AN EVALUATION OF THE GREEN DREAMS PROJECT

AN INTERIM REPORT BY THE HEALTHY SETTINGS UNIT AT THE UNIVERSITY OF CENTRAL LANCASHIRE (UCLAN).

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THE HEALTHY SETTINGS UNIT

The Healthy Settings Development Unit was established in 2001 and aims to support and facilitate the holistic and integrated development of health – acknowledging that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO: Ottawa Charter for Health Promotion, 1986). It has extensive experience of working in and with the criminal justice system and its portfolio includes:

- development, delivery and management of externally-funded settings-focused health promotion programmes – including the Big Lottery funded Pan-Regional Prisons Programme, Health, Inclusion and Citizenship; and the Regional Tobacco Control (Prisons and Criminal Justice System) Demonstration Project
- contributing to the development and management of WHO's Health in Prisons Project
- research, evaluation and knowledge exchange – including the national (Department of Health) evaluation of health interventions and promotion for blood borne viruses in prisons in England and Wales
- training, CPD and consultancy
- contributing to the delivery of undergraduate and postgraduate public health teaching – including the specialist Healthy Settings module
- leadership and co-ordination of UCLan's Healthy University initiative
- co-ordination of the English National Healthy Universities Network
- chairing the International Union of Health Promotion and Education's Global Working Group on Healthy Settings

EXECUTIVE SUMMARY

This interim report provides a preliminary summary of the thematic areas emerging from telephone interviews with key stakeholders and from client data monitoring forms. A full thematic analysis is due to be completed in the new year with the presentation of the final report due by the end of January 2013.

The Green Dreams project was perceived by stakeholders to confer substantial benefits to service users, to stakeholders and to the wider community and society. It was felt that service users' experience of the Green Dreams project has been overwhelmingly positive, and has enabled the development of many new and useful skills. Some of these skills are generic skills that are transferable to many areas of life, such as problem-solving, solution generation and time-keeping skills. The Green Dreams project can reduce feelings of social isolation for service users and provides them with an opportunity for social engagement with a range of different people.

As such, stakeholders suggest that early intervention with the Green Dreams project can prevent further deterioration for some individuals.

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INTERIM REPORT

1. INTRODUCTION

This interim report has been prepared by the Healthy Settings Unit in the School of Health, located in the University of Central Lancashire.

The report provides a reflection on stakeholder experience and organisational systems-level working of the Green Dreams project at this stage of data collection. Full data analysis is due to be complete in January with the end of project report intended to be available for the 25th January 2013.

This evaluation has sought to capture stakeholder learning and experience whilst scoping the wider benefits (such as the perceived potential cost savings and impact beyond the individual) from the development of the GP partnership between Health and Community Services in East Lancashire. Ultimately the evaluation aimed to:

- Demonstrate how the project works (what are the organisational systems, how joined up are they and what does it offer different people in different circumstances); and,
- Demonstrate the benefits of the project.

It comprised four elements:

- *Rapid Appraisal of the Literature*: Using literature review and informal conversations, this will provide contextual information and summarise evidence of effectiveness of developments to date.
- *Qualitative Review*: This comprised interviews with stakeholders (currently 4 out of 10 with the potential of one or two further interviews) involved in managing and delivering the project.
- *Analysis of monitoring reports*. This will comprise an analysis of key themes drawn from anonymised monitoring reports - approximately 10% - to draw comparisons and identify key improvements.
- *Joint Action Planning and Reporting*: Drawing on the above evaluation, a workshop will be held to present emergent findings, validate and expand data and enable action planning. This is proposed for the 30th January 2013.

This information will be analysed and triangulated, emphasising the value of reflecting on multiple sources of data in order to reliably answer the key questions.

All of the interviews were audio recorded, transcribed verbatim and anonymised. Thematic analysis is being used to categorise the data and organize the findings into different topics. Thematic analysis is an approach to dealing with data that focuses on the creation and application of 'codes' relating to identifiable themes and patterns within the data (Aronson, 1994). The initial task of thematic analysis is to extract a list of the patterns of experience and themes from the data. This involves reading the entire data pool several times and listing the common strands that emerge. From this, an initial coding frame will be developed and applied to further data. Once the coding frame is complete, it is used to identify in each transcript all data relating to the themes and sub-themes. Importantly, text can have more than one code allocated to it. Each theme is then analysed and written up to present the findings. Where previous literature exists, the team will interweave this with the findings from the fieldwork.

2. ETHICS AND CONSENT

Full ethical approval was sought from the University of Central Lancashire's Ethics committee prior to commencement. Stakeholders were invited to participate in the evaluation and were advised about the purpose and nature of it both verbally and in writing. They were advised that their participation was voluntary and that they can withdraw at any stage of the evaluation. They were assured of anonymity and confidentiality when the evaluation report is written up. All data is stored in a locked filing cabinet/password protected computer as per university and ethics guidelines.

3. BACKGROUND AND CONTEXT

3.1 NATIONAL CONTEXT

3.1.1 HEALTH AND WELLBEING

Health and wellbeing vary significantly across England, despite people living longer than ever before. People in disadvantaged areas experience a shorter life expectancy and a greater burden of ill-health that is driven by underlying social factors that affect people's health and wellbeing (Department of Health, 2010).

The implications of health inequalities are set out in Sir Michael Marmot's independent review *Fair Society, Healthy Lives* (The Marmot Review, 2010) which makes clear that material circumstance, social environment, psychosocial factors, behaviours and biological factors are all important influences on health. The review advocates for greater consideration of the broader context of people's lives in order to tackle health inequalities, highlighting that low income and deprivation are particularly associated with higher levels of obesity, smoking, mental illness and harms arising from drug and alcohol misuse. It goes further by arguing that some vulnerable groups and communities have significantly poorer life expectancy than would be expected based on their socioeconomic status alone, suggesting broader complexities that interact to shape people's lives.

The Coalition Government's long term vision and strategy for the future of public health in England is set out in the White Paper *Healthy Lives, Healthy People* (Department of Health, 2010) – which serves as its response to *Fair Society, Healthy Lives* (The Marmot Review, 2010) and seeks to strengthen both national and local leadership. While the strategy clearly recognises the wider determinants of health, it is also apparent that it is "driven by a philosophy of individual responsibility" (Parish, 2011). The strategy sets out support for the Government's localism agenda by advocating an approach that empowers individuals to make healthy choices and gives communities the tools to address their own particular needs.

Wellbeing has become increasingly important in recent government policy and the term is used in tandem with 'health' within *Healthy Lives, Healthy People* (Department of Health, 2010). It is useful to reflect on the term and its meaning by considering the following common understanding for policy-makers developed by the UK government's Whitehall Working Group set up in 2005 (Steuer & Marks, undated: 8):

> *'Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, security, rewarding employment and a healthy and attractive environment.*

Government's role is to enable people to have fair access now and in the future to the social, economic and environmental resources needed to achieve wellbeing. An understanding of the combined effect of policies on the way people experience their lives is important for designing and prioritising them'.

This statement illustrates the complexity and breadth of the term, which is perhaps most usefully thought of as the dynamic process that gives people a sense of how their lives are going through the interaction between their circumstances, activities and psychological resources or 'mental capital' (Michaelson et al, 2009). Research over recent years has suggested that some of the key components of wellbeing are: family relationships, financial situation, community and friends, health and personal freedom (Layard, 2005). Subjective wellbeing suggests that as well as experiencing good feelings, people need: a sense of individual vitality; to be able to undertake activities that are meaningful, engaging and which make them feel competent and autonomous; and a stock of inner resources to help them cope when things go wrong and be resilient to changes beyond their immediate control. It is also crucial that people feel a sense of relatedness to other people, and in addition to the personal, internally-focused elements, it is clear that people's social experiences – the degree to which they have supportive relationships and a sense of connection with others – form a vital aspect of wellbeing. The health and wellbeing of people is heavily influenced by their local community and social networks as those networks and greater social capital provide a source of resilience (Marmot Team, 2010). The extent to which people can participate and have control over their lives therefore, makes a critical contribution to psychosocial wellbeing and to health.

The World Health Organization [WHO] (1946) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). This definition reflects the importance of psychosocial wellbeing as part of a holistic model of health. Over recent years social factors have been increasingly acknowledged as being vital influences on health. Dahlgren and Whitehead (1991) put forward a model, 'The Main Determinants of Health' (figure 1), which depicts how an individual's health is determined by a wide range of factors, from individual genetic predisposition and individual lifestyle factors to wider socioeconomic, cultural and environmental factors (Dahlgren and Whitehead, 1991). Socioeconomic factors, such as poor housing, poverty, education, crime and unemployment, can have a substantial effect on both physical and mental wellbeing (Department of Health, 1999; University of Central Lancashire, 2008).

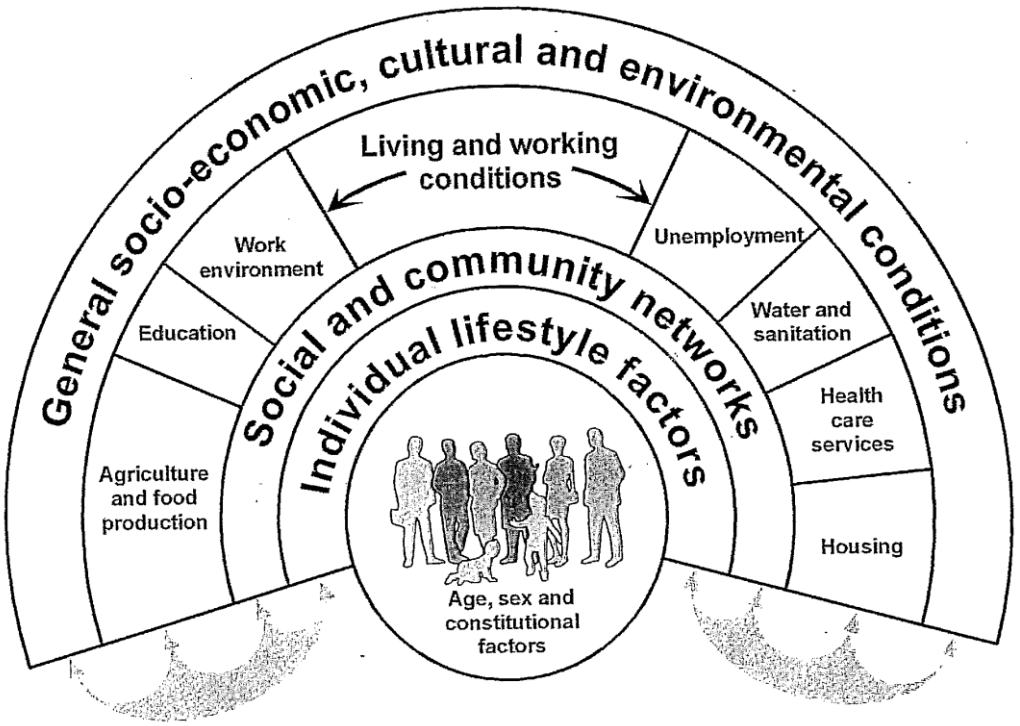

Figure 1. The main determinants of health (Dahlgren & Whitehead, 1991)

In the United Kingdom (UK) stark social inequalities in health currently exist. In 2010 the Marmot Review found a seven year difference in life expectancy between the least and most socially deprived areas in the UK, and a seventeen year difference in disability-free life expectancy (Marmot, 2010).This extreme social gradient in health was deemed a matter of social injustice (Marmot, 2010). Sadly, recent figures published by the UCL Institute of Health Equity (2012) show that, far from improving, social inequalities in life expectancy have increased during the last two years.

If health inequalities in the UK are to be reduced, then action is needed to address underlying social influences on health (Marmot, 2010). Following the Marmot Review, actions to tackle the underlying causes of poor health and wellbeing were prioritised by the government in their White Paper, 'Healthy Lives, Healthy People' (Department of Health, 2010). The policies put forward within this paper aimed to address the multiple social determinants of health. Action across all parts of society is needed in order to achieve a reduction in social inequalities in health (Marmot, 2010; Department of Health, 2010).

In the North-West of England life expectancy and general health are particularly poor. Life expectancy is on average three years lower than in other parts of the UK (NHS North West, 2008) and is one of the lowest average life expectancies in the country (Office for National Statistics, 2012). In addition to poor life expectancy, people in the North-West tend to lead unhealthier lifestyles (NHS North West, 2008; Office for National Statistics, 2012). For example, compared to many other parts of the UK there are a higher proportion of people in the North-West who smoke more than 20 cigarettes a day (Office for National Statistics, 2012), and 23% of adults in the North West are binge drinkers (NHS North West, 2008). NHS North West is therefore committed to increasing life expectancy in the North West and to improving the general health and wellbeing of the local population (NHS North West, 2008).

In summary, reducing health inequalities is high on the agenda of both local and central government. A reduction in health inequalities will only be achieved by addressing social determinants of health and wellbeing. It is therefore imperative that all sections of society play their part in helping to improve the socioeconomic, cultural and environmental conditions that underpin individuals' health and wellbeing.

3.1.2 Psychosocial Issues in Primary Care

Psychosocial problems are very common in primary care consultations. In their multi-practice survey, Gulbrandsen, Hjortdahl and Fugelli (1997) found that psychosocial issues affecting wellbeing were re-counted by over a third of participants. Social difficulties are often portrayed initially by patients as either physical or psychological problems, such as chronic pain or mood disorder (Cawston, 2011). For example, Popay et al (2007a) found that in total three quarters of social problems elicited in General Practitioner (GP) consultations were initially portrayed as either physical or psychological complaints. The most common social problems elicited by the GPs were difficulties relating to welfare benefits and housing (Popay et al, 2007a). It is not always easy for patients to distinguish between medical and social problems, and hence both types of problems may be brought to a GP consultation (Cawston, 2011). Problems that initially appear medical in origin may often be inextricably linked to the wider social context in which the patient is situated (Popay et al, 2007b).

Whilst social difficulties often underlie physical and psychological problems presented during primary care consultations, a reciprocal relationship also exists whereby physical and / or psychological problems can cause or exacerbate social difficulties. For example, Friedli (2009) describes how poor mental health can affect many areas of an individual's life, such as educational attainment, employment and social relationships. Physical, psychological and social factors are therefore inter-related, and all contribute towards an individual's overall health and wellbeing.

Despite their prevalence in primary care consultations, psychosocial problems are not always identified straightaway by GPs. Gulbrandsen et al. (1997), for example, found that only up to half of psychosocial problems were recognized by GPs. Factors affecting the likelihood of recognition included the nature of the problem, the patient's ability and wish to communicate, the GP's previous experience of the patient and the sociodemographic characteristics of the patient (Gulbrandsen et al, 1997). The tendency for psychosocial problems to be initially portrayed as either physical or psychological complaints (Cawston, 2011; Popay et al, 2007a) may also decrease the likelihood of recognition by the GP.

For many patients with social difficulties, the GP is the primary point of access for help (South et al, 2008) and the GP can act as an advocate for the patient, in providing support to access various social services (Popay et al, 2007b; Cawston, 2011). However, the ability of GPs to deal adequately and appropriately with social problems is constrained by logistical issues such as time and personnel (Cawston, 2011). Many social problems are better managed within the voluntary and community sector than within primary care (Cawston, 2011). However, it can be difficult for GPs to maintain up-to-date knowledge of relevant services in their local area, particularly because community services and groups are often changing (Popay et al, 2007a). This lack of knowledge and awareness of relevant services can make effective sign-posting to services difficult. For example, Popay et al (2007a) found that GP referrals for social problems tended to be relatively narrow, with a lot of referring to counselling services and to specialist advice services (e.g. for housing or finance), but relatively little referral to community groups. In addition to this, referral pathways from primary care to the appropriate community service(s) can be fragmented, complex and often inadequate (Popay et al, 2007b). Popay et al (2007b) found that, far from relieving stress, engagement with public services could actually exacerbate patients' stress. Whilst the role of primary care in first addressing patients' social problems is clearly vital (South et al, 2008), there is nevertheless a need for better, more integrated and more accessible pathways from

primary care to relevant community services (Popay et al, 2007b), in order for patients to be able to access the support that they need to address their psychosocial issues.

3.1.3 Social Interventions: Meeting Patients' Psychosocial Needs

There is increasing evidence to support the use of innovative social interventions particularly for vulnerable and at risk groups, people with mild to moderate depression and anxiety and, for people who are frequent attendees in primary care (Friedli et al, 2007). Social prescribing (sometimes called community referral), usually delivered via primary care, is one mechanism that can link patients with non-medical sources of community-based support. It is clear that better pathways are needed to signpost patients from primary care to appropriate community services, in order to best address their psychosocial needs. Over recent years in the UK a number of different local schemes have been developed to better address the psychosocial needs of patients. For example, opportunities for arts and creativity, physical activities, learning new skills, volunteering, befriending and self-help as well as support with benefits, housing, debt, legal advice or parenting problems (CSIP, 2009). Social prescribing involves connecting people with non- clinical sources of support within the community. Further, it not only provides a means to alternative support but also acts as a mechanism to strengthen community-professional partnerships. Such schemes provide a formal framework by which patients with non-clinical, psychosocial needs can be referred to non-medical sources of support within the local voluntary and community sector, in order for these needs to be best met (Care Services Improvement Partnership [CSIP], 2009; Scottish Development Centre for Mental Health, 2007; South et al, 2008). This framework allows for wider, social determinants of health (as discussed previously) to be both acknowledged and addressed (CSIP, 2009; South et al, 2008). Such a framework also enables the range of options available to a GP for dealing with psychosocial problems to be expanded (CSIP, 2009; Brandling and House, 2009; South et al, 2008). Hence, there is great potential for social prescribing to provide a mediating mechanism between different sectors and address social need to successfully extend the boundaries of traditional general practice through bridging the gap between primary health care and the voluntary sector (South et al, 2008).

There are multiple benefits to patients and to healthcare workers from community referral schemes. Benefits to patients include increased social inclusion; increased confidence and self-esteem; improved mental wellbeing; enhanced social networks; the development of transferable skills, and increased employability (CSIP, 2009; South et al, 2008; Stickley and Hui, 2012a; Stickley and Hui, 2012b). Additionally, the provision of appropriate community support to patients with psychosocial needs can in some cases empower individuals to better manage their own health (CSIP, 2009; Cawston, 2011). This is in keeping with an 'empowerment' approach to health promotion, in which individuals' skills and confidence are developed sufficiently to allow them to take control of their own problems (Naidoo and Wills, 2009). Community referral schemes also benefit the primary health care sector, by often reducing the frequency with which patients with complex social needs attend primary care, by reducing waiting lists for psychological services, and by increasing the range of options available to primary health care workers when such patients consult (CSIP, 2009; Brandling and House, 2009; Faulkner, 2004; Stickley and Hui, 2012b).

There are several examples of community referral schemes cited in the literature. Grant et al (2000) carried out a randomised controlled trial, that compared patients referred to the 'Amalthea Project' (an organisation that puts patients in contact with appropriate voluntary services) to patients receiving routine GP care. The study found that being referred to the Amalthea Project was associated with significant health and wellbeing benefits, including increased quality of life, greater improvement in anxiety and greater functional ability (Grant et al, 2000). A study by Faulkner (2004) provides an analysis of the 'Patient Support Service', a practice-based service that provides advice and / or referral to voluntary services for patients with psychosocial issues. Benefits elicited by Faulkner (2004) include an

improvement in mental wellbeing of patients as a result of being given the right help for their problems and a perceived reduction in attendance at the GP surgery. Finally, South et al (2008) describe a scheme consisting of the 'Community Health Advice Team' (CHAT), in which a CHAT worker facilitates the appropriate provision of community and voluntary services to patients with non-clinical needs. In this evaluation it was found that health care workers were confident in referring patients to the CHAT worker and were happy with the way in which the referral was dealt with (South et al, 2008).

Two factors are crucial to the success of community referral schemes. Firstly, the existence of a central link worker / facilitator to whom patients can be referred is important in coordinating the referral pathway between primary care and the voluntary and community sector (CSIP, 2009). Secondly, it is of paramount importance that close partnerships are forged between primary care organisations and voluntary and community services (Friedli, 2009; South et al, 2008). The importance of such partnerships has been emphasized by the government on a number of occasions, as demonstrated by the establishment of a Strategic Agreement between the Department of Health, the NHS and Social Care and the Voluntary and Community Sector (Department of Health, 2004), and the establishment of the National Strategic Partnership Forum (Department of Health, 2007)

A variety of different psychosocial problems can present to a community referral scheme. South et al (2008), for example, found that the two most commonly presenting issues to the CHAT scheme were social isolation and problems with housing / benefits. Reflecting the diverse nature of presenting psychosocial problems, a variety of different referrals can usually be made within a community referral scheme. Some referrals are to specific community services that will provide help with more explicit social issues (e.g. relating to housing or benefits) and some referrals may be to programmes in the community that aim to promote general health and wellbeing via non-clinical interventions. Examples of the latter include horticultural programmes, arts programmes, exercise programmes and social interventions. One of these examples will now be explored in greater depth.

Several studies have investigated the health benefits of horticultural activities and community gardens (Barley, Robinson and Sikorski, 2012; Gonzalez et al, 2011; Wakefield et al, 2007; Zoellner et al, 2012). Horticultural activities and community gardens have been found to improve physical, mental and social wellbeing. Physical wellbeing can be improved, for example, as a result of increased physical activity and improved nutrition (Wakefield et al, 2007; Zoellner et al, 2012). There are a number of benefits to mental wellbeing, including a reduction in depression and / or improvement in mood, an increase in self-esteem and the benefits gained from participating in a meaningful activity (Barley et al, 2012; Gonzalez et al, 2011; Wakefield et al, 2007). Finally, social wellbeing can be enhanced as a result of increased social contact and social networks, and improved community cohesion (Barley et al, 2012; Wakefield et al, 2007; Zoellner et al, 2012).

In summary, health and wellbeing are underpinned, not only by individual factors, but by wider socioeconomic, cultural and environmental influences. Addressing these wider determinants of health is of paramount importance in reducing the social inequalities in health that currently exist in the UK. Primary care consultations are often the point at which psychosocial problems may first present. However, the scope for primary care services on their own to adequately address psychosocial issues is limited. Community referral schemes have been developed to enable patients with psychosocial needs to be referred to services in the voluntary and community sector that may be better able to meet those needs. There is considerable evidence that such schemes can confer substantial benefits to both patients and to primary care.

3.2 LOCAL CONTEXT

3.2.1 GREEN DREAMS

Green Dreams Community Interest Company (CIC) was established by a General Practitioner (GP) within one general practice in East Lancashire in January 2011. It was recognised that GP's were often faced with patients who had multifaceted social concerns that were significantly impacting on their health and wellbeing, limiting their capacity to be employed and function within the local community. These patients would often present on numerous occasions to the GP, with often no physical health symptoms. The GP was left frustrated that he was unable to spend the time required to support the patient and often unaware of the services on offer locally.

Within the first twelve months, one project manager was employed. Significant outcomes were achieved by patients in rebuilding their lives. This led to a further benefit for the practice as it was noted that patients were attending for GP appointments less often, prescribing was reduced and the GP's felt this was benefiting the patients as they saw significant improvements in individuals' confidence, self-efficacy and social circumstances. There were also benefits noted for the wider community.

The Green Dreams Project partnered with Lancashire Care NHS Foundation Trust, Health Improvement Service, in March 2012. The project was successful in attracting funding from NHS East Lancashire for a twelve month pilot to establish whether the model can be replicated within further General Practices across East Lancashire.

The Green Dreams Project provides local, community-based solutions in East Lancashire to unemployment, isolation and reduced quality of life. It prioritises individuals whom other agencies have been unable to help. The unique approach comprises:

- Tailored coordinated care
- Marrying health needs with social needs
- The creation of meaningful group activities

There are now five full time project managers working in six different surgeries:

- Padiham Group Practice, Padiham;
- Thursby Surgery, Burnley;
- Rosegrove Surgery, Burnley;
- Peel Medical Practice, Accrington;
- Reedyford Healthcare Group, Nelson; and,
- Irwell Medical Practice, Bacup

Examples of Reasons for Referral:

- Support to find employment
- Low level depression
- Isolation from community activities
- Vulnerable to anti-social behaviour
- Recovered from addiction, support needed to gain direction in life
- Inability to work following a period of illness/injury and an unhappiness with this situation
- Low self-esteem/confidence
- Support completing application forms/official documents
- Chaotic lifestyle
- Volunteering
- Debt
- Poor Housing

The project is currently a 12 month pilot ending in March 2013 funded by NHS East Lancashire. It is anticipated that the project has potential to be rolled out nationally if further funding can be sought.

3.2.2 POPULATION

There are approximately 382,000 people living in 5 districts which make up East Lancashire.

East Lancashire developed around Cotton mills and manufacturing/ engineering industries. With the decline of manufacturing, no new industry has been brought in and the area is in decline. There is significant urban deprivation with generally poor health experiences. There is also a high prevalence of lifestyle and socially related diseases especially relating to smoking, alcohol, illicit drugs, obesity, lack of exercise and sexual behaviour.

East Lancashire is an increasingly diverse society. Average ethnic minority population per ward is circa 8 - 10% but in some wards it is over 70%. Most of this population has its roots in Pakistan, although there are significant Bangladeshi populations and an increase in the number of people from Eastern Europe living in East Lancashire.

A key concern for health in East Lancashire is the complex social circumstances that face many within the population, that are contributing to poor health and social outcomes.

4. KEY FINDINGS: EMERGENT THEMES

4.1 STAKEHOLDER INTERVIEWS

In this section, a preliminary summary of hand-written notes from interviews with stakeholders is presented. A full thematic analysis is currently underway and being cross referenced with findings from the data monitoring reports.

The Green Dreams project has engaged with a range of different individuals. Individuals who are commonly referred to the project include those with long-term mental health needs, those who are vulnerable and those who feel that they don't have anyone else who can help them. Many service users have social problems, for example relating to housing, finance and unemployment, but may be fearful of contact with social services. Sometimes patients have actually asked their GP themselves if they can be referred to the project. At other times a referral has been offered, and a patient has then decided whether or not they feel it would be appropriate.

Stakeholders' perceptions of the service user experience of the Green Dreams project have been overwhelmingly positive, with all stakeholders feeling that the project has been extremely beneficial to service users. The Green Dreams project enables service users to feel that they are more supported and that they have someone or some people who care about them and with whom they can talk. As a result they feel more able to cope with life's problems. The Green Dreams project can reduce feelings of social isolation for service users and provides them with an opportunity for social engagement with a range of different people. As a result of the Green Dreams activities in which they may partake, service users can feel a sense of achievement and can develop a sense of routine again. It is felt by stakeholders that the underlying approach to the Green Dreams project is one of empowerment and enablement, supporting service users to take control of their own lives. Green Dreams also facilitates service users to secure practical help such as childcare.

Stakeholders felt that the Green Dreams project has allowed service users to develop a wide range of skills. Some of these skills are generic skills that are transferable to many areas of life, such as problem-solving, solution generation and time-keeping skills. Other skills developed by service users are more specific to certain activities or tasks. The development of these skills can in some cases lead to the securing of further education (e.g. college courses), training or employment. In addition to the skills described, service users' self-confidence, self-esteem and general coping skills are increased as a result of the project.

There was a general consensus amongst stakeholders that the Green Dreams project provides value for money. Although stakeholders weren't generally aware of specific

financial details, the value for money they felt it provided was predominantly couched in terms of the indirect savings to society that arise. These savings were felt to occur as a result of a reduction in service user attendance at GP surgeries and as a result of, in some cases, possible avoidance of prison admission or avoidance of inpatient mental health care. Additionally, it was acknowledged that if the project helped a service user gain employment then this led to a cost saving to society in terms of unemployment benefits saved.

Many benefits of the Green Dreams project were described by stakeholders. With regards to the practical aspects of the project, it was felt to be a useful knowledge base for resources and an invaluable mechanism for signposting. It was felt easy to refer to the project, and the benefits of having a facilitator as a point of contact were acknowledged. With respect to the overall care provided for the service user, it was felt that the Green Dreams project provides a comprehensive and holistic package of care. The project provides an opportunity for help to be offered to service users at an early stage of a period of stress / anxiety in their lives, thereby often preventing further deterioration. The role of advocacy in the Green Dreams project was also deemed important. Finally, it was felt that the Green Dreams project offers a chance for different groups (e.g. GPs and voluntary and community groups) to work together.

In summary, the Green Dreams project is perceived by stakeholders to confer substantial benefits to service users, to stakeholders and to the wider community and society. It was felt that service users' experience of the Green Dreams project has been overwhelmingly positive, and has enabled the development of many new and useful skills. The main changes suggested for the project focus on its expansion to new practices and new areas, and on increasing awareness of the project in the local population.

4.2 Data Monitoring Analysis

It would appear from the data presented in the monitoring forms (n=10) that involvement with the Green Dreams project offers a variety of benefits to individuals including social support, referral, signposting and guidance that enables increased confidence, self-esteem and motivation. In turn, this appears to impact positively on wider lifestyle issues ranging from engagement with wider improved social circles to improved living condition through sourcing of appropriate aids and successful applications for a range of benefits.

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