Understanding the Barriers to Raising Population Wellbeing

A report for the Department of Health and Sciencewise-ERC

Preface

This report was written by Sorcha Mahony, Sam Thompson and Charles Seaford at the Centre for Wellbeing, **nef** (the new economics foundation), with significant input from David Corr and Hugh Willbourn at Corr Willbourn Research and Development.

The report provides details of research that was conducted for the Department of Health and Sciencewise-ERC, involving a public dialogue exercise designed to explore the barriers that people experience to increasing their engagement with activities thought to enhance subjective wellbeing. The public dialogue exercise, and this report, was commissioned by the Department of Health and Sciencewise-ERC. Whilst this report represents the culmination of the dialogue with the general public, it also marks the early stages of dialogue with policy makers, and in this sense can be understood as the beginning of a bridging process – of trying to bring the public's views to bear on the development of policy around wellbeing, public mental health and positive behaviour change.

The views expressed reflect the research findings and the authors' interpretation; they do not necessarily reflect Department of Health or Sciencewise-ERC policy or opinions.

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Report summary

Background

- Recent developments in UK mental health policy have emphasised the need for an approach to mental health based on promotion and prevention.
- These arguments were bolstered by the findings of the Foresight Project on Mental Capital and Wellbeing (MCW), a state-of-the-science review for the Government Office for Science.
- As part of the project, **nef** (the new economics foundation) developed *Five Ways to Wellbeing*,[1] a set of simple, evidence-based public health messages about the kinds of activities that promote positive mental health: *Connect, Be Active, Take Notice, Keep Learning, Give*.

The research

The Department of Health, in collaboration with Sciencewise-ERC, commissioned **nef** to undertake a public dialogue exercise, with the aim of exploring three questions:

- To what extent do people feel able to make the kinds of **discretionary changes** in their lives that (evidence suggests) would lead to increased subjective wellbeing?
- What, if any, are the **structural or systemic barriers** that prevent people engaging in activities that would improve their wellbeing?
- How might people react to **messages** that use concepts and words of wellbeing and positive mental health, and what should messages be like, who should they be from and should they use science?

A series of structured dialogue events was held in six locations around the country, covering a range of age, ethnic and socio-economic groups. The *Five Ways to Wellbeing* were used as a way to frame the discussion.

Results

Barriers

For some people there was no evidence of significant barriers to engaging in *Five Ways*-type activities; these people typically felt confident in their ability to change their behaviours as they wished, in control of their lives, or manifestly engaged in a high level of *Five Ways*-type activity already.

For others, however, there was evidence of experienced barriers. These can usefully be divided into three categories:

- **External barriers**. For some people, barriers to *Five Ways*-type activity were principally a consequence of factors external to them, and here

lack of time and money, lack of available facilities/ opportunities and major life events were salient.

- **Internal barriers**. Some people indicated that the major barriers they experienced to *Five Ways*-type activity were psychological in nature, such as depression or a strong sense of incapacity.
- **Psycho-social barriers**. Most of the barriers reported fall some way in between the external and internal realms, being a function of how the individual interacts with their social environment; for some people, engaging in (some) *Five Ways*-type activities does not occur to them; for some, finding an enjoyable, relevant form of activity proves difficult; for some, motivation to do relevant things is missing; for some habitual patterns of behaviour crowd out engagement in *Five Ways*-type activities. Some people clearly feel a lack of control in their lives and this in turn may imply the lack of a felt ability to initiate behaviour change. Some feel – and reflect explicitly on the way in which – group, cultural or social norms dictate which behaviours are inside and outside their frame of reference or lived world. Some people appear to feel that they are somehow not entitled to initiate relevant activities, and for some, communication technologies are experienced as a barrier to particular *Five Ways* activity. For some people, pre-existing groups – a key means of engaging with a number of *Five Ways*-type activities – are exclusive and isolating, and in any case there appears to be a lack of non-exclusive, structured groups (family and community) available.

Underpinning many of these barriers is the lack of a felt sense of **agency**. This emerges as a key issue preventing people from making lifestyle changes to improve their wellbeing. In addition, some of the most significant barriers relate to **social norms** and expectations rather than to 'hard' barriers of time and money.

Messaging

The public's responses to the term wellbeing are extremely mixed. Some feel that it is impenetrable and too abstract; some equate it with 'feel-good' products and services (skincare, aromatherapy); some link it to mental health problems. The *Five Ways to Wellbeing* themselves can be interpreted and experienced negatively as well as positively.

Rather than being motivating, framing wellbeing as a *scientific* issue seems to be unnecessary and even unwelcome for many people. Common sense or personal experience is more convincing than the science.

Next steps

Analysis of the findings suggests a number of areas for future research and policy development. In terms of communication, the research suggests that attempts to reach the public through social marketing should:

- Ensure that messages do not appear to come from 'the Government'
- Use concrete messaging that suggests particular activities or actions
- Avoid framing messages as 'scientific'.

The objective of communication should go beyond merely providing information about wellbeing and the *Five Ways* and should instead:

- Work to create a new common language for positive mental health, in a way that makes it seem desirable and attainable

- Raise awareness of opportunities for engaging in wellbeing activities
- Focus on increasing people's felt sense of agency.

Findings from the research are relevant for ongoing work in a number of areas of policy, including the public health and health improvement agendas, mental health, substance misuse and older people. A process of stakeholder policy engagement is currently underway in order to explore the implications of the findings for ongoing policy and strategy development.

Chapter 1: Introduction and background

Recent developments in UK mental health strategy have emphasised the need to move from a largely "deficit" model to an approach giving equal weight to promotion and prevention. In 2009, for example, the previous government launched a new mental health strategy *New Horizons: A Shared Vision for Mental Health* as a replacement for the previous 10-year National Service Framework for mental health. Unlike its predecessor, *New Horizons* emphasised the importance of considering mental health and wellbeing in the population at large, not instead of but *in addition to* a renewed focus on caring for those with particular mental health needs.[2]

In early 2011, the Department of Health launched the Coalition Government's mental health outcomes strategy, *No Health Without Mental Health*.[3] In a similar vein to *New Horizons*, the strategy identifies two overarching goals, namely to:

> *Improve the mental health and wellbeing of the population and keep people well; and*
>
> *Improve outcomes for people with mental health problems through high-quality services that are equally accessible to all (p.5).*

Throughout, *No Health Without Mental Health* gives considerable prominence to the idea that promoting positive mental health in the population is an important goal for policy.

Arguably, however, the approach outlined by the Coalition Government goes further by making explicit the importance of mental health for outcomes across a wide range of "non-health" policy areas. In the foreword to the new strategy, for instance, Secretary of State for Health Andrew Lansley notes that

> *The Government recognises that our mental health is central to our quality of life, central to our economic success and interdependent with our success in improving education, training and employment outcomes and tackling some of the persistent problems that scar our society, from homelessness, violence and abuse, to drug use and crime. (p.2)*

This broader perspective on the significance of mental health in the population is also reflected in the recent public health White Paper *Healthy Lives, Healthy People*,[4] which marks something of a departure over previous strategies by giving equal weight to both physical *and* mental health (the latter having, arguably, been neglected within mainstream public health discourse). At the heart of the strategy is a decentralisation of responsibility for public health to local authorities, through the introduction

of statutory Health and Wellbeing boards in each area and with the support of a new body, Public Health England. The clear intention is that these new bodies should regard promoting good *mental* health as part of their overall remit and will be expected to develop commensurate strategies and interventions.

At a more macro level still, the initiative by the Office of National Statistics (ONS) to develop new indicators of national wellbeing can be seen as reflecting the same agenda. Although the ONS are taking a broad view that encompasses economic and environmental factors, they have committed to include within their indicators a number of subjective measures – i.e. self-reports collected from large-scale surveys of how people feel about their lives both overall and day-to-day.

Improving the nation's mental health is important for a number of reasons. Significantly, if prosaically, mental health difficulties are estimated to account for 22.8 per cent of the total burden of illness in the UK, more than cancer or cardiovascular disease.[5] As such, they cost the UK some £110 billion per year, of which around £32 billion is attributable to lost productivity.[6] Evidently, successfully reducing the prevalence of mental health difficulties would be extremely beneficial from the perspective of the nation's economy.

But perhaps more importantly, whilst poor mental health can be particularly debilitating, recent scientific research strongly suggests that mere absence of mental health problems is not synonymous with good psychological health.[7] True psychological flourishing – what recent academic and policy discourse has labelled *subjective wellbeing* – has been demonstrated as an important correlate of many desirable outcomes both at the individual and social level.[8] Not only are people with high levels of wellbeing less likely to suffer from mental health difficulties, they are likely to have better physical health, better relationships, be more productive at work and more likely to be actively involved in their communities.[9] Longitudinal evidence suggests that these relationships are not merely correlational; in other words, positive wellbeing both pre-empts and drives good outcomes.[10]

Clearly, the concern for improving general wellbeing links to another central plank of the Coalition Government's agenda, namely the Big Society. As the Prime Minister said in a speech in July 2010, "the success of the Big Society will depend on the daily decisions of millions of people – on them giving their time, effort, even money, to causes around them. So government cannot remain neutral on that – it must foster and support a new culture of voluntarism, philanthropy, social action." Encouraging flourishing and high levels of wellbeing will be central to realising the Big Society ambition.

Arguments in favour of policy action to promote wellbeing were significantly bolstered by the findings of the *Foresight Project on Mental Capital and Wellbeing* (MCW), a two-year, state-of-the-science review led by the Government Office for Science.[11] Published in 2008, this report synthesised research from some 400 scientists on the causes and consequences of mental capital and wellbeing, and explored the challenges for government in supporting the mental wellbeing of the population in the future.

The Five Ways to Wellbeing and the business of mental health promotion

As part of the Foresight project, **nef** (the new economics foundation) were commissioned to develop a set of simple, evidence-based public health messages that could communicate key findings from the review about the kinds of activities that promote positive mental health.

The result of this project was the *Five Ways to Wellbeing*[12]: *Connect, Be Active, Take Notice, Keep Learning, Give*. Based on the Foresight project's main science reviews, these were launched alongside the final report in a convenient postcard format. The *Five Ways to Wellbeing* were deliberately framed so as to be straightforward for a non-specialist audience to understand, simple and memorable, and broad enough in scope to feel relatively non-prescriptive whilst remaining true to the evidence base.

Since their launch, the *Five Ways to Wellbeing* messages have been successful in capturing the imagination of many people working in mental health promotion and related fields. They have been used in a number of innovative ways, from school-based educational programmes to public festivals, and picked-up as far afield as Australia and New Zealand.[13]

However, attempts to use the *Five Ways to Wellbeing* illustrate some wider concerns about the efficacy of promoting population mental health, and indeed encouraging people to engage actively with the world around them, through what are, in essence, public education and social marketing methods. One important issue is exemplified in a comment made by a journalist at *The Guardian*, Lucy Mangan, shortly after the Foresight report was launched. In an article describing her experience of spending a day doing "*Five Ways*" activities, she concluded:

> *If I – and almost more importantly, all my friends and family – could find the time and inclination to do it all every day I'm sure I would feel better still. But it remains for all but a fortunate few – whom I suspect are quite happy enough already – essentially unworkable advice. You might as well instruct the nation to live in the 1950s: surely the last time there was any hope of living this way en masse.*[14]

Although evidently written with tongue slightly in cheek, there is an important idea here. The implication is that the kinds of activities implied by the *Five Ways to Wellbeing* may be, in effect, crowded-out by the pressures of modern life. Whilst people would like to do more connecting, being active, taking notice, learning and giving, they are prevented from doing so not because of a lack of motivation, but by a kind of lifestyle "lock-in" in the form of time, financial and other commitments that mitigate against doing those activities that research would suggest are most beneficial to mental health.

This is a serious concern, both for the public mental health and wellbeing agenda and – to the extent that they are related – the Government's Big Society initiative. At present, although real-world evidence on how to achieve population-wide improvements in wellbeing is relatively scant, it is usually assumed that public education and social marketing approaches will be effective (as they have been, to a greater or lesser extent, in other areas of public health). But if some – albeit not necessarily all – aspects of contemporary society are either antithetical to activities that promote

wellbeing or are actively harmful to mental health, then this is clearly problematic for any policy that aspires to promote mental health in the population at large.

Broad aims of the project

The current project was conceived by **nef** (the new economics foundation) and conducted with support from the mental health policy team at the Department of Health and the Sciencewise-Expert Resource Centre (ERC).[15] Sciencewise-ERC is the UK's national centre for public dialogue in policy making involving science and technology issues.

The aim of the project was to conduct a public engagement exercise to explore issues raised by the scientific evidence on promoting public mental health and wellbeing. In particular, the project set out to deepen current understanding of the extent to which people feel able to make the kinds of discretionary changes in their lives that scientific evidence suggests would lead to increased subjective wellbeing. In doing so, it hoped to begin identifying barriers – in particular, but not only, structural / systemic barriers operating at a group or society level – that might prevent people engaging in activities that would improve their wellbeing.

The **nef/**Foresight *Five Ways to Wellbeing* were used as a framing device to help people make sense of the issues. However, the dialogue was *not* intended as a test of the *Five Ways* messages *per se*, but an exploration of the feasibility and desirability of promoting the kinds of behaviours implied by the *Five Ways*. The dialogue was designed in order to allow for an open-ended discussion of wellbeing and the behaviours that support it. The hope was that stimulating public dialogue on this question would yield information of considerable importance for the future success of public mental health policy, in at least four ways.

Firstly, as policy makers and others begin developing interventions that are intended to promote wellbeing through behaviour change, it is important that they start with a solid understanding of what the public think is possible. Where are the areas of life where people feel they have the most power to make positive changes? Conversely, where are the areas where scope for change is most limited, and why? Understanding these issues should lead to a much more nuanced approach to the promotion of public mental health, with all its attendant benefits, and in particular would reveal those areas where social marketing approaches are likely to be most useful as opposed to those where some system-level policy change might have more impact.

Secondly, and relatedly, it was hoped that a public dialogue would yield important information about the desirability and acceptability of initiatives targeted at promoting mental health. Even if there is considerable scope for behaviour change in principle, it is not at all clear that the public are ready to accept efforts to make them change, nor whether the promise of "wellbeing" (or associated concepts such as "happiness", "contentment", "better mental health" and so on) has significant traction as an incentive.

Thirdly, a public dialogue would give rise to indicative information about the potential *effect size* of interventions. At present, limited knowledge about what works in public mental health promotion means that developing a solid economic case is difficult. Evidently, as the figures quoted above attest, the potential prize to the nation in terms of cost and productivity saving is huge.

However, without a thoroughgoing understanding of the scope and extent of the likely effect achieved by a given intervention, it is impossible to construct robust cost-benefit estimates.

Fourthly, although data from a dialogue exercise could not be regarded as representative, it was hoped to gain some insight into differences in terms of barriers experienced, acceptability of messaging amongst people of different ages, genders and socio-economic groups.

It is worth noting, finally, that a public dialogue about wellbeing was hoped to serve as an intervention in itself. The process of engaging with the dialogue would encourage participants to reflect on their own lives and consider the extent to which they could make changes in order to improve their mental health. As well as revealing policy-relevant information, then, it may be that the very process of conducting a Sciencewise-ERC dialogue on these issues would make a small contribution to a happier nation.

Specific research questions

In order to help focus the project, a number of key research questions were identified:

- To what extent do people feel able to make the kinds of discretionary changes in their lives that the scientific evidence – distilled in the *Five Ways to Wellbeing* – suggests would lead to increased subjective wellbeing or that they believe would enhance their wellbeing?
- What structural or systemic barriers to engaging in *Five Ways*-type activities can be identified in what people say?
- How do socio-economic and demographic factors appear to influence what people say about the above two issues?
- How might people react to messages that use concepts and words of wellbeing and positive mental health?
- What should messages be like, who should they be from and should they use science?
- What does all of this tell us about how to increase participation in the Big Society?

Overview of Methodology

There is already public dialogue about wellbeing and quality of life, as well as a considerable amount of activity in terms of public mental health and anti-stigma campaigning. The innovation of the current project was to combine an understanding of positive mental health that is accessible yet based on rigorous science with a wider perspective on the systematic and structural pressures of modern lifestyles. The research followed a five stage process:

1. **Rapid review of existing knowledge**
   nef conducted a "rapid review" of existing knowledge in four areas: 1) relevant science underpinning the *Five Ways to Wellbeing*; 2) known socio-economic "risk factors" for engaging in *Five Ways*-type activities; 3) existing attitudes to mental health issues; and 4) existing initiatives / policies around public mental health promotion.

2. **Design and development of the dialogue process**
   Following a competitive tender process, a specialist consultancy was recruited to conduct the public dialogue. The sampling frame and dialogue process itself was developed collaboratively, incorporating insights from stage 1.
3. **Fieldwork and initial analysis**
   Deliberative events were held in six locations across the country, with almost 100 members of the public from a range of age and socio-economic groups. A small number of in-depth interviews were also conducted with people identified as experiencing low wellbeing.
4. **Analysis**
   In-depth analysis of qualitative data from the dialogue (including transcripts, respondents' written submissions and video recording of group dialogue sessions) was conducted in order to identify key themes and to answer the research questions.
5. **Policy analysis and dissemination**
   A number of workshops and meetings were held with stakeholders within the Department of Health and elsewhere in central government. The aim of these meetings was to begin exploring possible implications of the research for ongoing policy development in a number of areas.

Chapter 2: Summary of the rapid review of existing knowledge

Overview of review process

In this section we present a brief summary of four rapid literature reviews that were conducted prior to the design and commencement of the public dialogue exercise. These focused on:

1. Relevant science underpinning the *Five Ways to Wellbeing*
2. Known socio-economic 'risk factors' for engaging in *Five Ways*-type activities
3. Existing attitudes to mental health issues
4. Existing initiatives/ policies around public mental health promotion.

The aim in each case was not to provide exhaustive coverage of research in each area – this would have been impossible in the time available. Rather, it was to provide the research team with a summary overview of the main issues and findings, in order to shape the design of the dialogue process and avoid 'reinventing the wheel'.

Summary of findings

More detailed summaries of the reviews, including the search methodology, can be found in Appendix 1.

Relevant science underpinning the Five Ways to Wellbeing

The review of literature in this area confirmed that there is a reasonably robust body of evidence to suggest that engaging in *Five Ways*-type activities has a positive effect on mental wellbeing. A range of scientific evidence supports the idea that practising the kinds of behaviours encapsulated within the *Five Ways* (being physically active, relating with other people, giving, being mindful and learning) have been show to be good for mental wellbeing. However, there is also debate concerning the optimum frequency, duration, intensity and types of activities in each behaviour area, and about the causal pathways involved in the relationships between particular activities and particular mental health outcomes. Whilst it was beyond the scope of this project to contribute to these debates directly, they highlighted the need to be clear during public engagement about which particular behaviours were associated with which particular mental health outcomes in people's experience.

Barriers to mental health and engaging in Five Ways-type activities

Existing research into the barriers to mental health and *Five Ways*-type activity has taken two broad approaches. On the one hand there are studies that highlight the systemic socio-economic conditions (such as deprivation and inequality) that are associated with poor mental health

outcomes, and on the other hand there are studies that explore the barriers people experience to engaging in behaviours that could enhance their mental health. With reference to the latter, research suggests that:

1. **Barriers are different for different activities**. For example; injury or poor physical health may be a barrier more relevant to *being active* than to *taking notice*; shyness may be a barrier more relevant to *connecting with others* than to *continued learning*; perceptions that volunteering is not "cool" may be a barrier to *giving* but not to other *Five Ways*-type activities; previous negative experiences of learning and negative self-perceptions as a student are barriers relevant to *continued learning* but not necessarily to other *Five Ways*-type activities; and lack of knowledge about the benefits of mindfulness and about relevant techniques is a barrier relevant to *taking notice* but not necessarily to other *Five Ways*-type activity.
2. **Lack of time and money are frequently cited barriers, yet are under-explored** in the sense that they have been taken at face value by researchers and rarely "unpacked". In other words it appears that there is little research into what might underpin "stock" reasons for non-engagement in positive behaviours such as lack of time and money, or into the extent to which these responses reflect the reality of people's lives.
3. **Barriers vary, or are experienced differently, according to key axes of social difference** (i.e. age, life stage, gender, ethnicity, physical ability). For example: physical impairment may be more likely to be experienced as a barrier to physical activity for older people than for younger people; unavailability of childcare is likely to be cited as a barrier to physical activity by parents of young children but not by those with no parental responsibilities; lack of safe places to go may be more likely to be cited as a barrier to connecting with others by women (especially young women) than men; experiences and perceptions of racism (a bias towards white perspectives) are more likely to be reported as barriers to continued learning in an institutional setting by ethnic minorities than white people; and physical disability is more likely to be cited as a barrier to formal volunteering by disabled people than able-bodied people.
4. **Barriers range from internal to institutional to systemic, although connections between these realms are again under-explored.** Literature in this area says comparatively little about the causal mechanisms by which socio-economic structures influence the individual, psychological realm or how individual behaviours relate to the broader systemic context in which they are located.

Existing attitudes to mental health issues

The majority of studies into attitudes towards mental health actually deal with attitudes towards mental *illness*. Stigma and discrimination are found to be prominent, albeit accompanied by more positive (reported) attitudes such as understanding and tolerance. Research into attitudes towards social messaging around mental health mirrors this tendency, focusing largely on mental illness with a view to reducing the stigma surrounding it. Comparatively little is known about attitudes towards positive mental *health* or towards social messaging that deals with promoting mental health in the "normal" population.

Existing initiatives / policy issues around mental health

There are numerous existing initiatives aimed at raising awareness of mental health and mental illness, emanating from the Government, government agencies and the charity sector. These are generally characterised by a drive towards the promotion of positive public mental *health*, yet maintain a strong residual focus on helping people with mental *illnesses* (i.e. improving services and access, reducing the stigma and discrimination).

However, a number of organisations have begun to make use of the *Five Ways to Wellbeing* as a means to raising awareness of positive mental health for the whole population. **nef** has published a report on the use of the *Five Ways to Wellbeing* that maps their take-up at the group, organisational and strategic level.[16]

From this rapid desk review, little evidence was found as to the likely reception and/ or efficacy of initiatives focused on the promotion of behaviours that enhance mental health in the general public.

Chapter 3: About the dialogue process

Delivery consultancy

A specification for the public dialogue was drawn up by **nef** and put out to competitive tender (see Appendix 2). Several contractors submitted bids and three were selected to interview for the project. The chosen contractor was Corr Willbourn Research and Development,[17] a small partnership specialising in deliberative market research.

Details of the dialogue

The public dialogue exercise was conducted between 7 February and 1 March 2011. It was based on a process proposed by Corr Willbourn in their response to the initial tender, amended and elaborated following subsequent discussion with **nef**, Sciencewise-ERC and DH.

The main strand of work was a series of public engagement workshops held with a cross-section of the public in a range of locations across the UK. In addition, a small number of one-on-one depth interviews were also conducted. Recruitment was conducted through a network of Market Research Society (MRS) trained recruiters, according to a specification developed jointly by **nef**, DH and Corr Willbourn. Further details of each strand of research are provided below.

Public engagement workshops dialogue

The main strand of research was a series of public dialogue events involving 96 members of the public.

Given the parameters of the project, it would have been impossible to recruit a truly representative sample of the population. Instead, recruitment was conducted according to the sampling frame given in Table 1, providing a reasonable cross-section of age and socio-economic group. **Table 1: Sampling frame for main dialogue exercise.**

Lifestage	Male	Female
Young singles 18 - 24	Group 1 C2DE Group 2 ABC1	Group 3 ABC1 Group 4 C2DE
Young couples or families 25 - 39	Group 5 ABC1	Group 6 C2DE
Teenage families 40 - 59	Group 7 C2DE	Group 8 ABC1
Adult families/empty nesters 60+	Group 9 C2DE Group 10 ABC1	Group 11 ABC1 Group 12 C2DE

Dialogue events took place in six locations across the UK: Altrincham, Coventry, Exeter, Guildford, London and Hartlepool. In each of the six locations, 16 participants were recruited.

The dialogue process itself was conducted in three stages:

1. **Initial group discussion.** At each location, participants came together in two separate groups of eight, divided by gender. In a 1.5 hour session, facilitated by one researcher, they undertook a discussion of life in general before being introduced to the notion of wellbeing and the Five Ways to Wellbeing. The discussion was audio recorded and subsequently transcribed.
2. **Self-guided deliberation.** Participants were sent home from the initial group discussion with a workbook. This contained a short summary of the scientific evidence about the impact of Five Ways-type activities on wellbeing (written by **nef**), along with links to sources of further information and some open-ended questions (a copy of the workbook is provided in appendix 3). Participants were invited to use the workbook to reflect on the issues discussed in the groups in any way they wished – e.g. by discussing with friends and family, reading more about the relevant research, and / or making notes of their thoughts and feelings.
3. **Group workshop.** One week later, participants came back together into one group of 16 for a 3 hour workshop at each location. Considerably more structured than the first group, participants worked through a series of discussion exercises developed in order to explore the research questions in detail. These sessions were video recorded.

Depth interviews

In addition to the group dialogue exercise outlined about, it was also decided to conduct in-depth interviews with an additional eight members of the public. Participants in these interviews were people who had been identified as having, or being at risk of having, low wellbeing as defined by scores on the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS[18]) and the presence of three or more known risk factors for low wellbeing. The sampling frame for these respondents is given in Table 2. Depth interviews with at-risk respondents took place in Manchester, Stoke-on-Trent and London.

Table 2: Sampling frame for main dialogue exercise.

Lifestage	Male	Female
Young singles 18 – 24	Depth 1	Depth 2
Young couples/families 25 – 39	Depth 3	Depth 4
Teenage families 40 – 59	Depth 5	Depth 6
Adult families/empty nesters 60+	Depth 7	Depth 8

The interview process had two stages.

1. **Self-guided deliberation.** After recruitment, a short introduction to *Five Ways to Wellbeing* was pre-placed with participants, who were invited to read and consider it before the interview.
2. **Depth interview.** Each participant was interviewed one-on-one by a researcher. Interviews lasted 1.5 hours and were semi-structured and informal, conducted either in participants' own homes or in a location of their choice. The focus of the interviews broadly reflected the research questions: emphasis was on the extent to which people feel able to increase *Five Ways*-type activity, on the barriers that might prevent people from engaging in such activities and on the messaging of *Five Ways*. However it is worth noting that in some of these depth interviews it proved extremely difficult to adhere to the discussion guide, as participants took conversations in their own direction. Interviews were recorded and subsequently transcribed.

Chapter 4: Results

In this chapter we present the major findings from the public dialogue exercise. As might be expected, the dialogue process gave rise to a set of extremely rich and nuanced qualitative data, and what is presented here is based on a joint analysis between **nef** and Corr-Willbourn. This analysis is the result of a three-stage process: the first stage entailed bringing together the preliminary thoughts of the researchers soon after the public dialogue ended; the second stage entailed deep immersion in the data produced through the public dialogue – in the video footage, in the workshop, discussion and interview transcripts and in the self-guided deliberation workbooks. This stage also involved development of a preliminary structure for discussing results. The third stage entailed developing in detail the overall narrative which guides the discussion of results – this is driven largely by the research questions – and selecting relevant quotes and offering observations on and insights into these. This three stage process was both iterative – in that it involved constant iteration between the data and discussion of results – and inclusive – in that it was a joint endeavour between members of the research team at **nef** and the researchers at Corr-Willbourn.

This analysis takes the position that people experience and interpret the world subjectively, and that in this sense their interpretations may differ widely, but that an objective external world – reality – does indeed exist. In other words, analysis combines an interpretivist and a positivist approach to the data.

Discussion of results is divided into three sections. The first section deals with the first, second and third research questions, concerning the extent to which people feel able to make the changes necessary to do more *Five Ways*-type activity, the barriers they experience doing so and the socio-economic and demographic variations in what people say. The second and third sections deal with the fourth and fifth research questions – with how the public might respond to messages around wellbeing and positive mental health. Specifically, the second section explores participants' responses to the term and concept of wellbeing, to the *Five Ways* activities and to the science behind them; and the third section turns to participants' ideas around who should have knowledge of the *Five Ways* and their wellbeing benefits and by whom such knowledge should be delivered.

In what follows, we try to bring participants' voices centre-stage; to let their words come through as much as possible in order to do justice to the public dialogue process. Where we quote from transcripts, these excerpts are in italics and indented. Facilitators' questions are in bold, and participants' names have been changed. After each public dialogue excerpt we offer

some basic details concerning the participants in question – their gender, age group and socio-economic position. However, this should not be interpreted as implying that quoted participants are necessarily representative of other people sharing similar personal characteristics.

Participants' experiences of barriers to *Five Ways*-type activity[19]

For some people there is no evidence of barriers

For some participants there appears to be no evidence of barriers. This is manifested in a number of ways; some appear to feel confident of their ability to change their behaviour, making specific reference to increasing *Five Ways*-type activity; others appear to feel a general sense of control in their lives which might indicate an ability to undertake behaviour change and increase *Five Ways*-type activity*;* and others appear to already be highly engaged in *Five Ways*-type activity, which suggests no felt barriers, or at least an ability to overcome them.

Some people appear to feel confident of their ability to do more *Five Ways*-type activity

The following excerpt is taken from the workshop in Hartlepool and indicates that for the speaker, there appears to be no felt barriers to turning intentions into action:

> ***You want to give more… Brian?***
>
> *I'm with him, I find it rewarding.*
>
> *It's a buzz isn't it.*
>
> *Mm.*
>
> ***And what stops you doing more of it?***
>
> *It doesn't stop me I continue trying to do what I can, I'll always continue trying to do what I can.*
>
> ***But you want to do more of it.***
>
> *Yeah.*
>
> ***Is there something that's in the way is there something to stop you?***
>
> *No I intend to do more of it.*
>
> ***You intend to do more of it.***
>
> *Yeah.*
>
> ***Right and so if we meet back here in 6 months time do you think you will be able to say to me 'yeah I'm doing more of it'?***
>
> *Yeah.*
>
> (man, 25-39 yrs age group, c2de)

Some people appear to feel a general sense of control in their lives

Whilst the excerpt above reflects a participant speaking directly about one of the *Five Ways*-type activities, others indicated from their discussions of other topics that they feel a general sense of control in their lives, and we might infer from this that they would be able to overcome barriers. The following excerpt is taken from the workshop in Altrincham:

I think you have a control over every single aspect of your life and you can change it. OK people are getting made redundant – find another job. You know, you haven't got money – manage your finances better. If you're ill it's maybe because you're not healthy. I'm not going to say things like cancer or something and you know you bring it upon yourself, but generally if you're unhealthy it's because you've got a bad diet or you're just – you know, you need to be more healthy. I think with the weather – yeah, you can't control the weather but if you're not happy, move. It's just…

[Laughter]

There's just loads of things that you can control.

(Inaudible)

Finish that off.

Yeah, there is. There's loads of things you can control like if you're not happy with the weather in England – it's crap but if you want sunshine then move abroad. If you're not happy with your friends, get new ones; if you're not happy with the media, don't watch it. There's – you can – you can control every single thing…

I just stay by what I said. I think you still have control of everything you do.

Can you control paying your taxes? You've got to pay them.

I don't have to pay them.

[Laughter]

I am going to the extreme but you have a choice… listen to me. I could go into work tomorrow morning and hand my notice in. I could let my husband pay the mortgage and the bills which he could do that but I choose to go to work because I enjoy it. Now that's a choice, I don't have to work – I go to work because I choose to.

What about money, how would it work.

Because I don't need the money. I'm financially stable that I don't have to work.

OK say something happens with you and your husband's relationship then what you do? You'd have to work.

You don't have to do anything.

(woman main speaker/ mixed, 18-24 age group, abc1)

Of course we do not know from this whether this general sense of control in life is linked to the take up of *Five Ways*-type activities, however it suggests a felt ability to engage in them, should one desire.

Some people appear to be already highly engaged in *Five Ways*-type activity

It is also evident, from what some participants said about their daily lives, that some people were already highly engaged in doing a number of *Five Ways*-type activities (and benefitting from their engagement), and we may infer from this that they either experienced no barriers to engagement or have been able to overcome them. The excerpt below is from the workshop

in Guildford, and follows the facilitator's question about how participants had got on with the week long deliberation exercise:

> *Well I was thinking of what I enjoy and what makes me feel good and perhaps if a few more people got out there and did a bit of exercise or music, walking or anything it can lift you so much. I mean I had a great class today, my aqua group, and you came out feeling so good and you sit and chat. The other side of it is the social side where you sit and chat and we're all different people different walks of life. It makes life interesting you know you can talk about all sorts of subjects and get a different perspective on life from other people. I find it's really quite a good thing.*
>
> (woman, 60+ age group, abc1)

We do not know from this excerpt whether this participant experienced barriers to engagement and overcame them, or experienced no barriers, or indeed whether the kind of active involvement referred to constitutes a behaviour *change* or has always been a part of her life. However, such active involvement – for this woman and others – suggests that, at the very least, some people are not prevented from engaging in *Five Ways*-type activities by barriers of any kind.

Whilst some participants appear not to experience or be constrained by barriers to doing more *Five Ways*-type activities, others – as we will see – do appear to experience barriers and are constrained by them.

For others, there is evidence of barriers

So, what are these barriers? From this public dialogue, the barriers can be understood in terms of the following categories: external, internal and psycho-social. This categorisation is intended as an analytical tool. As will become apparent from the quotes and excerpts given, separating them out in this way is somewhat artificial; for example saying 'I have no willpower' may be both an internal barrier (a low sense of self-efficacy) and a psycho-social barrier – a narrative on the part of the speaker which may reflect a cultural norm concerning personal responsibility (in this case for mental health and wellbeing). The narrative of 'having no willpower' may also be linked to an external barrier – working long hours, having family commitments and being drained by these. Reflective of this, within single narratives (in which participants explain why they don't do more of the *Five Ways* activities that they would like to do), people often move between different barrier types. Nonetheless, this categorisation is useful as an analytical and discursive tool, which in turn assists in categorising possible ways of addressing barriers.

External barriers

For some, external barriers could be default narratives that do not necessarily reflect daily life, but for some they will be real. Lack of time and money are central here, as are issues of access and availability.

Lack of time and money

To the extent that they are real (i.e. to the extent that a person really has no spare time available for engaging in *Five Ways*-type activities), lack of time and money may make it extremely difficult, if not impossible for some people to do more *Five Ways*-type activity. The following excerpts are from group discussions and workshops, and are examples of participants'

responses to the facilitator's question about what stops people from engaging in more of the *Five Ways*-type activity they desire:

> *…with two little kids and three jobs I just don't have the time.*
>
> (woman, Hartlepool workshop, 25-39 age group, c2de)

> *Money, it stops people from doing things, and as pensioners, not all of us are fortunate enough to have as much money as others.*
>
> (man, London workshop, 60+ age group, c2de)

> *I've recently started a new job and its very time consuming at the moment to get my head round everything I have to do, so it doesn't really stop when I get home … so its kind of yeah its very hard to fit all these things around what you do normally.*
>
> (man, Exeter workshop, 25-39 age group, abc1)

Lack of access and availability

Lack of physical access and availability of facilities for engaging in *Five Ways*-type activities are also important 'external' barriers. Again, to the extent that they are real, lack of access or availability can also make it difficult, if not impossible, for people to undertake (more of) the *Five Ways*-type activities they desire. The following excerpt is taken from one of the group discussions in Coventry, again in response to the facilitator's question about what stops people doing more of the *Five Ways* activities they would like:

> *Transport, I don't drive and so buses get in my way.*
>
> ***Say a bit more about that.***
>
> *Just like today I waited for an hour and fifteen minutes for a bus that didn't come and so I had to get a lift to get here. And even that was an obstacle because I had to eat my dinner late and it was just like everything and that puts you off doing something else.*
>
> (woman, 18-24 age group, c2de)

Here, the challenge of separating out different types of barriers is evident; this participant begins by talking about the lack of transport, then reports managing to get a lift in the end, and finally goes on to say how lack of transport (or more precisely, an unreliable bus service) 'puts [her] off doing something else', which may also be linked to an internal barrier. The following excerpt is from one of the group discussions in Hartlepool, and suggests a possible lack of access to facilities that enable engagement in *Five Ways*-type activities:

> *Everything's in London isn't it? You've got the Olympics, you've got the Wembley, you've got everything. Why couldn't it come to the centre of the country then?*
>
> (man, 25-39 age group, c2de)

Here again, we may be seeing something of the blurring of boundaries between barrier types, as lack of facilities could be an external constraining factor (especially given the effect of government cuts on community facilities such as libraries), but linked to a psycho-social barrier in the form of a discourse about provision being better in places other than one's own, or the 'grass being greener' elsewhere.

Major life events

Major life events, such as bereavement and major illness, can also be understood as 'external' barriers (in that they happen *to* people), both in the sense of mentally draining people and physically preventing people from engaging in *Five Ways*-type activities. The following excerpt is taken from one of the depth interviews:

> *I have had so much family die, both my parents. My mother died on the operating table and my Dad died of cancer and then I lost my sister to a tragic drowning accident, then I lost my brother out of the blue with pneumonia. Then my sister was found dead on the floor in the kitchen about three months after my mum had died on the operating table and I lost another brother which was out of the blue. There were 11 including my parents and there are 5 of us left, since 1990. And we have just buried my brother in law last week and we are burying my cousin this week on Wednesday.*
>
> (Mark)

It is interesting to note here that as well as functioning to prevent people from engaging in more *Five Ways*-type activities in the short term, in the longer term major life events can also function to inspire people to increase their *Five Ways* engagement, as such events sometimes leave people with a new appreciation of life and a desire to "live it to the full" or "make the most of each day". Related to this, engagement in *Five Ways* activities can also be a means of coping with difficult, or traumatic events.

Internal barriers

Whilst the barriers discussed so far can be understood as *external*, other barriers can be understood as *internal*. In particular, we found evidence that depression and a strong sense of incapacity can function as barriers to behaviour change.

Depression

For some participants (in particular but not limited to the additional sample of people with likely low levels of wellbeing), depression is experienced as an internal barrier. This does not mean that all people who were depressed were not engaged in *Five Ways*-type activities (indeed some in the additional sample appear to be highly engaged for much of the time). The point is rather that for some people, some of the time, depression prevents them from engaging in *Five Ways*-type activities. The following excerpt is taken from another in-depth interview:

> *I have bouts of depression. A thing I suffer with. Nobody can find out the reason why. Sometimes a couple of days, or weeks, or longer. It's a tiredness thing – I get so tired I can sleep all day. It's got nothing to do with life itself, it's connected with being tired like that – my body feeling weak. And when I'm like that you could drop a pin and I could cry.*
>
> (Sandra)

A strong sense of incapacity

For other participants, a strong sense of incapacity (possibly, but not necessarily linked to depression) appears to function as a barrier. This is manifested in a number of ways, and in the following excerpt it can be seen in the speaker's reference to her own lack of willpower:

What's stopping you doing more physical activity right now, if anything?

Physical and mental health is stopping me, and willpower because I haven't got none.

You haven't got none or you just haven't found it yet?

I've got very little willpower, I just haven't got no willpower to do it.

(woman, 25-39 age group, c2de)

Here again we can see something of the blurring of boundaries between barriers, as the participant begins by citing first physical then mental health as the reason for not doing more of the physical activity she would like, before settling on lack of willpower.

Psycho-social barriers

Whilst some barriers can be understood as external and others as internal, there is also a broad set of *psycho-social* barriers to behaviour change , which it appears we know least about, including how to address them. These psycho-social barriers are interlinked and, as has been suggested in the above discussion, can be connected to *external* and *internal* barriers.

Lack of awareness of possibilities

In some cases, it appears not to occur to people to do relevant things. The following excerpt is taken from the workshop in Hartlepool, and is an example of a participant reporting that she undertook more *Five Ways* activity during the second stage of the public dialogue process, prompted by exposure to the materials made available at the first stage:

Was there anybody else who done something different, was it you Karen? What was it that you did that was different?

I volunteered at the library and read to kids.

Cool, was it good?

Yeah it was awesome because I can't read to my nephew because he likes to be in control, he has to tell you the story. He prefers them books with no writing in so he can make up his own and so he won't let you read him a story. And so I actually went out and read a story to the kids because they come to our library once a week. It's normally the teachers that read to them but I read to them instead and felt great.

And was this prompted by this stuff [the previous discussion and workbook].

It was actually, reading this and, I don't know I just thought if I go to the library, just to do something. They were all sat there and they were screaming that they wanted a story and so I just read them a story.

(woman, 25-39 yrs age group, c2de)

The fact that the public dialogue process itself prompted this participant to engage in *Five Ways* activities suggests that it had not occurred to her to do so previously. This participant, and others who reported similar experiences of behavior change during the second stage of the research process, did report barriers to making such changes, but appears to have

overcome them once knowledge of the benefits of *Five Ways* activity were made available to them.

Lack of ideas around what to do

In other cases, people may want to do more relevant, *Five Ways*-type activities but not know what to do. The following excerpts are from the workshop in Altrincham, and illustrate this felt lack of inspiration:

> *…there needs to be more things to do other than going out and getting drunk.*
>
> ***Definitely.***
>
> *That's the only thing that I can really think to do on a weekend cos there's only so many times that you can go to the cinema or go bowling or go Laser Quest or something like that. Do you know what I mean? …something …that you can do socially without having to get drunk in the process.*
>
> (man, 18-24 age group, abc1)

> *It's kind of like – I tried going to the gym but I hated that kind of side of it cos it just used to bore me so I suppose mine as well is not finding what physically activity I enjoy like I could say "oh I can go for a jog." I know I'd hate that cos it will just bore me to death so it's – that's like – mine's like trying to find it – is trying to find what I enjoy that's physically active.*
>
> (woman, 18-24 age group, abc1)

Whilst these two excerpts are quite different in the degree of certainty they contain – the second suggesting a definite desire to do *something* and the first suggesting a more tentative position, they both point to the way in which, for some participants, not knowing what to do is a barrier to action.

Lack of motivation

In other cases, people may not be sufficiently motivated to do more of the *Five Ways*-type activities that would be likely to increase their wellbeing. The following excerpt is taken from the workshop in Altringham, where a participant reflects on why he isn't engaged in continued learning, despite wanting to be:

> *We [speaker and another participant] both work in an office a lot of hours in the week as well and it doesn't leave much time in general, stuff in life. You learn something new from watching news or reading the paper most days but as far as education goes for yourself to have a different path or a better life, it's hard to find the motivation to do a job then go home, get your stuff, go back out, educate yourself further, then go home, then it's literally time for bed, get up, start again.*
>
> (man, 18-24 age group, abc1)

Again, it is interesting to note the way in which the speaker moves between narratives on barriers, first referring to work and having insufficient time available for other activities (what we have labelled *external* barriers), then referring to the difficulty of finding the motivation to educate himself. Other participants used the language of 'effort' or 'mind set' to convey this sense

of a lack of motivation. The following excerpt is taken from the workshop in London:

> *Yeah I stop myself [spending time with others], in the summer we go to a caravan and we see people all the time it's fantastic, but in the winter I don't see half as many people and I really miss it, a lot of it is that oh, I can't be bothered, or I'm a bit tired or I'm doing other things but I think I could make more effort to see people, definitely.*
>
> ***And what would help you with that, if anything?***
>
> *Mind set. Just go and do it, instead of thinking I've got this to do and I've got that and I've got that.*
>
> (woman, 60+ age group, c2de)

Whilst in a sense this reported lack of motivation or effort could be understood as an internal barrier, it also functions as a psycho-social barrier in the sense that people may not feel motivated to do things that are not widely or explicitly valued in the context of their own lived worlds. Some people may not explicitly cite lack of motivation as a reason for non-engagement in *Five Ways*-type activities, however their active and explicit choice not to engage, or to spend their time in other ways, suggests such a lack of motivation. The following excerpts are taken from one of the group discussions in Altrincham:

> *[Physical activity] is not really my choice like I don't want to do it.*
>
> (man, 18-24 age group, abc1)
>
> *Like I could do something, but I just prefer to sleep in bed all day and go out at night. It's selfishness. Like I could do stuff but I don't.*
>
> (man, 18-24 age group, abc1)

Other people express a lack of motivation as a preference for passivity, which again could in a sense be understood as an internal barrier, but in another sense can be seen as a psycho-social barrier inasmuch as people choose to engage in things – in this case passive forms of leisure – that are widely promoted in the context of their lived worlds. The following excerpt is taken from one of the group discussions in Hartlepool, and is particularly self-reflective:

> *We're all glued to that little magnetic, hypnotic thing in the corner of the room called the TV.*
>
> (man, 25-39 age group, c2de)

Habitual behaviour that does not include Five Ways-*type* activity

Another set of barriers to engaging in more *Five Ways*-type activity can be understood in terms of habitual behaviour. Some refer to this as being (stuck) in a 'comfort zone', as highlighted by the following excerpt from one of the group discussions in Altrincham:

> *Cos like people just seem too scared to come out of their own comfort zone like they'll go to work, they'll go home and they're so set in their own shell that they won't come out of it and that's the problem I think.*
>
> (man, 18-24 age group, abc1)

Another participant referred to being in his own "personal rut", as we can see in the following excerpt from the Altrincham workshop:

> *It's not stopping me from doing it, it's just – I've just got to get out of that little rut of not doing it if you know what I mean?... my personal rut … probably when I started being old enough to drink and getting in pubs I was (inaudible) on Saturday due to going out on a Friday…*
>
> (man, 18-24 age group, abc1)

Whilst engaging in certain types of activity out of habit could be understood as an internal barrier, it is perhaps more usefully understood as a psycho-social barrier, in the sense that habits are formed in interaction between individuals and the socio-cultural context in which they live – as a person internalises certain norms and values from the lived social and cultural world in which they are located.

Lack of sense of control in one's life

In some cases people appear not to feel in control of their lives, and this could function as a barrier to doing more of the *Five Ways*-type activity that people desire. The following excerpt is taken from one of the group discussions in London:

> *What determines how you live your life is what powers outside of your family do. We're looking at now; you've got a government that wasn't even elected that's going to ruin a lot of people, going to throw a lot of people out of their homes, going to put a lot; well they're already putting people out of work. They're going to put thousands and thousands and thousands of people out of work. These are things that determine the way you live and how happy people are. I mean you can have a simple life, you can be happy. You can be rich and be happy but it's outside influences that at the end of the day determine how you're going to live your life.*
>
> (man, 60+ age group, c2de)

The issue of control was raised in the first section of this chapter, when we noted that those who feel a sense of control over their lives are likely to feel able to engage in *Five Ways*-type activity should they wish, or to feel able to overcome barriers to such activity. The issue of control was also raised indirectly in the section on internal barriers, when we noted that some people appear to feel a strong sense of incapacity, which in turn is linked to non-engagement. However, not feeling in control of one's life can also be understood as a psycho-social barrier in the sense that a felt lack of control may be produced in a context which systematically undermines people's sense of self-efficacy (ironically at the same time as relying on such self-efficacy for initiatives such as the Big Society to work).

A number of participants raised the issue of living in a culture that undermines self-efficacy, both reflecting on how it is manifested, and alluding its negative effect on people. The following excerpts are taken from the Guildford workshop and one of the Altrincham group discussions respectively:

> *We've got to a society today I feel, and I discussed this with my husband before we came out, that we're always being told what we can't do. You can't do this, the children can't climb trees, you can't go to the edge of a hill and look down its too dangerous, you can't*

go near water it's too dangerous. You're not experiencing life. If people are made just to go and do something themselves, participate in something, help themselves, helping someone else at the same time they're helping themselves. The government should be encouraging all this sort of thing.

(woman, 60+ age group, abc1)

'You can't do that'. 'You're not going to have a chance because you're from that area'. 'You're not going to have a chance'. 'You're not going to be able to do that' – then what do they think that people are going to turn out like? If it's installed in people from a young age that maybe you can do this and you can have ambition and you will succeed if you want to, then maybe give that a try.

(man, 18-24 age group, abc1)

Through these excerpts we can again see the way in which the psychological and social realms can interact to engender a felt lack of control amongst some people, which in turn functions as a (psycho-social) barrier to increased engagement in *Five Ways*-type activity.

Group and cultural norms

As alluded to above, in some cases people appear to be circumscribed by group or cultural norms, or at least some participants refer explicitly to group or cultural norms as barriers to doing more *Five Ways*-types activity. The following excerpt is taken from the workshop in Altrincham, and suggests that the participant is strongly influenced by the current – widespread – valuation of learning as relevant only for career enhancement and financial gain:

… at the moment if I was to learn it would be to get more money which would be career. Once I'm at a point in my career where I feel like I'm earning the money that I want to be earning then I'd go to the hobby side of it.

(man, 18-24 age group, abc1)

The following excerpt, taken from one of the group discussions in Altrincham, also points to the influence of group/ cultural norms on people's choices of leisure activity, and by implication on engagement in *Five Ways*-type activity. It is somewhat unusual in the level of reflection (self and societal) and the explicit framing of behaviour as produced through cultural norms:

But people, they may want to make a change. I'm sure they could. If people thought I don't want to go out tonight; I used to go, like last summer go and chill out in Dunham Park or Dunham Massey or Tatton Park. It sounds pretty probably lame to a lot of people but people like myself and my friends, it's just somewhere to chill out and it don't cost anything. It costs a bit of petrol to go down there, it's free to hop over and go in the park and you know.

No I use the park all the time.

Do you not think that this is a culture that can't because of all that which you've mentioned? I mean I know it's quite shallow to say that you know, I mean I go out and get drunk at the weekend and

whatever but it's slowly come through the generations because of everything there and everything negative that's…

It's just been drilled in through generations oh this is the way that we live.

Yeah definitely.

Like stuff on TV like Coronation Street. They've all got a pub in them; everyone's happy in the pub. Do you know what I mean?

Yeah that's what they show it as don't they. The pub is the happy place.

It is just our way.

(men, 18-24 age group, abc1)

Felt lack of entitlement to initiate relevant activities

Related to the influence of group and cultural norms on people's engagement in *Five Ways-type activity*, in some cases people appear to assume that others are responsible for initiating relevant (*Five Ways*-type) activities, or assume it is not their place to do so. In a certain sense this can be understood as a cultural norm in itself, which has perhaps developed in response to the controlling culture noted above. Some participants reflected explicitly on this shared assumption that others will initiate relevant activities, as can be seen in the following excerpts from one of the group discussions in Altrincham:

Who should be responsible for developing these ideas [about what to do apart from getting drunk]? Developing new things, new ways for people

Everyone.

Yeah exactly, everybody should get involved and do it.

We can't just rely on, we have this mentality where we rely on everyone else like 'she'll do it, he'll do it'. We can do it ourselves.

(men, 18-24 age group, abc1)

How hard is it to go in the park and kick, like you don't need to tell anyone you can do it, just say get them roped in and have a kick about? Like when I was a kid that's all everyone wanted to do was kick a ball around.

(man, 18-24 age group, abc1)

Communication technologies

Whilst some participants' narratives point to the influence of cultural norms on their engagement in *Five Ways*-type activities, others point to the way in which the communication technologies at the heart of modern culture enable less face-to-face communication, thereby functioning as a barrier to what we might call more 'meaningful' connections between people. The following excerpt is again from one of the group discussions in Altrincham, and reflects explicitly on this:

We have become very insular I think with our, well I am like, with my own friend group, and a lot of stuff now can be done over the phone, by text, instant messaging. You don't have to go out and do

quite so much and physically see people and meet people. You don't get the same connections, the same emotions, the same feelings from doing stuff when you're not actually there.

(man, 18-24 age group, abc1)

Exclusivity of existing groups

Whilst for some, modern communication technologies or group/ cultural norms function as barriers to engaging in *Five Ways*-type activities – and in particular as barriers to engaging in certain group activities, for others it is the groups themselves, and specifically their perceived exclusivity, that functions to deter engagement. The following excerpt is taken from one of the group discussions in London and indicates how, for some people, the exclusivity of pre-existing group activities functions as a barrier to involvement:

But if you join a group like that I mean I do line dancing and I joined the ramblers, you go to these groups and they're already there and they've already got their little cliques and to be honest with you…

Then you feel left out.

Yeah.

Yeah they don't make you very…

They don't seem to make you very welcome you know. I mean our local library does talks and so I went there. You know I mean I've talked to this lady and you know we've got on really well and she's talked to me and you know I'm sure that if I was at a club we would be good friends. But you know I feel I could talk to anybody here, but you go to these clubs and they've all got their little cliques already and they look upon you as a bit of an outsider and they don't really make you very welcome. You talk to them and sometimes they look at you as if to say, you know, 'you're talking to me?' type of thing.

(women, 60+ age group, c2de)

Lack of pre-existing, non-exclusive, structured groups

As well as being deterred by the exclusivity of pre-existing group activities, in any case it appears that some people experience a lack of strong, non-exclusive structured groups, either community-, work- or family-based. The following excerpts, taken from one of the group discussions in London, point to this felt lack of provision:

The thing I miss more than anything is, I was always involved with unions and, not politics as such, but the legal, the union thing, and I miss sitting in a lot of smoky rooms with a lot of like minded people, that I don't do now.

So that's a particularly social; a good gang of people you'd socialise with, work with.

Well maybe a good gang, maybe not a good gang but good discussions.

(London, group, male, 60+, c2de)

There's no family tradition for a start.

No.

I mean my family, years ago when I was small, we would meet Christmas Eve and we'd all still be in the same house New Year's Eve and someone would play the accordion and someone would do something else and the blokes would play cards and the women would go and sit in the other room and do whatever they did, and that went on for a week, ten days. Now, I've got four children and seven grandchildren and one of my sons … I mean I phone him occasionally and say I've just phoned you to tell you I'm alive.

That's normal.

'Oh yeah well dad I'm busy dad. I know you're all right'.

That's normal.

It's gone. It's something that's gone.

(London, group, male, 60+, c2de)

Of course, these reminiscences may not reflect an actual lack of community-, work- or family-based groups, however at the very least they reflect a felt sense amongst some that such a thing is absent from their lived worlds.

It is worth noting here that whilst it is tempting to focus on group activity as a particularly fruitful way of achieving *Five Ways*-type activity on the basis that it appears to encapsulate a number of the *Five Ways to Wellbeing*, seeing structured group activity as a necessary means to engagement in *Five Ways*-type activity can itself function as a barrier; for some the level of effort and commitment (socially and in terms of time) associated with group activity may be off-putting. For some people, incorporating *Five Ways*-type activity into existing routines and activities may be more appealing.

Agency

As should be apparent from much of the preceding discussion, the issue of agency is highly relevant here: some participants indicated, either directly or indirectly, a felt lack of agency. And if agency is understood as a necessary precursor to engagement in *Five Ways*-type activity, then we can see felt lack of agency as a significant barrier in itself. Some participants reflected explicitly on this:

I was just saying like seeing it all written down and listening to different people's opinions it seems kind of like if you feel like you've got more control then your wellbeing's improved and if you feel – if you're someone who says 'I've got no control' you're not taking any personal responsibility and your well being can't improve because you're not doing anything about yourself so you've got to get yourself over to that side that says 'I have got control' and improving your well being starts with getting yourself to that point.

(Man, Altrincham workshop, 18-24 age group, abc1)

Socio-economic and demographic variations

One of the research questions for this project concerned the existence of socio-economic and demographic variation in the extent to which participants feel able to initiate behaviour change and experience barriers. From this public dialogue we are unable to identify any clear socio-economic or demographic patterning concerning people's ability to change behaviour/ engage in more *Five Ways*-type activity or overcome barriers to such activity. However, we can identify some patterns, and some of these may in turn be linked to the extent to which people feel able to increase their engagement in *Five Ways* activity. None of these patterns is particularly surprising, nonetheless it is worth drawing attention to them, as they may have implications for the recommendations of this public dialogue.

Young people

One of the strongest patterns we observed was that young people framed learning almost entirely as useful for enhancing a career, which in turn they saw as valuable inasmuch as it would increase their earning power. The following excerpts are taken from the workshops with young people and reflect this tendency:

> *Yeah I'd like to go to uni … and if I did it would earn me more money and therefore I'd be happier.*
>
> (man, Coventry, 18-24 age group, c2de)

> *… at the moment if I was to learn it would be to get more money which would be career. Once I'm at a point in my career where I feel like I'm earning the money that I want to be earning then I'd go to the hobby side of it.*
>
> (man, Altrincham, 18-24 group, abc1)

As noted earlier, this may point to the way in which learning is, within the prevailing norms of British society, widely understood as valuable insofar as it produces increased productivity and financial gain. This in turn may have implications for the extent to which young people are likely to engage in learning activities which they do not perceive as being directly beneficial for career enhancement or financial gain.

We also observed a strong pattern in what young men and women cite as their preferred leisure time activities (shopping and drinking with friends for young women, and going to the pub with friends for young men). Whilst we did not intend to explore leisure time activities per se through this research, these – and importantly the prevailing norms that legitimate certain types of leisure time activity for certain groups of people, could have implications for the extent to which young people are likely to utilise their leisure time to engage in *Five Ways*-type activities.

People in lower socio-economic positions

We also observed a number of things about people in lower socio-economic positions. First, many tended to voice a strong sense of unfairness or inequality in society, both in direct relation to facilitators' questions and apparently unprompted by these. The excerpt below is from one of the group discussions in London, and was part of a somewhat meandering dialogue which followed the facilitator's question about the things participants think contribute to their wellbeing:

Well this [people at the top of charities getting paid and people at the bottom working for free] is the way of the world. The poor gets the blame.

Well yeah.

Who pays? Put up tax, let the poor pay a fortune.

(men, 60+ age group, c2de)

The excerpt below is taken from one of the group discussions in Hartlepool, and is also indicative of this sense of unfairness amongst those in lower socio-economic positions:

People who've never, ever worked in their lives get child tax credit. Well they haven't put anything into the system. They're better off than we'll ever bloody be. And this is where the heartache and anxiety is, from my point of view. Sorry for getting strong but I do feel that it's a very big thing.

(man, 25-39 age group, c2de)

Similarly, in Coventry, we can infer a felt sense of inequality from the way in which participants in one of the group discussions stated that equality, or treating everyone equally, would make Britain a better place:

If you woke up tomorrow morning and the Prime Minister phoned you up at your house or on your mobile and said … 'right I want you to give me one idea to make Britain better', what would be your idea?

… Equality.

Treat everyone equally.

I'd say standard wage. Make everyone earn the same amount.

Yeah, yeah, yeah, yeah.

OK so let's just go round, so equality, treating everyone equal.

Yeah, treat everyone equal.

(men, 18-24 age group, c2de)

There is no evidence from this research that the felt sense of unfairness has a direct bearing on the extent to which people in lower socio-economic positions engage with *Five Ways*-type activities, or experience barriers to them. However, there is a suggestion of a direct connection between this sense of unfairness and low wellbeing ("*They're better off than we'll ever bloody be. And this is where the heartache and anxiety is")*, and this in turn may have implications for the extent to which people engage in *Five Ways* type activities.

The second issue of particular prominence within the lower socio economic groups – and for women in particular – was the level of stress, largely related to financial and family problems/ worries, which participants voiced. The following excerpt is taken from one of the group discussions in Hartlepool, and is the point in the discussion after the facilitator posed a general opening question about what life was like for participants at the time:

Busy.

… Expensive.

… Stressful.

… Tiring.

… ***so this emotion of stress, who's ever experienced stress? That's a full house. What does it mean to you, how do you know when you're experiencing stress?***

Sleepless nights.

… Aches and pains.

…Get poorly.

And down yeah.

Not bothered about yourself.

… Worrying, bad tempered.

So what are the things … that you yourself have found either consistently or sometimes help you either deal with, cope with, manage, reduce or make better, stress?

My friends.

… Family.

… Exercise.

… Wine (laughter).

… Smoking.

… Screaming.

… Just stand there and scream.

Crying. After a good cry you feel better after 10 minutes.

… Head in the pillow and just scream.

… Head in the pillow and just scream, it's fantastic. Or breaking all crockery against the wall.

… Or cups.

(women, 25-39 age group, c2de)

Of course, this is not to say that people in higher socio-economic positions didn't experience or voice stress, or have lives that might be widely described as stressful, but rather to note that women in lower socio-economic positions tended to express this very strongly, and it may in turn have implications for the extent to which they feel able to engage in *Five Ways*-type activities.

The third issue of particular prominence amongst those in lower socio-economic groups, in particular older participants, was physical ill-health. Again, this is not to say that (older) people in higher socio-economic groups didn't experience or express physical health problems, but at the very least they didn't display the same readiness to discuss their experiences of physical ill-health and of medical treatment at considerable length with their peers. It is beyond the scope of this report to explore this issue in any

detail, and it is not clear what the implications might be, especially given that physical ill-health did not necessarily deter people from engaging in *Five Ways*-type activity. Nonetheless, it is worth mentioning here with a view to exploring further as part of the upcoming policy engagement stage of this project.

Participants' responses to wellbeing, the *Five Ways* and the scientific evidence

Responses to wellbeing

Many interpreted or defined wellbeing quite straightforwardly as being healthy and happy. However there was also considerable confusion, misunderstanding and suspicion around the term wellbeing.

It's too impenetrable

Some participants indicated that they, and the people they engaged with during the second stage of the public dialogue process, found the term wellbeing somewhat impenetrable. The following excerpts are taken from the Altrincham and Guildford workshops respectively, and are responses to the facilitators' requests for participants to reflect (in pairs) on their experience of the week-long personal deliberation process:

> *… people couldn't get their head round it.*
>
> (man, 18-24 age group, abc1)

> *… it's all very abstract and airy fairy.*
>
> (man, 60+ age group, abc1)

It's a private issue

Other participants, in response to the same question, indicated that wellbeing is not something that they feel comfortable talking about with other people, implying that it does not belong in the public domain, or is a private affair. The following excerpt from the Exeter workshop illustrates this:

> *I don't want to actually ask people, and ask people about their… it's a personal thing and I've witnessed, I just don't think it's a thing that you generally do is it.*
>
> ***Well quite often when we meet each other we go, 'how are you?'***
>
> *It's a general question isn't it, you either say 'fine' or…*
>
> *Yeah I think you do that then out of politeness as well, don't you.*
>
> *And do you really listen?*
>
> *Yeah.*
>
> *You're not going to go into great lengths of how….*
>
> *It's just a form of introduction isn't it.*
>
> ***So has anyone got a thought on why this whole area of well being is something that we generally don't talk about?***
>
> *In society people keep themselves to themselves generally, don't they?*
>
> (women and men, 25-39 age group, abc1)

It's about skincare and auras

Other participants seemed to feel they had a clear idea of what wellbeing means, but one that was evidently mistaken. The following excerpts are taken from various group discussions, and are participants' responses at the point when facilitators asked whether people were familiar with the term 'wellbeing':

> *It's how you look…*
>
> (woman, Hartlepool, 25-39 age group, c2de)

> *…your wellbeing is looking after yourself, your skin. That's what I think anyway.*
>
> (woman, Coventry, 18-24 age group, c2de)

> *Just like hygienic, how you look after yourself, what you wear. If you shave every day; it's your personal wellbeing ain't it? It's just how you treat yourself on a day to day basis.*
>
> (man, Coventry, 18-24 age group, c2de)

> *…your wellbeing, you know your aura, that's if you're into all that.*
>
> (woman, London, 60+ age group, c2de)

One of the things these excerpts point to is the way in which the term wellbeing has been adopted by commercial (in this case skincare product) interests, and possibly – with reference to the last excerpt – by the 'new age' agenda.

It's too heavy

As well as being misinterpreted, it appears that the term wellbeing can also engender feelings of intense discomfort, with participants reporting for example that it's just 'too heavy'. The following excerpt is taken from one of the group discussions in Hartlepool, and illustrates how discussions of wellbeing, even if they begin with uncontroversial notions such as happiness and health, can quickly descend into confusion:

> *How healthy you are…*
>
> *How happy you are…*
>
> *I would see it as a holistic thing.*
>
> ***Say a bit more about that. It's a holistic thing.***
>
> *I would say physical, mental. The whole thing about life as well and whether you feel challenged enough, stimulated enough.*
>
> ***Ah right.***
>
> *Whether you feel as if you're needed. Whether you feel you're fulfilled.*
>
> ***Sorry, if you feel that you're needed?***
>
> *Mmm. Feel like you've got a purpose. Feel like you belong…*
>
> *Well it's kind of like three isn't it? Physical, mental, spiritual.*
>
> ***And by spiritual do you mean this purpose, this sense of belonging?***
>
> *A sense of self. The whole sense of self. Sense of purpose.*

He's lost me.

Yes. I was quite happy with that. Happy and healthy. I'm knackered now. Fucking hell, where we going here? What's that - 'holistic'? Isn't that what you get when you smoke them funny cigarettes? Jesus.

OK so Mike what's going on for you right now?

What's going on with me right now? Get me down from the ceiling. Oh you've lost me there man, I'll tell you.

OK at what point did you start?

At the beginning; holistic. I started seeing magic mushrooms and all sorts.

OK so let's wind it back, so when we had how healthy you are and how happy you are, you were healthily happy with that?

Yeah I'm happy, I can live with that. I can live with that oh yeah I can live with that.

Just stay with it and see if I say it again, see if that makes a difference. So what Ronnie's talking about is that wellbeing has a number of aspects. I'm paraphrasing what Ronnie said, but it has a number of aspects to do with physical, to do with mental, to do with spiritual, to do with your sense of self, whether you have a sense of challenge or purpose in your life. Is that going too far for you or what?

It's too heavy.

Too heavy.

Yeah. Just get on with life man.

I like that mate. That's good that.

Just get on with it. You're making a mountain out of a molehill and before you know it you're going to be in a state of depression and you're going to be wanting tablets and shit.

(Hartlepool, group, male, 25-39, c2de)

It's all a bit suspect

Some people indicated that they were highly suspicious of the wellbeing agenda; that it is one amongst many things that the health profession/ government is trying to make profit from, or that it's yet another box-ticking exercise:

…today I went to Great Ormond Street with Joshua, we had to see a professor because of his head and while I was there I got a phone call from the GP, the GP surgery and you've got to come to have a wellbeing check… So I said 'but why?' 'You've got to have this wellbeing test, you're 58 now'. I said 'no, excuse me I'm 57'. And I've got to have it. I said 'is the GP going to get money for that?' This is what is really aggravating me.

(woman, London, 60+ age group, c2de)

It becomes a box ticking exercise that somebody somewhere has thought up with all of these things. (In answer to general feedback on reflecting on wellbeing.)

(man, London, 60+ age group, c2de)

We found really what's it all about? Who is so interested in us, is it a government thing, we want to know more about it.

(woman, Exeter, 25-39 age group, abc1)

It's about depression

In addition to the confusion, misunderstanding and suspicion surrounding the term and concept of wellbeing, this public engagement also revealed the persistence of a deficit model; of a sense that wellbeing is about dealing with mental illness, depression, disaffection, alcoholism, learning difficulties, general anxiety or even homelessness:

People that need to be looked at about wellbeing are probably over Waterloo in cardboard city, the bloke sleeping in the doorway that nobody is ever going to speak to.

(man, London, 60+ age group, c2de)

Like all these [other participants] are older than us, like they're out in the real world and I'm with my mum so for me to come here and comment on people's wellbeing would be like wrong I mean cos I'm fine… The biggest worries I've got is like when I bottle my homework. Do you know what I mean?

(man, Altrincham, male, 18-24, abc1)

Related to this, discussions of mental health, where they took place, also tended to be grounded in the deficit model; for the participants who spoke directly of it, mental health is about dealing with depression, learning difficulties etc.:

I mean it depends on the severity of mental health, it could be as you've said depression or it could be learning difficulties and so it depends on what scale of the spectrum you're on.

(woman, Coventry, 18-24 age group, c2de)

There is no widely accepted alternative

Alternative words for wellbeing appear to be equally as tricky, albeit for different reasons. For example, 'happiness' is perceived by some as momentary and fleeting:

I think the difference between happiness and contentment is happiness comes in shorter bursts. Where as contentment is a general overall thing.

(woman, London, 60+ age group, c2de)

Similarly, 'life satisfaction' is perceived by some as denoting a less than ideal state:

I was thinking of the word 'satisfied' and now I'm thinking of the word as being more like, if I'm satisfied I'm happy with some of it but it could have been better … the word 'satisfied' for me is a bit, you're happy with it but you're not 100 per cent.

(woman, Altrincham, 18-24 age group, abc1)

'Satisfaction' just sounds like bog standard to me like.

(man, Altrincham, 18-24 age group, abc1)

The main point here is that through this public dialogue we did not find an alternative term for 'wellbeing' that resonated widely with the public.

Responses to Five Ways activity

In general, many agreed that *Five Ways*-type activity was indeed good for them.

They're all interlinked

In particular, many appeared to feel that *Five Ways* activities are linked:

And you can interlink spending time with other people and being aware and taking notice and it makes you happy.

(man, Altrincham, 18-24 age group, abc1)

I'm doing my Masters in Teaching and Learning at the minute so I get a lot of satisfaction and gratitude from that class although I take into account all these different areas here, like I get to give more to the children I'm teaching because I'm learning more. I get to be more aware of what I'm doing. Take notice of what other people are doing and they just kind of feed into each other so…

(woman, Altrincham, 18-24 age group, abc1)

Each of the *Five Ways* carries negative connotations

However, some people appeared to have had negative as well as positive experiences of *Five Ways*-type activity:

…giving, that makes you lose something you have if you're giving money, if you're giving time.

(man, Altrincham, 18-24 age group, abc1)

I don't really find a lot of satisfaction in giving. I mean I like to help people out where I can but I don't think you really get acknowledged for the things you do and if you're not getting acknowledged for it, what's the point?

(man, Coventry, 18-24 age group, c2de)

In addition, it appears that framing 'giving' in terms of the wellbeing gains for the giver was insulting, and can undermine the altruism that people see as driving their giving behaviour:

I think that's a selfish attitude to be honest.

You think what's a selfish attitude?

To make yourself feel good by giving to other people.

(man, London, 60+ age group, c2de)

As with giving, connecting, learning and taking notice were similarly experienced negatively by some:

I think there's a lot more effort with your family isn't there? You've got to put the effort in there with your family because my dad and my mum drive me fucking nuts.

(woman, Coventry, 18-24 age group, c2de)

… when you think of learning you just think about exams and A levels or what not.

(woman, Coventry, 18-24 age group, c2de)

One of the things I am trying to work out with this being aware bit and I was thinking could it also include things like being aware of all the issues that are going on in the world at the moment? World issues, political issues and then I thought that may not lead to wellbeing. When you see a lot of it you find it quite depressing and you worry about all these things that are happening especially when you listen to the news.

(woman, Exeter, 25-39 age group, c2de)

'Take Notice' is particularly difficult to grasp

Another observation of participants' responses to *Five Ways* activities is that for many participants, 'take notice' was particularly hard to get to grips with:

Being aware was quite a hard one to get to.

(woman, Altrincham, 18-24 age group, abc1)

I don't quite get that one. It doesn't sit right with me.

(man, Hartlepool, 25-39 age group, c2de)

But that is like trying to clear your mind.

That's certainly part of it.

It's very abstract isn't it, very abstract.

It's like being contemplative, like Fucius, you know, thinking.

(woman, Guildford, 60+ age group, abc1)

Once aware of the *Five Ways*, many people re-interpret existing activity within a *Five Ways* framework

Whilst some people emphasized the negative experiences of *Five Ways* activities, others couched what they already do as *Five Ways* activity:

If you're aware of what's going on around you, I mean, i.e. the newspapers, the TV, I know people say you can't believe everything that goes on, but if you pick the right things out of everything that's gone on around you, then you're learning every minute of the day.

(man, London, 60+ age group, c2de)

As with 'wellbeing', some participants were suspicious of the *Five Ways*/ their promotion; in particular, some people perceived these as being part of the Government's Big Society agenda, which in turn was interpreted as 'getting people to run things for nothing':

The way I see things is, going back to say Cameron's big idea of running things, is to put people out of work and get people to run things for nothing. When they talk about putting people on the

community work instead of putting them in prison, sack a road sweeper, get someone else to do it for nothing. Close the library. Get people to run it for nothing. To me it don't work. If a job's worth doing, pay people to run it and pay people to do it.

(man, London, 60+ age group, c2de)

Responses to the science behind the Five Ways to Wellbeing

As well as gauging participants' responses to 'wellbeing' and *Five Ways*-type activities, this public dialogue explored people's views of the science behind the *Five Ways* and their benefits.

Science can be important as a prompt for behaviour change

Some people found the scientific evidence behind the *Five Ways* an important element in the choice to engage more activity with them:

Yeah science has affected me for this wellbeing thing because I really was down in the dumps and I didn't want to get up on a morning and I didn't want to look after my daughter. Well I did but I just felt generally crap. And I kind of knew about it but now I've actually got into it and looked into it I've made the effort to do it and I do feel better.

(woman, Hartlepool, 25-39 age group, c2de)

And some people suggested that the scientific evidence behind the *Five Ways* would be important as a support for any messaging, if not as a convincing factor in itself. The following excerpt is taken from the workshop in London, and shows participants' responses to the facilitator's question about what should be said in any messaging around the *Five Ways*:

We've written 'the facts'.

Which are?

Of the five things that we practice or we don't practice.

Do you think people need the evidence?

… We more or less said the same but only confirmed facts. Scientifically confirmed.

… Only confirmed facts, things that you can actually prove.

(women and men, London, 60+ age group, c2de)

Common sense or experience are more convincing than the science

Other people emphasised that common sense, not science, is what convinces them to do *Five Ways* activity.

How many scientists did you say were used?

They've looked at the work of something like over 400 scientists.

From all over the world?

Yeah.

To come up with what is essentially common sense…

(man, Coventry, 18-24 age group, c2de)

Others emphasised that experience, not science, is the convincing factor for doing *Five Ways* activity, indicating that the science was redundant for them:

> *I know what works for me and so I don't need science telling me that this is good for me and this works and this works because by experience I know what works. But I'm interested at the same time if that makes sense.*
>
> (man, Hartlepool, 25-39 age group, c2de)

The 'science' of wellbeing is not proper science

Other people found the science problematic on the basis that it is not 'proper' (physical) science:

> *You know like I was just saying to Paul there you know like if it's something about its scientific like you know splitting the atom and that then you listen to scientists because obviously you know they know. But something like this I wouldn't say this is a scientific thing what we're talking about do you know what I mean.*
>
> (man, Hartlepool, 25-39 age group, c2de)

> *Social science is quite a new thing so that there's still quite a lot of education and evolution to go through with the science of the mind so we're just kind of at the start really. I know it's been 100 years or so but you know life science like factual science has been going back thousands of years so we've got to a point now where we can really test things and find out facts and everything but when it comes to psychology and stuff it's still new.*
>
> (women, Altrincham, 18-24 age group, abc1)

In any case, science is untrustworthy – it is subject to change/ it has been commercialised

Other participants appeared not to trust any kind of science, on the basis that science is changing all the time:

> *I mean take alcohol I mean one day you're supposed to drink red wine because it's good for your heart and the next day it's bad for your veins and then it's white wine and then it's beer and you know you go round… I mean you dismiss most of the research by the time you've gone round in three circles.*
>
> (man, Guildford, 60+ age group, abc1)

> *Look at Thalidomide, everyone praised that and look at what happened.*
>
> (man, London, 60+ age group, c2de)

> ***Do you think that in a month's time or a year's time or ten years time scientists will turn round and say do you know what we got [science around Five Ways] wrong?***
>
> *Definitely.*
>
> *Definitely.*
>
> *Learning, giving, this stuff, it's not good for your well being.*

(women and men, London, 60+ age group, c2de)

Others were skeptical of science because of the way it has been commercialised and used to sell products:

> *One thing that really, really pissed me off was, and I'm not going to name the company, there was an expensive, I love creams, and there was an expensive anti wrinkle cream came on the market and I went and bought it, I've looked at the ingredients, 'scientifically proven to get rid of your wrinkles', exactly the same ingredients that was in pile cream and nappy cream. 'Scientific'.*
>
> *Did it work?*
>
> *No, I've got piles in my mouth now! … I'm talking about scientific evidence, but it's just the actual make up companies, everything, even down to Avon and everyone, an Avon thing, 'scientists says this is the best cream', 'scientist says'.*
>
> ***Do you believe them or not?***
>
> *Not now it's in nappy cream and pile cream.*
>
> (woman, London, 60+ age group, c2de)

The science/ statistics don't reflect me

Others indicated that they felt the science did not reflect them:

> *Who was it that came up with* [the science behind the *Five Ways*]*? Were they professors, doctors?*
>
> ***Yeah it's scientists working in this field from different countries.***
>
> *So they weren't Hartlepudlians then?*
>
> *(man, Hartlepool, 25-39 age group, c2de)*

Participants' ideas around imparting knowledge of the *Five Ways* to wellbeing

Everyone should know about the Five Ways to Wellbeing

Many participants stated that they thought everyone should have knowledge of the *Five Ways* to wellbeing:

> *Everyone … Because we felt, well I felt it's the message, there's something in it for everyone isn't there, the young people growing up the future if you want to call it that. People who perhaps are trapped in this kind of possessions, the middle aged people and the elderly as well.*
>
> (man, Exeter, 25-39 age group, abc1)

The Five Ways to Wellbeing are relevant for people with mental health problems

Some participants stated that it is only people with mental health problems who should have knowledge of the *Five Ways* to wellbeing:

> *The only people that need to know about it are the people that are not happy. The people that are depressed and the people who need to sort their heads out really.*
>
> (woman, Coventry, 18-24 age group, c2de)

Who might be interested? I guess people that are unhappy with their lives, so anyone that walked into like a psychiatrist's.

(man, Exeter workshop, 25-39 age group, abc1)

The Five Ways to Wellbeing are especially relevant for young people

Many participants stated that children and young people especially should have knowledge of the *Five Ways* to wellbeing:

If it's installed within the younger generation it breeds to the next generations.

And by younger you mean?

Teenagers.

… We've put everybody as well but we think it should be instilled from a younger age…

And so younger than teenagers?

Oh yes definitely.

And so at what age would you start?

… I actually put nursery down.

… Everyone should know especially kids because it's easier to educate kids about the facts and obviously the earlier you start the better it is.

Yeah.

Promoting the Five Ways to Wellbeing is too prescriptive

However, many participants indicated that they do not like being told what to do or not to do:

Well I've had cancer three times and the last time I had to have extensive radiotherapy and quite frankly the effort of getting over that, I just threw all my energies into just doing anything and I don't appreciate anybody coming along and saying 'oh God you're 73, you ought to come down to the tea dance, you ought to do this, you ought to do that' and I'm just not interested… I'm fighting it just to get over everything and just to lead my own life. I mean I was in hospital the other week for a failed procedure and this young chap comes over to me and he said, he's making all these notes and everything, and he said 'can you run up four flights of stairs?' And I looked at him and I said 'why would I want to be running up four flights of stairs at 73?' So he said 'well my dad's 69 and he can do it'. So I said 'well bully for your dad, if he wants to do it, let him do it', I said, 'but I'm just not interested and I don't want to know'.

(man, London, 60+ age group, c2de)

Uum, I mean I'm just happy enough as I am without encountering all these people telling me what to do and what not to do.

(man, London, 60+ age group, c2de)

We have a worry about the nanny state and the populous being dictated to.

(man, Guildford, 60+ age group, abc1)

…not being in someone's face saying you need to do this to make you feel that, you need to do that.

(woman, London, 60+ age group, c2de)

Messaging should be enabling and supportive in tone – and not come from 'The Government'

Some stated that an 'advisory', 'non-confrontational', 'non-judgemental', 'empathetic' tone would be more likely to engage them. In addition, many participants stated that knowledge of the *Five Ways to Wellbeing* should *not* come from government. In particular, many felt that it should be imparted by parents, teachers, health professionals and employers. For many people, a documentary or series of documentaries was the preferred reported medium of messaging:

Well … we said like a prime time TV programme like Embarrassing Bodies.

A documentary type thing they should do one category at a time over say six weeks and then have all five categories and then summarise it with the sixth one at the end. And put it on at a couple of different times, each one at different times during the day because obviously media is a big way of advertising it.

(Hartlepool workshop, 40-59 age group, c2de)

Chapter 5: Next steps – Policy analysis and dissemination

In this chapter we present some initial analysis of the results of the dialogue process in terms of implications for policy and strategy.

How to reach people: Channels of communication

To the extent that the *Five Ways to Wellbeing* and similar health promotion initiatives are intended as *messages* for individuals, the question arises as to how to deliver the message. Findings from the dialogue have implications for two channels of communication that might be utilised:

- Social marketing
- Communication via trusted professionals.

Communication via social marketing

So-called 'social marketing' is using the methods and techniques of commercial marketing for socially useful ends. Typically, social marketing campaigns incorporate conventional strategies such as advertising on television, in newspapers, on the internet and so on. They may also use 'market segmentation', the methodology whereby potential targets for the communication are grouped according to factors such as attitudes to the issue in question, likely receptivity to a message, willingness and ability to make changes and so on.

Various governmental departments, third sector organisations and other agencies already use, or are exploring, social marketing approaches to improving wellbeing. For example, *No Health Without Mental Health* implies that social marketing will be an important part of the ongoing strategy.

> *The Government will continue to work with partner organisations to explore different ways – in the media and elsewhere – of improving public understanding of mental health issues. This will include working with Time to Change, the national campaign to raise awareness of mental health issues and change attitudes and behaviours towards people with mental health problems. (p.31)*

And:

> *The Government will ensure that the population as a whole knows what it can do to improve its wellbeing and stay healthy. There are many things individuals can do to improve their own mental health; for example, drinking within safe limits, taking regular exercise and participating in meaningful activities, such as arts and sports activities and experiencing the natural environment. (p.31)*

With these initiatives in mind, a number of relevant learning points arise from the research:

Ensure that messages do not appear to come from 'the Government'
A recent report from the Cabinet Office, MINDSPACE, summarises findings from recent work in psychology and behavioural economics on the factors that influence people's behaviour and in particular their propensity to change behaviours. MINDSPACE is an acronym, the 'M' of which stands for 'messenger', referring to the importance of *whom* a message is delivered by in determining how it will be perceived and acted upon.

This was clearly borne out in the current research. The strongest inference to draw from the data is that messaging campaigns need to avoid appearing to be from 'the Government'. As noted in the second and third sections of the previous chapter, across the sample, there was a general wariness about government interest in this area; issues of happiness, wellbeing and emotional life were just not regarded as areas of concern for government. Moreover, conversations about the Government's role quickly moved into widespread 'nanny state' and 'cuts agenda' discourses, which had a negative tone for most people.

Use concrete messaging that suggests particular activities or actions
As discussed in the second section of Chapter 4, it was evident from the dialogue that 'wellbeing' is a potentially confusing idea. Moreover, the relatively abstract, high-level phrasing of the *Five Ways* provoked a degree of disengagement from some respondents, as well as considerable disagreement. Each of the *Five Ways* offered the potential for different interpretations or ambiguity traps. For example, the following sequences of inference were typical:

> *Be Active* → Physical activity → Exercise → Gym → "not for me"
>
> *Connect* → Spending time with other people → Some people take advantage → Argue → "not for me"
>
> *Keep learning* → Courses → Schoolwork → Careers → "not for me"
>
> *Give* → Money to charity → Gets lost in admin → Government getting us to work for free → "not for me"
>
> *Take notice* → Aware of depressing news / aware of troubles in my circumstances → "not for me"

As noted at the beginning of this document, the aim of the dialogue was not, per se, to test the *Five Ways to Wellbeing*. However, it seems likely that these kinds of problems of interpretation will be common to any messages that try to subsume a range of possible activities under a broad heading.

One way to help overcome this problem may be to frame messages in more concrete terms. Clear, simple versions of messages that utilise a practical example may reduce ambiguity and the potential for negative interpretations, whilst also helping people relate the message more readily to their own lives, e.g. 'Go for a run', 'Walk in the park', 'Phone a friend', 'Lend a hand' and so on.

Avoid framing messages as 'scientific'

Given the remit of Sciencewise-ERC to promote dialogue on scientific issues, it was interesting to observe how participants responded to the scientific evidence underpinning *Five Ways*-type behaviours. This is relevant to the issue of communication since it seems plausible, *prima facie*, that framing a behaviour change message in terms of its support by scientific research could help to make it effective. Similar approaches have proven effective in the past, as for example in efforts to encourage people to change their smoking behaviours by highlighting research on the impacts of passive smoking.

Generally, however, and as illustrated in the second section of Chapter 4, the findings from the dialogue were counter to expectations, in that people were reluctant to see wellbeing as a scientific issue. For some, research on wellbeing did not seem like 'proper' science (such as physics or chemistry) and so did not command the same authority. In some cases, people had difficulty either understanding or accepting specific claims, especially if these ran contrary to their own personal experience. More widely, there was a common view that scientific findings 'come and go' and that as such you can pick and choose what you want to believe. This seemed to be born of a weariness with the kinds of scientific claims that are commonly heard in the media, which are often overblown and frequently contradicted by subsequent claims.

A particular issue is that, unlike areas of public scientific debate that are remote from most people's experience (e.g. genetic modification), wellbeing, happiness and so on are intensely personal and – by definition – subjective issues. People rightly consider themselves experts on their own feelings and, moreover, on the kinds of activities and behaviours that make them feel good or bad. Few people disagreed that *Five Ways*-type behaviours were enjoyable and beneficial, but the very fact that they were 'common sense' seemed to make the scientific framing redundant. The existence of a scientific evidence base was not motivating in itself; indeed, for at least some people, invoking science in a discussion of things that were so intuitively obvious seemed to arouse suspicion.

Communication via trusted individuals

Empower professionals to deliver effective wellbeing promotion

As noted in at the very end of Chapter 4, many respondents felt that a behavioural 'push' would be acceptable and enabling if delivered by the right messenger. When asked from whom (if not 'the Government') they might accept advice and messages about wellbeing, respondents mentioned a variety of possible sources.[20] Most prominent on this list were healthcare professionals, such as GPs. However, others working in professional roles were also mentioned frequently (e.g. social workers).

It is important to remember that this was a hypothetical question; what people say about who they might accept a message from at some point in the future should probably not be interpreted too literally. Nevertheless, the general thrust of responses raises the question of how professionals might, in principle, be empowered to discuss and promote wellbeing messages as part of their ongoing work.

One approach, for instance would be to develop ongoing professional development training for those who have professional contact with the

public, so that they can present wellbeing promotion messages in effective ways. This could include, for instance, explicit training in Motivational Interviewing and other evidence-based health promotion techniques.

Teach children about wellbeing through teachers and parents
Participants in the dialogue were also enthusiastic about the idea that children should know about wellbeing and the *Five Ways*. They suggested that this might be achieved through training teachers, but also through helping parents to understand the benefits of *Five Ways*-type activities.

With regard to teachers, at present, a number of schools around the UK are already developing and piloting wellbeing programmes that can be incorporated within the curriculum; however, these are relatively embryonic and as yet there is little robust evidence that they are effective in raising children's wellbeing. As for parents, the ongoing Early Intervention Review already places strong emphasis on the importance of parenting for future wellbeing outcomes, but it is not clear by what mechanism parents could be informed about the wellbeing evidence base, nor whether this would in fact be a useful and effective thing to do.

What to say: The communication objective

Having established the mode of communication, the next question is of course: what to communicate? Simplistically, the objective could be just to raise awareness of the *Five Ways to Wellbeing*, or of some other set of public health messages if they were found to be more effective. However, findings from the dialogue and our subsequent analysis suggest a number of more subtle communication objectives.

Work to create a new common language for positive mental health
Throughout much of the dialogue, there was a sense that whilst people were not unhappy with their current lives, they did not have an expectation that they might be able to make changes in order to feel better. This is clearly a problem from the point of view of encouraging behaviour change since, to be motivated to change, people have to understand what change will achieve and why it might be desirable.

Our analysis of the dialogue suggests that this is not just (or even primarily) a problem of motivation, so much as a problem of *discourse*. By illustration, it is interesting to compare the discourse of physical and mental health and illness. As illustrated in Table 2, in the physical domain there is clear discursive distinction between being healthy and being ill. Whilst they are obviously related, physical health is not widely understood as synonymous with the absence of infirmity. Rather, it is associated with the *presence* of positive states (e.g. low resting heart rate) and behaviours (e.g. regular exercise). These are regarded as valuable and desirable, such that many people are motivated to become 'healthier' or 'fitter' even without any immediate threat of illness.

By contrast, it was clear in the dialogue that the term 'mental health' has become essentially synonymous with 'mental illness' in everyday discourse. However, there seemed to be a corresponding conceptual gap where a positive vision of mental *health* should be; in other words, there simply was no commonly understood way of talking and thinking about positive aspects of mental life.

One aim of a wellbeing communication strategy could therefore be to focus on filling this conceptual space with a positive vision of mental health that makes sense to people and has motivational appeal. In order to achieve this, however, more work is required to explore what the right language might be. It seems evident that 'mental health' has become linked (perhaps irrecoverably) with mental illness, and so will not be suitable. As part of the dialogue, participants were asked to respond to a number of different alternatives. As noted in the second section of Chapter 4, although 'wellbeing' was felt to lack resonance, no strong alternative emerged, but several alternative options commanding varying degrees of support: these included happiness, satisfaction, quality of life, contentment and flourishing. Further focus group and dialogue work could be used here in order to unpack how people respond to these and other terms, with a view to identifying that which has most potential as the basis for communication.

Table 2: Comparison between mental and physical health and illness discourse

	Physical	Mental
Health	e.g. Eating fruit and vegetables Taking regular exercise Strength and flexibility	???
Illness	e.g. Cancer Obesity Heart disease	e.g. Depression Anxiety Psychosis

Raise awareness of opportunities for engaging in wellbeing activities

As was made evident in the first section of Chapter 4, one of the barriers to *Five Ways*-type activities cited by respondents was a lack of facilities (e.g. clubs, parks), or a lack of awareness of the facilities one could use. Of course, it was impossible within the constraints of the dialogue exercise to tease apart for which respondents the reported lack of facilities was true – i.e. there really were no facilities available within their local area to which they had realistic access. However, it was clear in some case that people were unaware of the opportunities that were available to them, either because they literally did not know about them or because they were not within the set of options 'allowed' by prevailing social norms ("people like me don't do that kind of thing").

To the extent that this is a barrier to action, communication could focus explicitly on raising awareness of facilities and opportunities that exist within an area. We might expect this to help in two related, but distinct ways. Firstly, of course, the mere fact of knowing that opportunities and support are available helps individuals to see *how* they could, in principle, make positive changes to the lifestyles. Secondly, it might also be expected that increased awareness of opportunities may help to normalise certain behaviours within a given group or area. So, for example, a group of people

may have no strong norm around participating in physical exercise. But, if the presence of a local gym was made widely known, the idea of going to the gym may gradually enter the 'possibility space' for people in the group – it may become something that becomes more socially acceptable.

Focus on increasing people's felt sense of agency

As noted in at the end of the first section of Chapter 4, the issue of *agency* emerged strongly from our analysis of the dialogue, such that a sense of agency appeared to be predictive of respondents' ability and willingness to engage in *Five Ways*-type activities. However, it is important to emphasise that we understand agency here as *psycho-social* in nature. In other words, agency is seen as arising from an interaction between the individual's psychology (e.g. their sense of self esteem and competence) and their social environment (e.g. the extent to which they are free to make certain choices).

An objective of a wellbeing communication strategy might be to help increase people's sense of agency and so 'give permission' for people to make different choices. A psycho-social analysis of agency suggests that this could be achieved in two ways, which are not mutually exclusive. The first broad approach is to focus on the *individual*, offering guidance and support in a way that empowers and reinforces their own decision, rather than paternalistically telling them what they should be doing. It is worth noting, on this point, that a large number of respondents in the dialogue were already engaged in many *Five Ways*-activities, even if they did not consciously understand them as such. Rather than telling people to change their behaviour, then, an alternative would be to provide messages that give evidence supporting their existing choices and encouraging them to keep doing what they are doing.

A second approach is to focus on the *social*, seeking to change the norms that influence how people perceive their options and opportunities. It is here that some of the techniques of 'nudging' would seem to be particularly useful. For instance, it is well understood that people are more inclined towards certain activities and behaviours if they believe them to be popular or commonplace amongst other people like themselves. Communications that convey a message about the popularity of *Five Ways*-type behaviours to target demographic groups might serve to increase individual's sense of agency may making new, different behaviours seem possible and desirable.

Exploring the reality of external barriers

As was noted in the first section of Chapter 4, across the sample, time and money were the most frequently cited barriers to engaging in more *Five Ways*-type activities. In itself this is unsurprising and is consistent with what has been found in previous research literature on changing health behaviours.

A limitation of a dialogue process such as that undertaken here is that there is no way of ascertaining objectively the relationship between what people report and the reality of their situation. As such, it is not possible to judge – for any given respondent – the extent to which 'time and money' is a genuine barrier to action or reflects a discursive strategy used to deflect attention from some other barrier (such as low motivation or perceived agency to make changes). When questioned further, for example, some

respondents acknowledged that they could probably “make the time” if they had different priorities. Likewise, for at least some people, money might not be such a significant barrier were they to decide to spend their resources differently. To some extent, then, concerns about time and money can be seen as reflecting wider priorities which are influenced by social norms and values (e.g. shaped by advertising, media, etc.). Indeed, the very availability and prevalence (even saturation?) of certain negative discourses – e.g. ‘pace of life’, ‘negative media’, ‘social problems’, ‘inequality’, ‘cuts agenda’, etc. – can be regarded as substantive barriers, because they diminish sense of felt agency, provide a ready justification for low motivation and so inhibit action.

Nevertheless, it is evidently important not to assume that all mention of time and money as barriers is ‘just’ rhetorical, for this would be to downplay the fact that these (and other objective factors) are real and important limitations for some people. Assuming that ‘hard’ external barriers (time, money, access to opportunities) *are* a significant issue for some subset of the population, what can be done about them?

Answering this question is clearly outside the remit of the current research. However, we would note an important issue, which is that these kinds of barriers reflect the outcome of decisions taken in areas of policy that give little or no consideration to mental health issues (e.g. employment policy, taxation, local transport planning, etc.). A first step, already strongly signposted in *No Health Without Mental Health*, is thus to ensure that mental health and wellbeing considerations are at least factored-in to strategy development across all policy areas.

Ongoing policy engagement

Stakeholder meetings

Having formed an initial view about opportunities and barriers to promoting wellbeing in the population, based on findings from the dialogue, the final stage of the project was to conduct follow-up meetings involving policy-makers. The aim of these meetings was to explore the implications of the findings for current policy development across a range of policy areas.

An initial feedback meeting was held on 17 March 2011 to the project steering group. This involved a full presentation of findings from the dialogue, and initial analysis of policy areas where the findings might be relevant. Subsequent to this meeting, a short briefing paper was written for circulation amongst stakeholders within the Department of Health. A second meeting was then held on 18 May 2011. This again presented a summary of headline findings and analysis to a group consisting of stakeholders from across different policy teams, including mental health, public health, substance misuse, children and older people.

Subsequent to this second meeting, a number of formal and informal meetings have been held. These include:

- A follow-up meeting with the Deputy Director for Mental Health at the Department of Health to discuss implications of the research for ongoing development of the mental health strategy.
- A meeting with representatives of the Children and Young People’s Mental Health team within the Department of Health to explore findings relating to the young adults who participated in the project.

- A meeting with policy officers at the Department for Work and Pensions to explore their ongoing work to raise awareness of well-being issues amongst staff at JobCentrePlus.

Policy impact

At the time of writing, it would be premature to attempt to attempt to assess the impact of the project findings on policy. The development and execution of the current research coincided with the first year of the new Coalition Government. The areas of policy most directly relevant to the current research – mental health and public health – have been subject to considerable upheaval during this period, with a number of new white papers, consultations and strategic initiatives being undertaken.

When the project was initially conceived, the intention was that findings from the research would feed directly into the development of the new mental health strategy *No Health Without Mental Health*. In practice, due to a delay in initiation of the project as a result of unforeseen contractual complications, the strategy was released whilst the fieldwork for the project was ongoing – the project was mentioned in the white paper, but there were no findings to report. Feedback from members of the project steering group suggests that the findings have since influenced their ongoing thinking about implementing the strategy.

Our assessment, based on the meetings that have been held as detailed above and numerous informal conversations, is that the most likely area for the project's findings to have policy impact in the future is in the development of the new public health arrangements. As set out in the white paper *Healthy Lives, Healthy People*, responsibility for public health is undergoing considerable change, with a devolution of powers from central to local government, new statutory Health and Wellbeing Boards in local areas, and the instigation of a new executive agency Public Health England that will provide support and guidance to the local Health and Wellbeing Boards. There is evident scope for findings of the project to influence this guidance as it relates to health promotion, behaviour change and social marketing in relation to population wellbeing.

Appendix 1

Reviewing the evidence for the *Five Ways to Wellbeing*.

Research process

The search for relevant science underpinning *Five Ways*-type behaviours was undertaken as follows.

- Snowball reference search, beginning with three key documents:
    - Foresight Mental Capital and Wellbeing Project. (2008). *Foresight Mental Capital and Wellbeing Project: Final Project Report*. London: The Government Office for Science.
    - Aked, J., Marks, N., Cordon, C., & Thompson, S. (2008). *Five Ways to Wellbeing: The evidence*. London: **nef**.
    - Delichte (2010)[21], unpublished MSc dissertation on barriers to behaviour change
- Google Scholar search using search terms: 'mental' and 'health'/'wellbeing' and 'benefit' and 'physical activity' or 'social' 'network'/'support' or 'giv*'/'volunteer' or 'learn*' or 'education' or 'mindful*'.

Search criteria were restricted to articles published between 1990 and 2010 and, for each search, to the first 20 hits generated by the Google Scholar search engine.

Results

In summary, the review of desk research confirms that there is a reasonably robust body of evidence to suggest that engaging in *Five Ways*-type activities has a positive effect on mental wellbeing. In particular, there is clear evidence that practising the kinds of behaviours encapsulated within the Five Ways (being physically active, relating with other people, giving, being mindful and learning) is beneficial for mental wellbeing across a range of measures, and that this claim is supported by a range of scientific evidence.

However, there is also some debate within this evidence concerning the optimum frequency, duration, intensity and types of activities in each behaviour area. Moreover, there is also debate concerning the causal pathways involved in the relationships between particular activities and particular mental health outcomes (e.g. between physical activity and mental wellbeing), and the determinants and mediators at work (e.g. in the association between volunteering and mental wellbeing). Whilst it is beyond the scope of this project to contribute to these debates directly, knowledge of them highlights the need to be clear during public engagement about

which particular behaviours are being associated with which particular mental health outcomes.

In the following paragraphs, we briefly summarise the research pertaining to each of the *Five Ways* to Wellbeing, in each case giving a flavour of the studies underpinning the summary.

'Be active': Physical activity and mental health

Evidence for the links between physical activity and mental health/ wellbeing is well established, in particular within the fields of sports science and psychology. There is debate concerning the optimal type, timing, intensity, frequency and duration of activity; however, findings from primary research and reviews tend to conclude that those who are regularly physically active "experience a sense of psychological wellbeing".[22]

Large scale surveys and experimental studies, as well as meta-analytic reviews of these, form the basis of the evidence: for example, Hassmen *et al* (2000)[23] conducted a cross-sectional questionnaire study of 3,403 Finnish adults age 25-64. Respondents answered questions about exercise habits and completed standardised measures of depression, state-trait anger, cynical distrust and sense of psychological coherence. Those who exercised at least 2-3 times a week experienced significantly less depression, anger, cynical distrust, and stress than those exercising less frequently or not at all. In a longitudinal study, Yaffe *et al* (2001)[24] followed 5,925 American women age 65 and over, across a 6-8 year period. Participants were measured for physical activity by amount of walking, stair-climbing and calories expended per week, and for cognitive performance at baseline and again towards the end of the study. Those with higher levels of physical activity were less likely to develop significant cognitive decline. Summarising a review of literature into the role of exercise in treating mental illness and improving population mental wellbeing, Fox (1999) concluded that:

> *Sufficient evidence now exists for the effectiveness of exercise in the treatment of clinical depression. Additionally, exercise has a moderate reducing effect on state and trait anxiety and can improve physical self-perceptions and in some cases global self-esteem. Also there is now good evidence that aerobic and resistance exercise enhances mood states, and weaker evidence that exercise can improve cognitive function (primarily assessed by reaction time) in older adults.*[25] (p.411)

Social relationships and mental health

Evidence for the link between positive social relationships and mental wellbeing is well established within psychological and sociological research. Evidence points to the correlation between strong social networks, social support, close relationships and participation in social activities, and mental health. It is recognised that social relationships can also have negative effects on mental health, for example if they are critical or overly demanding (Seeman, 2000)[26] and that *subjective appraisal* of one's social resources and not only the resources themselves is important as a contributor to mental wellbeing (Martin & Westerhof, 2003)[27]. It is also recognised that the direction of causality is not always clear in research in this field and that strong social relationships can follow from positive mental health as well as contribute to it. Nonetheless, evidence shows that positive social relationships are linked to enhanced mental wellbeing.

Meta-analyses, longitudinal and cross-sectional studies and qualitative research form the basis of the evidence. In the *Future challenges* report on mental health for the Foresight project, Jenkins *et al* (2008)[28] summarise a number of studies supporting links between social support and mental health, finding that "Belonging to a social network involving communication and supportive relationships is protective of good health and positive wellbeing" (p.22). One of these studies is reported in Brugha *et al* (2005)[29], who conducted a longitudinal study of 8,886 UK men and women age 16-74. The revised Clinical Interview Schedule (CIS-R) and the Interview Measure of Social Relations (IMSR) were administered to respondents at baseline and 18 months later. A primary group size of three or less predicts worse mental health.

Another, now frequently cited paper by Deiner and Seligman (2002)[30] studies 222 American undergraduate students. Participants were measured for happiness using various measures (including a satisfaction with life scale, affect balance tests and a trait self-description task) and various analyses performed relating these to social relationships. The authors found that "very happy people have rich and satisfying social relationships and spend little time alone relative to average people". They concluded, further, that "good social relationships are… universally important to human mood" (p.83).

'Give': Altruism, volunteering and mental health

Evidence for the positive association between giving and mental wellbeing is growing, although the benefits of giving *per se* are less well-evidenced than those for being physical active and socially connected. Much of the research in this area is based on studies of volunteering (and these are plentiful), often with particular reference to older people (for example Greenfield & Marks, 2004)[31]. Here it has been noted that volunteering may contribute to mental health through the mediating role of social interaction.

Studies noted that positive mental health is likely to be a pre-cursor for the performance of informal altruistic behaviours. Randomised controlled trials, large scale surveys and analyses of multi-wave data sets form the basis of the evidence. For example, Boehm and Lyubomirsky (in press)[32], conducted a randomised control study in America involving a behavioural intentional activity. Participants were invited to regularly practice "random acts of kindness" over a ten week period and their levels of happiness measured at baseline, mid-intervention, immediately post-intervention and one month later. The study found that "Engaging in kind acts (e.g., holding the door open for a stranger or doing a roommate's dishes) was thought to impact happiness for a variety of reasons, including bolstered self-regard, positive social interactions, and charitable feelings towards others and the community at large." (pp.11-12)

Meier and Stutzer (2008)[33] conducted a cross-sectional survey of 22,000 German men and women age 17 and over. Respondents were asked about their life satisfaction and extent of volunteer work (amongst other things), with analysis of the results suggesting "… robust evidence that volunteers are more satisfied with their life than non-volunteers." (p.39) Another cross-sectional survey, reported by Musick and Wilson (2003)[34], related a standard measure of depression and self-report measures of volunteering activity in a sample of 3,617 American men and women age 25 and over. Respondents engaging in regular volunteering experienced lower levels of

depression overall, and beginning volunteering lowered levels of depression for those over 65.

'Keep learning': Learning across the lifecourse and mental health

Evidence for the positive association between continued learning and wellbeing is well established. Much of the evidence is focused on formal/ institutional learning, and here it has been noted that outcomes are affected by course type and level, educational background, and institutional support, and that experiences can be negative if, for example, institutional support is lacking or course levels are too high. As with the other behaviour areas, there are issues around causal pathways and the direction of causality; for example, it is possible that the mental health benefits of group-based learning are mediated by the social interaction dimension of such learning. Nonetheless, it is generally acknowledged that positive learning experiences are associated with enhanced mental wellbeing.

Review studies and qualitative studies form the bulk of the evidence in this area. Feinstein (2002)[35] reviewed evidence of the social benefits of learning in the UK, finding, for instance, that women who gain qualifications are less likely to develop depression. Schuller *et al* (2002)[36] reviewed a range of evidence pertaining to learning in adult life, including conducting qualitative research with 140 UK men and women between 16 and 70 years of age. They concluded that "education can help directly as a therapeutic activity for people with mental health problems" and that it has a preventative effect, whereby learning helps "avoid, minimise or address depression". A similar study by Dench and Regan (2000), summarised by then Department for Education and Employment (DfEE)[37], explored the impact of lifelong learning with 336 UK men and women age 50-59, finding that "80% per cent of learners reported a positive impact of learning on at least one of the following areas: their enjoyment of life; their self-confidence; how they felt about themselves; satisfaction with other areas of life; and their ability to cope" (p.1). In another qualitative investigation, Hammond (2004)[38] found that learning throughout the life-course "has effects upon a range of health outcomes; wellbeing, protection and recovery from mental health difficulties, and the capacity to cope with potentially stress-inducing circumstances" (p.551).

'Take Notice': Mindfulness, present-focus and mental health

Evidence for the benefits of mindfulness for psychological wellbeing is robust. Much of this evidence refers to participation in (eight week) group-based mindfulness courses or mindfulness trainings, with reference to specific psychological problems such as stress and anxiety, although a limited number of studies refer to the effectiveness of mindfulness in everyday life. Whilst there are some who take a more cautious approach to the benefits of mindfulness (for example Teasdale *et al* 1995/2003)[39,40], and although the studies point to the way in which duration, nature and frequency of mindfulness practice determine benefits, there is now a sound body of evidence pointing to the positive effects it has on psychological wellbeing, both for those with disorders and those without.

Experimental and qualitative studies form the basis of this evidence. Brown and Ryan (2003)[41] reported a mixed method study (including correlational, quasi-experimental, laboratory, experience-sampling and clinical intervention elements) to establish the role of mindfulness in psychological

wellbeing. Results from these investigations suggested that "Mindfulness is … associated with a number of wellbeing indicators", in particular self-knowledge and self-regulation.

The use of mindfulness in clinical applications has become increasingly common in recent years. Kabat-Zinn *et al* (1992)[42] conducted an experimental study involving 22 American participants with anxiety disorder or panic disorder. Participants took part in an eight week Meditation-Based Stress Reduction (MBSR) programme, resulting in significant reductions in their symptoms of anxiety and panic. Finucane and Mercer (2006)[43] conducted a study involving 13 men and women with a history of depression or depression and anxiety in Scotland. Participants took part in an eight week Mindfulness Based Cognitive Therapy (MBCT) course, resulting in reductions in mean depression and anxiety scores.

'Risk factors' for engaging in *Five Ways*-type activities

Research process

Research into the risk factors for engaging in *Five Ways*-type activities comprised preliminary exploration of two literatures[44]: 1) broad, structural risk factors known to be determinants of mental health; 2) barriers to particular types of behaviour known to have a positive effect on mental health.

The search for literature on socio-economic risk factors took the following forms:

- Snowball reference search, beginning with three key documents:
    - Foresight Mental Capital and Wellbeing Project. (2008). *Foresight Mental Capital and Wellbeing Project: Final Project Report*. London: The Government Office for Science.
    - Aked, J., Marks, N., Cordon, C., & Thompson, S. (2008). *Five Ways to Wellbeing: The evidence*. London: **nef**.
    - Friedli, L. (2009). *Mental health, resilience and inequalities*. Copenhagen: World Health Organisation.
- Various Google Scholar searches (search terms are given as footnotes in the relevant subsections below). Search criteria were restricted to articles published between 1990 and 2010 and, for each search, to the first 20 hits generated by the Google Scholar search engine. Studies cited are listed as endnotes at the end of the document.

Results

The two literatures explored in this desk research take two very different approaches to risk factors for mental health: the former makes the case that systemic (often socio-economic) conditions play a crucial role in determining mental health and wellbeing outcomes; the latter takes a more individual approach and attempts to ascertain what prevents people from engaging in everyday behaviours known to help mitigate against mental illness and/ or enhance mental health. The former work, whilst highlighting the undeniably important role of socio-economic structures and systems in determining mental health outcomes, tends not to explore the nature of the interactions between the systemic and the personal realms, but rather assumes that a relationship exists between the socio-economic and the

individual, psychological spheres. The latter, whilst attending to the equally important role that individuals play in determining their own mental health through (non)engagement in behaviours known to prevent mental illness and enhance wellbeing, tends not to relate the level of individual behaviour to the broader systemic context in which such behaviour is nested.

Below we present some of the evidence in more detail. Firstly, we briefly summarise what is known about structural, socio-economic determinants of mental health. Secondly, we summarise studies that focus on what prevents people from behaving in ways that are known to enhance mental wellbeing – again pointing to what we know from this literature as well as to the gaps it leaves in our knowledge.

Socio-economic determinants of mental health

The following (life-course related) broad factors have all been shown to be important in influencing mental health outcomes:

Childcare provision – availability of, access to and quality of

Education

Peer group

Consumerism/ materialism

Employment – status, job security, nature and intensity of work

Debt

Income

Housing

Physical Environment

Inequality

A life-course approach to understanding the socio-economic risk factors for mental health is particularly important, since such risk factors are played out and experienced differently according to people's stage of life, i.e. whether they are for example dependent children, working/ parenting adults or older adults.

Discussed less in these key references are the pathways through which structural socio-economic risk factors actually influence mental health. Friedli (2009) does refer to the pathways (as discussed for example by Wilkinson [1996/2005] and Zavaleta [2007] who write on the psycho-social aspects of poverty), in particular to the way in which socio-economic inequality produces feelings of shame amongst those at the bottom of the socio-economic ladder, which in turn functions to erode self-esteem and confidence (see Friedli 2009, p,35ff). However, causal pathways are relatively under explored within the texts identified through this exercise.

Studies that explore barriers to engaging in behaviour known to enhance mental health.

Barriers to physical activity[45]

We know from the studies generated through this search that the following are commonly cited as barriers to engaging in physical activity[46]:

Lack of time (due to work, school work, family commitments)

Lack of motivation

Lack of money

Lack of skill/knowledge

Childcare responsibilities/ lack of available child care

Lack of transportation

Injury/ poor health

Lack of energy

Lack of suitable facilities

Lack of safe places

Lack of enjoyment

Lack of competence

Not a priority

Peer influence

We know also from these studies that stage of life, gender and ethnicity are important factors in understanding how barriers to physical activity operate for particular groups of people. For example, for parents of young children, unavailability of childcare is more likely to be cited as a barrier to physical activity, whilst for older people, poor health/ injury is more likely to be cited as a barrier (for example see Booth *et al* 1997[47]). We also know that perceived barriers to physical activity range from those that are internal (e.g. perceived lack of competence) to those that are institutional/ systemic (e.g. lack of suitable facilities).

Barriers to social interaction[48]

This search reveals a relative lack of information on barriers to social interaction. From the limited number of studies identified here, what we know is that the following are cited as barriers to social interaction[49]:

Lack of time

Lack of money

Geography – suburbanisation/ sprawl

Electronic entertainment

Generational change (replacement of the 'civic' generation)

Male domination of social spaces

Social phobia

Lack of opportunity

We also know that, as with barriers to physical activity, life stage and gender are important factors in understanding how barriers to social interaction are experienced for particular groups of people. For example, it is noted that the dangers associated with socialising in particular places are more pertinent for girls and women than for boys and men (for example, see Tucker & Matthews, 2001, Valentine, 1989). With social interaction/ relationships, barriers also range from 'internal' (e.g. social phobia) to institutional (e.g. lack of facilities that allow for social interaction) and, discussed to a lesser degree, systemic (e.g. patriarchy).

Barriers to giving[50]

The vast majority of literature identified in this area focuses on barriers to formal volunteering. Whilst there is a good deal of research on altruism (e.g. experimental research using the prisoner's dilemma game, the dictator game, or the lost wallet game) very little of this explores barriers to practising altruistic, or other-regarding behaviour. This reflects a strong tendency towards exploring whether altruism is a matter of nature or nurture, which (even if it is understood as a matter of nurture) stops short of investigating what might prevent people from behaving altruistically. From discussions of barriers to formal volunteering, what we know is that the following are commonly cited[51]:

Lack of time

Lack of information on volunteering opportunities

Poor health/ old age/ disability

Lack of skills/ experience

Work commitments

Childcare responsibilities

It's not cool

Lack of spouse support

Language (for non EFL)

Lack of organizational support (financial and other)

Lack of confidence

Lack of money

Bias towards 'mainstream' (i.e. white, middle class) groups.

As with the preceding discussion, we also know from this literature that key axes of social difference (e.g. age, gender, ethnicity) are important in understanding how particular barriers function for particular groups of people. For example, the 'image problem' of volunteering may be more of an issue for young people (see Davis Smith, 1999), whilst for older people, physical impairment may be more pertinent. Barriers here range from 'internal' (e.g. lack of confidence) to institutional (e.g. lack of adequate reimbursement).

Barriers to learning (by deliberative effort)[52]

The majority of the literature identified in this area focuses on adult formal, or institutional, learning. What we know from these studies is that the following are cited as barriers to formal learning[53]:

Mack of money

Lack of time

Family responsibilities/ lack of childcare

Lack of confidence

Low priority

Low perception of need/ low interest

Access/ transportation

Feeling intimidated/ marginalised → institutional and cultural reproduction of dominant ideologies

Male domination

Lack of course relevance

Prior negative learning experiences/ low attainment

Negative self concept as student/ negative experiences

Lack of motivation

Lack of institutional support

Lack of technology/ technical-technological skill

As with previous barriers, key axes of social difference are crucial in understanding how particular barriers to formal learning are experienced by particular groups of people. For example, experiences and perceptions of racism (a cultural bias towards white perspectives) have been found to deter those from ethnic minorities from engagement with certain courses or institutions as a whole (Guy, 1999). Again, barriers range from 'internal' (e.g. lack of confidence) to institutional (e.g. lack of support from learning institution) and, discussed to a lesser degree, systemic (e.g. patriarchy).

Barriers to being mindful[54]

There appears to be a considerable lack of research into the risk factors for practicing mindfulness; desk research returned no references relevant to this issue. Likely reported/ perceived barriers may be:

Lack of knowledge about the process, benefits and techniques themselves.

Lack of time

In sum, from the literature identified in this desk research we know the following about barriers to engaging in *Five Ways*- type behaviours:

- Barriers are different for different activities
- Lack of time and money are frequently cited, yet under-probed, perceived barriers.
- Barriers vary, or are experienced differently, according to key axes of social difference (e.g. age, gender, ethnicity, physical ability)
- Barriers range from internal to institutional to systemic, although relationships between these realms are under-explored.

Despite the number of studies exploring the barriers people cite to undertaking *Five Ways*-type behaviours, gaps remain in our knowledge about many of the issues involved, to which this project aims to make a contribution. First, there is insufficient knowledge concerning what lies behind cited barriers such as lack of time and money; a tendency to take these kinds of statements at face value without probing further into what may be producing such statements and perceptions. This project aims to explore this in further detail, including with reference to the dominant cultural narratives that inform peoples' perceptions and statements. Second, there is insufficient knowledge concerning the ways in which the internal, institutional and systemic realms interact in the context of barriers to behaviour. Even within those studies that note how barriers range from internal to institutional to systemic, there is insufficient exploration of interactions between them. This project also aims to explore these

linkages. Thirdly, there is insufficient knowledge concerning peoples' perceptions of how barriers might be overcome. Again, this project aims to explore these through dialogue with the public.

Existing attitudes to mental health issues

The search for information on existing attitudes to mental health and to social messaging around mental health took the following forms:

- Google Scholar search using search terms: 'attitude' and 'mental' and 'health'.
- Google Scholar search using search terms: 'attitude' and 'social' and 'messag*' and 'mental' and 'health' or 'attitude' and 'public' and 'campaign' and 'mental' and 'health'.
- Search of major mental health charity websites: Mind, Young Minds, Mental Health Foundation, Rethink, Sane, Samaritans. Internal search using search term 'attitude'.

Search criteria were restricted to articles published between 1990 and 2010, and to the first 20 hits generated by the Google Scholar search engine.

Results

The vast majority of research into attitudes towards mental health actually deals with attitudes towards mental *illness*. What we know from the overwhelming majority of this research is that there is considerable stigma and discrimination attached to mental illness. Selected references identifying this stigma and discrimination as mentioned below are included as a list in the endnotes.[55]

To a much lesser degree, research reveals evidence of more positive attitudes towards people with mental illnesses. References here include the TNS-BMRB (2010) report on attitudes to mental illness.

Research into attitudes towards social messaging around mental health again tends to focus on mental *illness*, and here several arguments can be identified. First, it is argued that social messaging around mental illness needs to take account of the fact that attitudes differ depending on the particular condition in question (Crisp *et al,* 2000). Second, it is argued that short-lived social messaging, or campaigns, are insufficient as a means ending stigma (Sartorius, 2010). Third, it is argued that social messaging around mental illness actually has adverse consequences, in that it reinforces stigma (Pescosolido *et al,* 2010). Fourth, it is also argued that campaigns on mental health/ illness themselves need to be targeted at particular groups of people, as attitudes towards mental illness vary according to, for example, ethnicity, gender and life stage (Wolff *et al,* 1996[56]). It is also argued that interventions to improve public knowledge about mental illness can be effective (Thornicroft *et al,* 2007)[57].

What we don't know from this research is much about attitudes towards positive mental *health* or towards social messaging that deals with mental health as opposed to mental illness. This project aims to contribute to this by exploring these issues directly with members of the public, gaining an insight into how a social messaging campaign around positive mental health might be received amongst the UK population.

In summary, what we know from this desk research is that the majority of studies into attitudes towards mental health actually deal with attitudes

towards mental *illness*, and that stigma and discrimination are particularly prominent, albeit accompanied by more positive (reported) attitudes such as understanding and tolerance. Research into attitudes towards social messaging around mental health mirrors this tendency, focusing largely on mental illness with a view to reducing the stigma surrounding it. What we don't know is much about attitudes towards positive mental *health* or towards social messaging that deals with mental health as opposed to mental illness. This project aims to contribute to this by exploring these issues directly with members of the public.

Existing initiatives/ policies around public mental health promotion

Research process

The search for information on existing initiatives around mental health took the following form:

- Google search, using following search terms: 'mental' and 'health' or 'wellbeing(+wellbeing)' and 'policy' or 'initiative' or 'strategy' or 'campaign' and 'UK'.

Search criteria were restricted to nation-wide initiatives and to relevant texts within first 20 hits of each search.

- Search of campaign sections of websites of major mental health organizations: Mental Health Foundation, Mind, Young Minds, Rethink, Sane and Samaritans.

Results

There are numerous initiatives around mental health, emanating from the Government, from government agencies and from the charity sector. There is a broad (governmental) drive towards the prevention of mental illness and the promotion of positive public mental health, *at the same time as* an enduring tendency to focus on mental illness and reducing the stigma associated with it within social messaging campaigns and other initiatives. The following is a list of the initiatives identified in this desk research.

Department of Health[58]

Two main characteristics stand out as defining DH's initiatives in the realm of mental health. First, the broadening of mental health policy from curative to preventative, and second the importance of cross-government support for mental health strategies. "Policy around mental health is developing … A consensus has emerged recently around broadening the focus of mental health from improving services to include public mental health and mental wellbeing. Mental health policy cannot be devised and implemented by any single government department or the NHS alone - it requires collaboration across central government, local government and the independent sector."

Other relevant documents include:

- *Healthy Lives, Healthy People* white paper (2010) (see endnote 4) – including mental health and with an emphasis on prevention, protection and strengthening (in particular for example self esteem).
- *New Horizons* (2009) (see endnote 2) (being replaced). Population-wide wellbeing/ mental health + targeted approaches for high risk groups – preventative.
- *No Health Without Mental Health* (2011) (see endnote 3) – current mental health strategy.

National Mental Health Development Unit (NMHDU)[59]
Launched 2009 (closing 2011). Funded by DH and NHS. The agency charged with supporting the implementation of mental health policy in England in collaboration with the NHS, local authorities and other major stakeholders.

NMHDU programmes for 2010/11:

- *Improving Access to Psychological Therapies* (IAPT).
- *Supporting Effective Mental Health Commissioning*.
- *Improving Mental Health Care Pathways*.
- *Promoting Equalities in Mental Health*.
- *Promoting Social Inclusion and Social Justice*.
- *Promoting Wellbeing and Public Mental Health*. This programme aims to help support the increasing importance of mental health and wellbeing across a range of public and social policies including modern mental health policy. The initial focus will be on supporting what the NHS and local authorities are already doing and what more they can do together with other key partners, including the voluntary sector, to improve and sustain community, family and individual wellbeing. Building and transferring knowledge, experience, skills and capacity among commissioners and providers and developing ways to identify, describe and measure wellbeing will form the early work of the wellbeing programme in collaboration with local, regional and national partners.
- *Personalisation in Mental Health Programme*.
- *Shift.* An initiative to tackle stigma and discrimination surrounding mental health issues in England. Includes 'Working it out', a resource (DVDs and training manual) designed to raise awareness of mental health conditions in the workplace.
- *Mental Wellbeing Impact Assessment.* Toolkit to bring a wellbeing focus to policies, programmes, services and projects.
- *Centre For Mental Health.*
- *Impact on Depression (IoD).* An initiative comprising a programme of training aimed at helping workplaces manage mental health issues at work. Delivered by the Centre for Mental Health Training Ltd, a trading subsidiary of the charity Centre for Mental Health.

Mind[60]
- *Benefits and welfare reform*. Initiative to assist those with mental health difficulties through changes in the welfare system
- *Mental Health at work*. Initiative aiming to improve population-wide workplace mental health
- *Care in Crisis*. An initiative with the aim of campaigning effectively for improvements in hospital and community crisis mental health services across England and Wales.
- *We need to talk*. Campaign for getting the right therapy at the right time (within 28 days of referral)

- *In the red – debt and mental health*. Initiative to increase mental health awareness amongst creditors and for better regulation of bailiffs.
- *Time to change*. Mind is a leader on this campaign to end mental health discrimination - see below
- *Time to get moving.* To bring people together across the mental health spectrum
- *Time to challenge.* To raise awareness amongst employers/ employees/job seekers.
- *Open up.* Social networking to share experiences and raise awareness
- *Education not Discrimination*. Initiative to train professionals working with people with mental health problems.

Rethink[61]

- *Fair treatment now.* To help increase access to decent treatment and support.
- *Welfare reform and benefit changes.* To try and ensure a fair deal for people with mental illness.
- *Criminal Justice.* Ensuring offenders with mental illness get appropriate help.
- *Stigma and Discrimination.* To challenge stigma and discrimination faced by people with mental illness.

Mental Health Foundation[62]

- *Be Mindful*. Initiative to promote mindfulness – combines meditation, breathing techniques and paying attention to the present moment to help people change the way they think, feel and act
- *Loneliness and Mental Health.* Initiative aimed at raising awareness of loneliness in order to to tackle the stigma that surrounds it, and help individuals who are feeling lonely to connect with others.
- *Mental Health Action Week, annual.* Campaign on an issue concerning mental health of the general public.
- *World Mental Health Day***.** An international activity day used to campaign for better mental health.
- *Research Mental Health***.** An initiative from the Institute of Psychiatry and King's College London with the help of scientists, academics and public figures, to promote the importance of mental health research in the UK. Includes a declaration calling for more investment in mental health research.

Depression Alliance[63]

- *Depression Awareness Week.* An annual initiative to raise awareness of a particularly serious or prevalent aspect of depression.

BBC[64]

- *Headroom.* Closed 1st December 2010. Initiative which had the aim of encouraging people to look after their mental and emotional wellbeing and of reducing stigma around mental illness.

Samaritans[65]

- *Emotional Health Promotion Strategy*. An initiative aiming to provide education and positive coping skills around emotional health, and ultimately to change societal attitudes towards emotional health.

In sum, whilst there is an emphasis on the part of government on the *prevention* of mental illness and the strengthening of population wide mental *health* and wellbeing, there is a residual focus within many of the existing initiatives identified here on mental *illness*, and in particular on improving services and access to them and reducing the stigma and discrimination associated with it. What we don't know from this research is the extent to which an initiative focused on the promotion of positive behaviours that enhance mental health and wellbeing might be received by the UK population. This project aims to shed light on this, by engaging with the public to provide an understanding of possible responses to such an initiative.

Appendix 2

Ways to Wellbeing Project

Brief for bidders

Background

The 2008 Foresight Project on Mental Capital and Wellbeing (MCW) reported on a two year, state-of-the-science review that synthesised research from some 400 scientists on the causes and consequences of mental capital and wellbeing. At its heart was the recognition that improving the nation's mental health is important: mental health difficulties are estimated to account for 22.8 per cent of the total burden of illness in the UK, more than cancer or cardiovascular disease.66 As such, they cost the UK some £110 billion per year.67 Further, positive mental health – psychological flourishing – is correlated with other positive outcomes such as improved physical health, better relationships, increased productivity at work and higher levels of active community involvement.

As part of the project, Foresight commissioned **nef** (the new economics foundation) to develop *Five Ways to Wellbeing*,68 a set of simple, evidence-based public health messages about the kinds of activities that promote positive mental health and wellbeing: *Connect, Be Active, Take Notice, Keep Learning, Give*. Since their launch, the *Five Ways to Wellbeing* messages have been successful in capturing the imagination of many people working in public health, health improvement, mental health promotion, community development and related fields.

However, attempts to use the *Five Ways to Wellbeing* illustrate some wider concerns about the efficacy of promoting population mental health through public education. Commenting in *The Guardian*, one journalist suggests that the kinds of activities implied by the *Five Ways to Wellbeing* are, in effect, crowded-out by the pressures of modern life. This is a serious concern. At present, although evidence on how to achieve population-wide improvements in wellbeing is relatively scant, it is usually assumed that public education will be effective (as they have been, to a greater or lesser extent, in other areas of public health and health improvement). But if some aspects of contemporary society are either antithetical to activities that promote wellbeing or are actively harmful to mental health, then this is clearly problematic for any policy that aspires to promote mental health through social marketing approaches.

Recently, the Coalition Government has announced its intention to publish a new Mental Health Strategy. It is expected that a core outcome will be that:

- *More people will have improved wellbeing and mental health.*

The project: Ways to Wellbeing

nef (the new economics foundation), is to be commissioned by the Department of Health to oversee *Ways to Wellbeing*, a public engagement exercise designed to explore how key findings of the Foresight MCW project can be translated effectively into the new UK mental health policy and strategy and co-funded by BIS through Sciencewise-ERC (subject to formal confirmation). **nef** will do this by overseeing a series of public engagement sessions, based on the *Five Ways to Wellbeing* (and other ways in which individuals can enhance their wellbeing) and will sub-contract the delivery of the sessions.

nef will be responsible for preparing the stimulus materials and the topic guide for the sessions (in discussion with the sub-contractor) and for developing the policy recommendations that arise from these (primarily in conjunction with the Department of Health but naturally involving discussion with the contractor). The sub-contractor will be responsible for recruiting participants, delivering the sessions (with the possibility of DH and **nef** staff viewing), preparing transcripts and a summary of the outcomes of the sessions.

This brief: Public engagement sessions

The aim of these sessions will be to explore with members of the public the following issues:

- to what extent people feel able to make the kinds of discretionary changes in their lives that the scientific evidence – distilled in the *Five Ways to Wellbeing* – suggests would lead to increased subjective wellbeing
- What structural or systemic barriers might prevent people engaging in activities that would improve wellbeing.
- What sort of messages, and from whom, would do most to encourage such activities among those, such as the young and the old, who could benefit most from improvements in mental health.
- How the evidence from MCW might encourage public participation in Big Society initiatives.

In preparing your proposal please pay attention to the following issues:

- How will you ensure that the process captures the range of issues that different segments of the population may face? An exercise such as this cannot be ‘representative’ but it is important that the insights we gain are broadly relevant.
- How will you ensure that the situation of vulnerable groups (who may be expected to face more serious structural barriers) is captured?
- What features of the process design will help to ensure that the findings move the agenda on – that the deliberative process helps identify solutions rather than simply already well known problems?

The following is a potential process. You may choose to adopt this or to modify it, but in either case please explain your rationale.

Morning: Participants review the scientific evidence from the Foresight MCW and how it underpins **nef**'s *Five Ways to Wellbeing.* They then discuss how the *Five Ways* relate to their own lives, concerns and priorities: how relevant they find them (and what other 'ways' they might find helpful), what impedes them, and what they would have to change in their lives in order to benefit from them. These could be recorded as 'reactions'.

Afternoon: Participants work in five teams of three to develop messages and methods to deliver them – posters, advertisements, radio and TV messages, and any others they choose – that they believe would communicate the *Five Ways* effectively to different target groups. These sessions could be energetic, fun, perhaps slightly competitive, and designed to balance entertainment with the serious underlying task. The results could be recorded as 'products'.

The day could end with an evaluation process asking participants to reveal their reactions to the day's events, whether it has caused them to reflect on their own wellbeing and, if so, what conclusions they have reached. These could be retained as 'reflections'.

Each day will be video recorded, with the reactions, products and reflections collated and summarised by project managers, facilitators and observers.

Following all six meetings the reactions, products and reflections generated by each will be carefully analysed for common elements, and differences will be cross-referenced with region, ages and socio-economic information about participants.

'Reflections' will be followed up by telephone within two weeks of each workshop, with participants being asked what they have retained of what they heard and whether they feel the event has affected their own sense of wellbeing or their personal behaviour.

The final project report will document the entire process and will provide qualitative as well as quantitative analysis of reactions, products and reflections.

As the timetable states, if you are successful in your bid for this contract, you will need to identify participants, book venues and produce process plans in December 2010/early January 2011. Public engagement sessions, as well as follow-up telephone conversations with participants, will need to take place in late January 2011.

Timetable

Project steps	Timing
1. **nef** to contact potential bidders and issue brief for application	29 November 2010.
2. Contractors to submit written proposals	6 December 2010
3. **nef** to advise short listed contractors	8 December 2010
4. short listed contractors to present proposals	10 December 2010
5. **nef to issue contract to selected contractor**	14 December 2010
6. Contractor to identify participants, produce process plans, book venues	December 2010 - early January 2011
7. Contractor to run six one-day workshops in different parts of the United Kingdom, each with up to 15 participants	late January 2011)
8. Contractor to conduct follow-up telephone conversations with participants to review reactions and collect further reflections	End January 2011
9. Contractor to produce transcripts and short report summarizing what was said	Very early February 2011
10. **nef** to produce preliminary analysis of reactions, products and reflections, to be discussed with contractor	Early February 2011
11. Final report by **nef**	End February 2011
12. Evaluator's report	End March 2011

Budget

The budget for this contract is up to £55,000, including costs and payment to approximately 90 participants. Payments will be made by **nef** on receipt of corresponding payments from DH.

What you need to do

Please prepare a written proposal setting out how you would go about this work and your budget and **submit it to Sorcha Mahony at nef by Monday 6th December 2010** (please email bids to sorcha.mahony@neweconomics.org). If you are shortlisted, you will be asked to attend an interview and give a presentation **at nef on Friday 10th December 2010 in the morning.** Please keep this confidential at this stage.

Appendix 3

Ways to Wellbeing Project

Workbook content

[Cover]
Personal deliberation on health and wellbeing
Workbook

Deliberation: Careful consideration with a view to decision. The consideration and discussion for and against a measure
(The Shorter Oxford Dictionary 1973)

[Introduction]
This workbook contains:

- Some examples of the scientific evidence of the effects of various activities on health and wellbeing (section 1)
- Some questions for your consideration (section 2)
- Some blank sheets of paper for you to record your deliberations.

Over the next week or so, we would like you to think about, discuss and explore the issues around heath and wellbeing such that your opinions become more informed and developed.

We have outlined a few suggestions below, which you may find helpful. The most important thing is simply to deliberate in your own way, and use this workbook to help you record the key elements and conclusions or questions that you reach.

So, for example, you could:

- Make a note of any conversations you had about the issues with your children, family, friends or colleagues etc.
- Note down any thoughts that you had about any of the issues that you see as relevant, interesting, troubling etc.
- Make a note of news items or programmes you saw about these issues
- Keep a copy of a page from a website you visited
- Use a search engine to research your ideas or hunches.

At the back of the workbook you will find a plastic wallet into which you can put anything related to these issues that you collect during this process, such as: news cuttings, e-mails and so on.

We have provided some blank pages to record your thoughts, and if you want you can insert extra sheets. Equally, don't feel obliged to fill the space provided. The most important thing is that you feel that whatever you do is an accurate reflection of you, your interests and your deliberations regarding this topic area.

PLEASE BRING THE COMPLETED WORKBOOK WITH YOU TO OUR SECOND MEETING.

PLEASE ALSO NOTE THAT WE WOULD LIKE TO KEEP IT AS PART OF THE RESEARCH DATA.

[Section 1]
Some of the scientific evidence for the effects of various activities

1. *Being physically active*
    a) Research among men and women aged 25–64 years of age has shown that exercising at least 2–3 times per week leads to:
        - Less depression
        - Less anger
        - Less cynical distrust, and
        - Less stress

        compared to those exercising less frequently or not at all.1
    b) Other research has shown that active older women have less decline in their cognitive functions (such as memory deterioration) compared to those who are less physically active.2
    c) Research has also shown that the risk of depression is reduced by 28 per cent in men, of all ages, when they have high levels of physical activity[3].

2. *Spending time with other people*
    a) Research shows that people who have a social network with good communication and supportive relationships experience greater positive wellbeing. This sense of belonging has also been found to be protective of good health.4
    b) Friends really do make a difference. For example, a study of men and women between 16 and 74 years of age found that those with only a small number of friends/associates that they can count on were more likely to experience common mental health problems.5 It appears that a person is at greater risk when their primary social network (i.e. the people they can count on) is three or fewer.
    c) In a study of undergraduate students, researchers found that “very happy people have rich and satisfying social relationships and spend little time alone relative to average people.” The researchers

also noted that "... good social relationships are ... universally important to human mood".6

3. *The role of early and continuing learning*

a) Research shows that learning in childhood and subsequent educational attainment reduces the risk of developing depression later in life.7

b) In a study of men and women between 16 and 70 years of age, researchers found that "education can directly help as a therapeutic activity for people with mental health problems". It has also been shown that learning helps "avoid, minimise, or address depression".8

c) In one study 80 per cent of older men and women still engaged in learning reported that learning had a positive impact on their self-confidence, self-perception or their ability to cope.9

d) Researchers have also found that learning throughout life "has effects upon a range of health outcomes; wellbeing, protection and recovery from mental health difficulties, and the capacity to cope with potentially stress-inducing circumstances".10

4. *Being aware*

Mindfulness can be defined as being attentive to, and aware of, what is taking place in the present as opposed to being preoccupied with thoughts of the past or the future. Meditation is one way of developing the skill of mindfulness.

a) Research has indicated that wellbeing is improved by learning simple mindfulness activities (such as attention to breathing etc.).11

b) Research has also shown that symptoms of anxiety and panic can be effectively reduced through participation in a group meditation programme.12

c) Researchers at Glasgow University have shown that adults suffering from recurrent depression and anxiety benefited from a programme that included meditation. The results showed that 72 per cent of patients with depression, and 63 per cent with anxiety, had statistically significant levels of improvement.13

5. *Giving*

a) It's long been said that performing random acts of kindness makes the giver happier. Recent research has shown this folk wisdom to be true.14

b) In a survey of men and women aged 17 and over, researchers found that the average life satisfaction for people who regularly volunteer was 7.35 on a 10 point scale. For those who never volunteer the average life satisfaction was 6.93. The researchers said that this difference between the two groups was "sizeable and statistically highly significant".15

c) When survey data of men and women in middle and later life is analysed it shows that volunteering lowers depression levels for

those over 65. It has also been shown that prolonged volunteering benefits all.16

If you would like access to any of the articles referenced here, please contact David Corr, by email: david@corrwillbourn.com or by telephone: 01372 801 141.

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If you would like access to any of the articles referenced here, please contact David Corr, by email: david@corrwillbourn.com or by telephone: 01372 801 141

For additional information on the research areas identified here, see the following:

Aked, J. *et al*. (2008). *Five Ways to Wellbeing: The evidence*. London: **nef**. Available at: http://www.neweconomics.org/publications/five-ways-well-being-evidence

Foresight Project Final Report and scientific reviews, available at: http://www.bis.gov.uk/foresight/our-work/projects/current-projects/mental-capital-and-wellbeing/reports-and-publications

[Section 2]

The scientific evidence shows that people do well when they do some or all of the following activities: physical activity, spending time with other people, learning, being aware and giving.

Q1. To what extent do these activities play a role in your life currently? Can you provide some examples for each activity that work for you?

Q2. Are there any of the activities that you would like to play a greater role in your life?

a. If so, which one or ones?
b. What do you think and/or feel prevents you from, or gets in the way of, doing more of these activities (the ones you discussed in (a) above? Can you think of any possible solutions that would work for you?

Q3. Thinking about your own life (i.e. you, your family, friends, neighbours etc.) what evidence have you witnessed regarding the benefits of the activities (i.e. physical activity, spending time with other people, learning, being aware and giving)?

Q4. Again, thinking about your own life (i.e. you, your family, friends, neighbours etc.) have you witnessed any evidence of any downsides or negative effects of the activities (i.e. physical activity, spending time with other people, learning, being aware and giving)?

Q5. Thinking as broadly as you wish, are there any things/activities etc., that you believe play a positive role in maintaining physical health, wellbeing and good mental health that haven't been mentioned in the scientific evidence?

Q6. Imagine that you woke up one morning and as a nation we had a much greater sense of wellbeing and satisfaction with life. What would have had to change for these changes to have come about? [Please be as creative and imaginative as you wish.]

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