Office of the Deputy Prime Minister.

Social Exclusion Unit (2005) *Excluded older people: social exclusion unit interim report.* London: Office of the Deputy Prime Minister.

Stansfeld, S.A. (2006). *Social support and social cohesion. in: Marmot, M., Wilkinson, R. (Eds.), Social determinants of health*. Oxford: Oxford University Press

Staricoff RL (2004) Arts in health: a review of the medical literature. Research report 36. Arts Council England. http://www.nasaa-arts.org/nasaanews/B-Health-MedLitReview.pdf

Status, Stress and Health. Seminar Series 2: Paper 1. Glasgow: Glasgow Centre for Population Health.

Stephens, L., Ryan-Collins, J. et al (2008) *Co production: a manifesto for growing the core economy.* London: New Economics Foundation (available: http://www.neweconomics.org/gen/z_sys_publicationdetail.aspx?pid=257)

Steptoe, A. (2005) *How stress gets under your skin: psychobiological studies of social status, stress and health.* Glasgow Centre for Population Health Seminar Series 2: Paper 1 (availability: http://www.gcph.co.uk/content/view/41/57)

Steptoe, A. *et al*. (2007) Neuroendocrine and cardiovascular correlates of positive affect measured by ecological momentary assessment and by questionnaire. *Psychoneuroendocrinology,* 32(1), pp.56-64.

Steptoe, A. and Feldman, P. (2001) Neighbourhood problems as sources of chronic stress: development of a measure of neighbourhood problems and associations with socioeconomic status and health. *Annals of Behavioural Medicine,* 23(3), pp.177-185.

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Steptoe, A. and Wardle, J. (2005) Positive affect and biological function in everyday life. *Neurobiology of Aging,* 26(S1), pp.108-112.

Steuer N and Marks N (2008) *Local well-being: Can we measure it?* nef London, UK (available: http://www.neweconomics.org/)

Stiglitz, J.E., Sen, A. et al. (2009) *Report by the Commission on the measurement of economic performance and social progress.* Paris:Commission on the Measurement of Economic Performance and Social Progress (available: http://www.stiglitz-sen-fitoussi.fr)

Sylva K, Melhuish E, Sammons P et al (2007). Effective pre-school and primary education 3-11 project (EPPE 3-11) a longitudinal study funded by the DfES (2003-2008) Promoting Equality in the Early Years: Report to the Equalities Review. London: Institute of Education. http://archive.cabinetoffice.gov.uk/ equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/promoting_equality_in_the_early_years.pdf

Taylor, M. (2008) *Transforming disadvantaged places: effective strategies for places and people.* York: Joseph Rowntree Foundation.

Taylor,L.,Gowman,N.,Quigley,R. (2003) *Evaluating health impact assessment* London,UK: Health Development Agency (available: http://www.apho.org.uk/resource/item.aspx?RID=83401)

Taylor, M., Jenkins, S. et al. (2009) *Financial capability and well-being: evidence from the BHPS.* London: Financial Services Authority.

Thiel, V. and Nissan, S. (2008) *UK CDFIs – from surviving to thriving: realising the potential of community development finance.* London: New Economics Foundation/Hadley Trust (available: http://www.neweconomics.org/gen/uploads/0jigj3vvcnllcm45vkggnpu007102008165143.pdf)

Thoits, P.A. and Hewitt, L.N. (2001) Volunteer work and well-being *Journal of Health and Social Behavior, 42,* pp.115–131.

Thomson, H., Jepson, R. *et al*. (2008) Assessing the unintended health impacts of road transport policies and interventions: translating research evidence for use in policy and practice. *BMC Public Health,* 8(339) (available: http://www.biomedcentral.com/1471-2458/8/339)

Thompson S and Marks N (2008) *Measuring well-being in policy: issues and applications* London, UK (available: http://www.neweconomics.org/)

UNICEF Innocenti Research Centre (2007) Child poverty in perspective: an overview of child well-being in rich countries. Florence: Innocenti Report Card.

Vale, D., Watts, B. et al (2009) *The receding tide: understanding unmet needs in a harsher economic climate.* London: The Young Foundation.

Van de Weyer, C. (2006) *Changing diets, changing minds: how food affects mental well being and behaviour.* London: Sustain (available: http://www.sustainweb.org/foodandmentalhealth/)

Victorian Health Promotion Foundation (2004) *The health costs of violence: measuring the burden of disease caused by intimate partner violence.* Victoria, Australia: VicHealth (available: http://www.vichealth.vic.gov.au/)

Waddell G, Burton AK (2007) Is work good for your health and well-Being? Independent Review for DWP, DoH, HSE London. http://www.workingforhealth.gov.uk/documents/is-work-good-for-you.pdf

Warner, J., McKeown, E., et al. (2004) Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: results from a survey based in England and Wales. *British Journal of Psychiatry*, 185, pp. 479-485.

Warwick Edinburgh Mental Well-being Survey (WEMWBS), a 14-item validated well-being survey tool (available at: http://www.healthscotland.com/documents/1467.aspx)

Watts, B. (2008) *What are today's social evils: the results of a web consultation.* York: Joseph Rowntree Foundation (available: http://www.socialevils.org.uk/documents/social-evils-report.pdf)

Weyer, S., Dragano, N., *et al*. (2008) Low socio-economic position is associated with poor social networks and social support: results from the Heinz Nixdorf Recall Study. *International Journal for Equity in Health,* 7(13) (available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2424055/)

Wheeler, F.A., Gore, K.M. et al. (1998) The beneficial effects of volunteering for older volunteers and the people they service: a meta-analysis. *International Journal of Ageing and Human Development*, 47, pp. 91.

Wilkinson, R.G. and Pickett, K.E. (2006) Income inequality and population health: a review and explanation of the evidence. *Social Science and Medicine,* 62, pp.1768-1784.

Wilkinson, R.J. and Pickett, K.E. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: The Equality Trust (available: http://www.equalitytrust.org.uk/resource/the-spirit-level)

Woodcraft S (2009) *Neighbourhood working: where do we go from here? Towards a new research agenda* London: Young Foundation (available: http://www.youngfoundation.org.uk/neighbourhood-working-where-do-we-go-here-towards-a-new-research-agenda-saffron-woodcraft-2009)

World Health Organisation (1986) *Ottawa Charter for Health Promotion* Geneva: WHO

WHO. (2001a) *Promoting mental health – concepts-emerging evidence-practice* WHO

WHO (2004a) *Prevention of mental disorders: effective interventions and policy options. Summary Report*. A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: World Health Organization (available: http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf)

WHO (2004b) *Promoting mental health: concepts, emerging evidence, practice: summary report*. A Report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and The University of Melbourne. Geneva: World Health Organization (available: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf)

WHO (2005a) *Facing the challenges, Building Solutions*. Ministerial Conference on Mental Health. EUR/04/5047810/6. Helsinki/London: World Health Organization (available: http://www.euro.who.int/document/MNH/edoc06.pdf)

WHO (2005b) *Mental Health Action Plan for Europe: facing the challenges, building solutions.* Copenhagen: World Health Organisation.

Worpole, K. and Knox, K. (2007) *The social value of public spaces.* York: Joseph Rowntree Foundation.

Zaveleta, R.D. (2007) *The ability to go about without shame: a proposal for internationally comparable indicators of shame and humiliation.* Working Paper 3. Oxford: University of Oxford (available: http://www.ophi.org.uk/research/missing-dimensions/without-shame)