

COMMISSIONING  
**HEALTH +**  
**WELLBEING**

**CHRIS HEGINBOTHAM**  
**KAREN NEWBIGGING**



Los Angeles | London | New Delhi  
Singapore | Washington DC



Los Angeles | London | New Delhi  
Singapore | Washington DC

SAGE Publications Ltd  
1 Oliver's Yard  
55 City Road  
London EC1Y 1SP

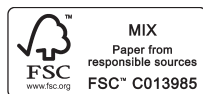
SAGE Publications Inc.  
2455 Teller Road  
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd  
B 1/1 1 Mohan Cooperative Industrial Area  
Mathura Road  
New Delhi 110 044

SAGE Publications Asia-Pacific Pte Ltd  
3 Church Street  
#10-04 Samsung Hub  
Singapore 049483

---

Editor: Alex Claburn  
Assistant editor: Emma Milman  
Production editor: Katie Forsythe  
Copyeditor: Gemma Marren  
Proofreader: Anna Gilding  
Marketing manager: Tamara Navaratnam  
Cover design: Wendy Scott  
Typeset by: C&M Digitals (P) Ltd, Chennai, India  
Printed in Great Britain by Henry Ling Limited, at  
the Dorset Press, Dorchester, DT1 1HD



© Chris Heginbotham and Karen Newbigging 2014

First published 2014

Apart from any fair dealing for the purposes of research or private study, or criticism or review, as permitted under the Copyright, Designs and Patents Act, 1988, this publication may be reproduced, stored or transmitted in any form, or by any means, only with the prior permission in writing of the publishers, or in the case of reprographic reproduction, in accordance with the terms of licences issued by the Copyright Licensing Agency. Enquiries concerning reproduction outside those terms should be sent to the publishers.

**Library of Congress Control Number: 2013934400**

**British Library Cataloguing in Publication data**

A catalogue record for this book is available from  
the British Library

ISBN 978-1-4462-5254-3

ISBN 978-1-4462-5255-0 (pbk)

# CHAPTER 1

## Introduction

Health and wellbeing are elusive concepts and the aim of this book is to support commissioners translate current aspirations of public mental health into tangible commissioning strategies. This book provides a carefully structured and comprehensive look at the resources designed to improve population health and wellbeing outcomes. It is being published at a time when there are major changes in commissioning arrangements in England and we hope that our contribution will enable a debate within Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBs) and other emerging organisations about the possibilities for using current resources, both human and financial, by focusing on health and wellbeing as well as illness.

This chapter starts by setting the background and explains our view about positive mental health and wellbeing, making the general case for investments by health and social care commissioners in wellbeing interventions.

### 1.1 Introduction

The importance of mental and physical wellbeing and the positive benefits it brings to individuals and communities is now widely recognised. These include better health and health-related behaviours, greater resilience, an enhanced capacity for creativity and innovation, stronger social networks, positive relationships and connected communities as well as reduced mortality (Aked et al, 2010; DH, 2009a; National Mental Wellbeing Impact Assessment (MWIA) Collaborative, 2011). In the last six years, there have been several valuable reports published by the New Economics Foundation (nef) (see, for example, *Measuring Wellbeing in Policy*, 2008; *Five Ways to Wellbeing: The Evidence*, 2008),<sup>1</sup> the Government Office for Science (the Foresight Report, 2008) and the Marmot Review in 2010 (Marmot, 2010). The National Institute for Health and Clinical Excellence (NICE) and the Department of Health (DH) have also published a range of reports, summarising the evidence base and promoting commissioning for mental wellbeing as a key strategic programme. Together these reports provide an evidence base for why it makes sense to focus on wellbeing and the role played by the social determinants of health, and a bibliography is available as an Appendix. The reason wellbeing has gained so much attention is the understanding that mental capital is needed to enable us to adapt to the challenges ahead, particularly to those of the global economic recession, climate change and its consequences, population growth

and its effect in a reduction of resources, and greater equality between nations and continents. Even at times of austerity, an emphasis on social protection and active labour market programmes that support personal development, as well as simply getting people into a job, can encourage and promote wellbeing.

Wellbeing has become a more accepted way of understanding how people feel about the society in which they live. Since November 2010, when the Office for National Statistics (ONS) launched the Measuring National Well-being programme, a set of measures has been available that complements figures for Gross Domestic Product (GDP), offer a greater understanding of the way people feel about changes taking place in society and assist ordinary people to understand what is important to the country (ONS, 2010). Bhutan was perhaps the first country actively to consider a Gross National Happiness (GNH) quotient, but the UK may soon be catching up.<sup>2</sup>

Before we go any further, however, we need to explore what we mean by wellbeing. Although physical and mental wellbeing are inextricably linked, our focus is on mental wellbeing. Mental wellbeing is a multi-dimensional concept and is the foundation for positive health and effective functioning for an individual and for a community. We explore the concept of mental wellbeing in more detail in Chapter 2; however, the terminology is problematic and work in Scotland has found it can evoke strong emotions. There is a paradox. If we speak about 'health' alone, it will not be clear that we mean the totality of health-promoting psychological and physical interventions that have wellbeing as the goal; if we speak about 'mental health', it will not be clear that we mean comprehensive positive mental health as well as preventive strategies to reduce the risk and incidence of mental illness. We are rightly concerned with achieving positive mental health as a concomitant of a wider description of wellbeing; improvements to mental wellbeing come from improvements in physical health, and in this way physical and mental health are intimately connected. The term 'mental health' often, indeed usually, conjures up in the reader's mind the idea of mental health *care*, or in other words mental illness services. In the discussion here we do not want to place any more than marginal emphasis on mental illness or services labelled as mental health care; our purpose is the positive mental health that stems from those aspects of society that support flourishing and resilience (see Chapter 2) whether those are social, familial, psychological, biological, organisational, economic or political determinants of wellbeing. Consequently we have called the book *Commissioning Health and Wellbeing*, not *Mental Health and Wellbeing*, hopefully for what are now obvious reasons.

In this book, we want to offer ideas that will enable commissioners to commission to achieve physical and mental health wellbeing. First, the focus will be on public (mental) health in addition to primary, secondary and tertiary prevention of any disease or distress where its course can be modified by early preventive interventions that reduce or ameliorate distress such that the long-term consequences are much improved. Second, we are concerned with cost-effective interventions in health and social care that support or improve wellbeing, for individuals, their families and communities. Third, we are concerned with the health and wellbeing of specific populations whose situation and social processes further disadvantage them and increase their vulnerability to poor health. Inevitably this includes people with a diagnosis of mental illness and so we are also concerned with interventions that will assist with recovery of service users towards the objectives they set themselves for their lives. We are not concerned with mental health care (mental illness services) except where these impinge on the generic promotion and prevention agenda; but we

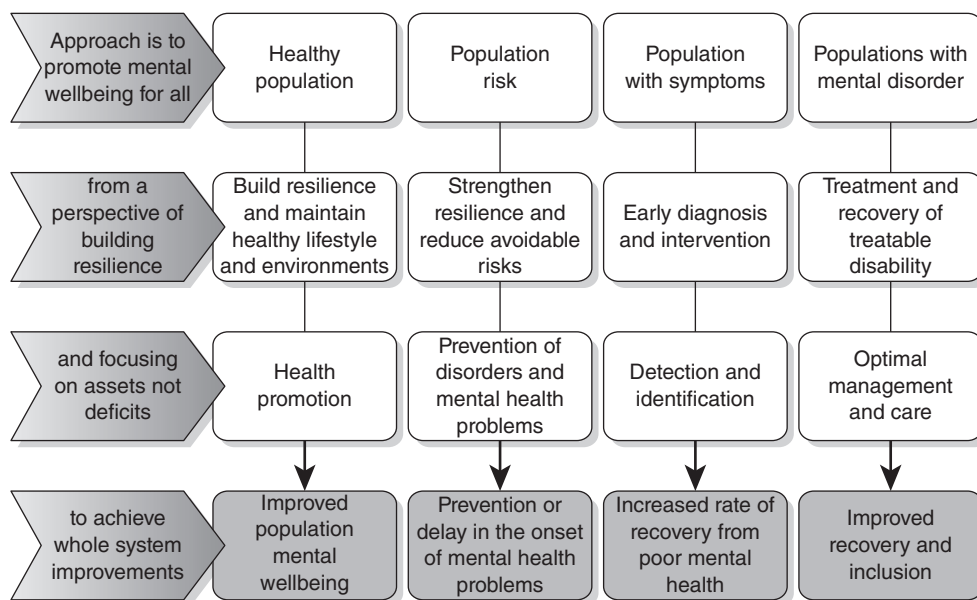
are interested in commissioning health and social care that promotes wellbeing, applying lessons from the literature wisely and correctly to achieve savings and longer-term benefits for wider society.

## 1.2 Improving health and wellbeing

Mental health as a positive concept is a key element of what we mean by health and wellbeing. Perhaps mental wellbeing might be a better term. Wellbeing is a broad construct that encompasses a variety of theoretical approaches including eudaimonic wellbeing, hedonic wellbeing, and social wellbeing (Gallagher et al., 2009). Whatever term we use though, mental health is an essential component of general health. In other words there is no health without mental health (Royal College of Psychiatrists, 2010). Mental wellbeing is a critical asset in the fight for improved health – it is both an objective and a support on the road to that objective. This means it is a resource both at an individual level, enabling people to cope with the demands of everyday living and the unexpected – in other words it is concerned with resilience – and at a social level, fostering stronger and sustainable social relationships and communities. It is a resource for the long-term social and economic prosperity of society.

In contrast to psychological ‘ill-being’ (i.e. pervasive negative feelings and poor functioning in life), positive psychological wellbeing (PPW) reflects the positive components of psychological health that characterise individuals who feel good about life and function well (Keyes and Annas, 2009; in contrast to Kashdan et al., 2008 with whom this paper disagrees. See also Tiberius and Plakias, 2010). Improving mental wellbeing requires efforts to be focused on promoting wellbeing for communities and individuals and on those at risk of poor mental health: communities, social networks and the environment play a central role alongside education, transport, health and social services, employment, financial security and leisure opportunities in strengthening resilience both at an individual and a community level. Responsibility for promoting mental wellbeing extends across all disciplines and government departments and encompasses a concern for social values, culture, economic and social, as well as health policies. It includes approaches that involve and strengthen the active participation of local communities and local people, particularly those from vulnerable groups, who are central to improving mental wellbeing. Consequently, commissioning for mental wellbeing should be focused on delivering the best possible health and wellbeing outcomes through the best use of the available information and resources.

Commissioning for mental wellbeing involves considering three sets of objectives: health and wellbeing promotion for the whole population; primary, secondary and tertiary prevention of potential health and social risks; and wellbeing developments for those living with or recovering from mental illness. The Figure 1.1 summarises this approach and provides a useful framework for developing a strategic approach to commissioning for mental wellbeing. The first three columns are the focus for this book – positive wellbeing for all; prevention; and promoting health for those with incipient or actual mental health problems – but the last column is not within the remit of the book as that describes mental health services. However, this is an important area for commissioners, who will be concerned to commission mental health services that promote recovery and wellbeing.



**Figure 1.1** Opportunities for mental health promotion: a population perspective (adapted from Barry and Jenkins, 2007)

### 1.3 Commissioning for outcomes

At a time of austerity it may seem naïve, even foolish, to suggest health promoting and preventive interventions; yet there is a strong case to be made on the basis of the evidence available for a range of outcomes including social and economic ones. Improving population mental wellbeing has the potential to contribute to far-reaching improvements in physical and mental health, a better quality of life, higher educational attainment, economic wellbeing and reduction in crime and anti-social behaviour. The main outcomes, which have been well evidenced, are illustrated in Box 1.1 (see, for example, Kim-Cohen et al., 2003; Saxena et al., 2006; Barry and Jenkins, 2007; Friedli and Parsonage, 2007).

The foundations for positive mental wellbeing are laid down in early life and as we grow and mature through our teenage years. This is when we learn most rapidly. The quality of the relationships and experiences we have in our early years and the learning that we do about our emotions and our relationships as we grow up are vital. For example, half of lifetime mental illness (excluding dementia) is already present by the age of 14 (Kessler et al., 2005) so the early years provide a critical opportunity for intervention. Mental wellbeing is important across the life span and the health and wellbeing of older generations affects that of younger people. Thus, better outcomes are likely to be achieved through the adoption of a life course approach that recognises that mental capital, as discussed in Chapter 2, is a resource we develop and use throughout our life and is available to and built by others, reflecting our interdependencies and interconnectedness.

### Box 1.1 Advantages and outcomes of focusing on health and wellbeing

- Increased quality of life and overall wellbeing.
- Increased life expectancy, provide protection from coronary heart disease, improve health outcomes from a range of long-term conditions (e.g. diabetes).
- Reduce risks to health through influencing positive health behaviours, such as reductions in alcohol and substance use.
- Reduced health inequalities – both physical and mental health – and impact positively on the social determinants of health.
- Improved educational attainment, outcomes and subsequent occupation.
- Safer communities with less crime.
- Improved productivity and employment retention, reduced sickness absence from work and reduced ‘presenteeism’.
- Reduced levels of poor mental health and mental illness and the adverse consequences of mental illness or distress (NB wellbeing is *not* the opposite of mental illness).

## 1.4 The case for commissioning for mental wellbeing

Current health (NHS) and local authorities’ policy is that commissioning for health, wellbeing and independence<sup>3</sup> is as important as commissioning for ‘illness’ (see, for example, North Yorkshire County Council, 2007; Bennett et al., 2011; DH, 2011a). This emphasis includes a growing awareness of the negative impact of poor mental wellbeing and indeed poor mental health, as well as opportunities for intervention at a population and individual level. The case for mental wellbeing improvement is an increased quality of life and overall wellbeing, and wider health benefits to individuals and the population. Mental wellbeing is entwined with physical health with the potential for positive feedback both ways.

There are five arguments that support the case for commissioning for health and wellbeing: demographic changes; an increasingly robust evidence base; the economic dimension – invest to prevent and save; tackling social injustice and promoting equalities; and underpinning all of these, a moral argument. Readers will have their own preferences but we take the approach that together they make a strong case for commissioning for wellbeing and that not to do so wholeheartedly is merely a shift in lexicon rather than the paradigm change that is needed. We will explore these arguments in this book but want to introduce them here to provide a starting point for the subsequent material.

## a) Demographic changes

Demographic changes over the forthcoming decades will place very significant pressures on individuals, communities, local authorities and health agencies. This will be especially true of the growing numbers of older people, one fifth of whom over the age of 80 will have dementia and another fifth will be unable to carry out the usual activities of daily living. A substantial number, perhaps 10%, will have diabetes or at least one other long-term condition, such as cerebrovascular disease (CVD), heart failure, end stage renal failure associated with hypertension, and possibly digestive tract disorders. This will have far-reaching impacts on individuals' quality of life and the budgets of statutory authorities, which are unlikely to be able to cope without a radical rethink of how we commission for a healthy older age, making investment in this area essential. In Chapter 8, we explore the interconnection between depression, diabetes and dementia as an exemplar of the inter-relationship between mental wellbeing and physical health and how wellbeing interventions for one may have a wider value. Chapter 9 considers the opportunities and assets that older people represent and how their continued contribution has both individual and social benefits.

## b) An increasingly robust evidence base

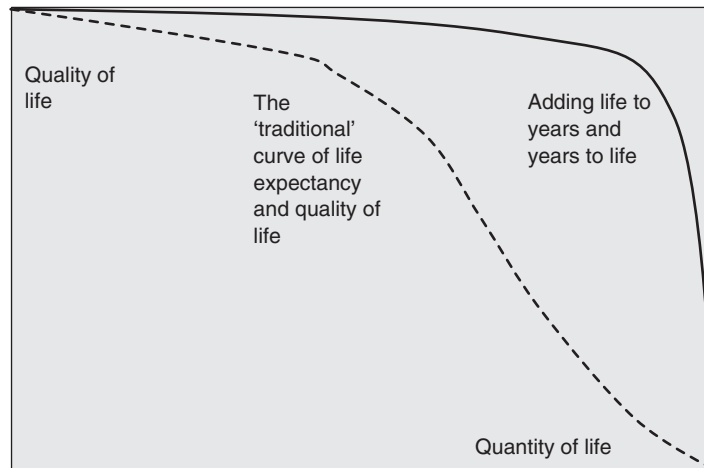
The evidence for the effectiveness of wellbeing interventions has become more persuasive steadily over the preceding ten years. Gone are the days – or so they should be – when health commissioners could simply refuse to listen. Many of the health promotion objectives can be delivered through health and wellbeing interventions that are (a) much cheaper, and (b) prevent, in many cases, precisely the illnesses (or at least the worst aspect of those illnesses) that cost the NHS so much money. We recognise that this sounds like the worst sort of rhetoric; but we would ask anyone reading the book to do so with an open mind and reflect on the quantity and quality of the evidence. Of course not everything is as well evidenced as the best, but that is true of much acute medical and surgical care now. Chapters 6 to 9 provide an overview of the evidence for significant interventions for children, young people and adults, including older adults. This is a partial look at the evidence but the areas we have chosen we think represent the key areas for commissioners to consider, as a starting point to improving population wellbeing.

## c) Invest to prevent and save

Commissioning public mental health and wellbeing offers significant potential savings by strengthening protective factors and reducing risk factors, which will have significant implications for health and social care usage elsewhere in the system. Taking a life course approach, as we suggested previously, places a premium on early intervention, but there are many interventions that are available for older adults. As our wider preventive strategy develops it must be hoped that disability and death will be pushed away and the life curve (quality against quantity) will be 'squared-off', as shown in Figure 1.2.

Public health has an important role in identifying locally the opportunities for investment in wellbeing that will have an impact elsewhere in the system. Lower health



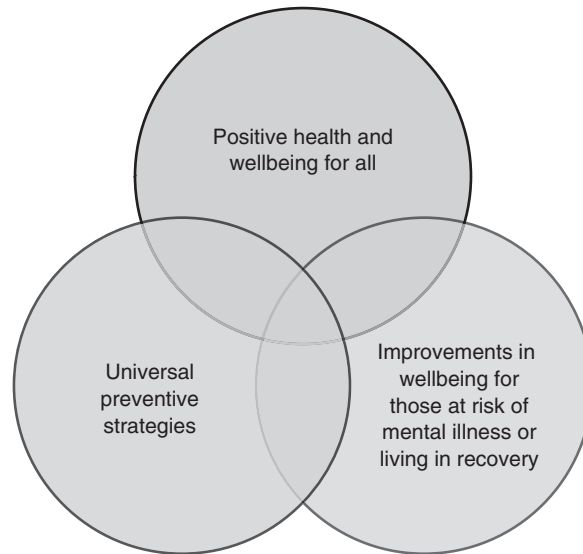


**Figure 1.2** Adding years to life and (especially) life to years 'squares' the life expectancy curve

care utilisation is also likely to result so that investment in mental wellbeing interventions will have positive impacts in other parts of the health and social care system, not to mention the savings that may accrue in other sectors. Even at a time of austerity, focusing on wellbeing means that we give precedence to positive psychological health and investing in people's resilience. This places an emphasis on health promotion and illness prevention, and by preventing illness occurring, and taking a long-term perspective on such matters as child physical and sexual abuse, it will both improve wellbeing and save significant levels of financial resources for reinvestment elsewhere. It seems perverse that, just when people are losing their jobs as a result of the recession, the government should reduce the benefits that have been part of the social contract, offering social protection that has sustained individuals and families, reduced their anxiety and made it easier for them to find employment again. Some of those savings become available quite quickly, within two years; some are only realised after longish periods of time, over 20 or more years. Some of the savings are not in health or social care but appear in other areas of the public sector: criminal justice, the prison service, education, housing and so on. However, heartening news from the Spearhead<sup>4</sup> group of local authorities is that a programme to tackle inequalities that was begun in the early to mid 'naughties' is now bearing fruit, after ten years or so.

Certain interventions are more cost-effective than others, certain interventions are easier to implement. We will see as we explore different areas for interventions, some objectives will be more achievable than others. What we have described above is summarised in Figure 1.3. This suggests a more holistic reality in which it can be seen that the three areas are not mutually exclusive. They overlap in ways that are frequently demonstrated by the outcome achieved in an area that differs from the one in which the intervention is targeted.

Positive health messages are relevant to people with mental illness as much as anyone else; wellbeing for people with mental illness is one of the elements of a proportionate approach that focuses on those deemed at risk; and universal preventive strategies can bring benefits in positive health and wellbeing in addition to the specific outcomes to be achieved by the intervention.

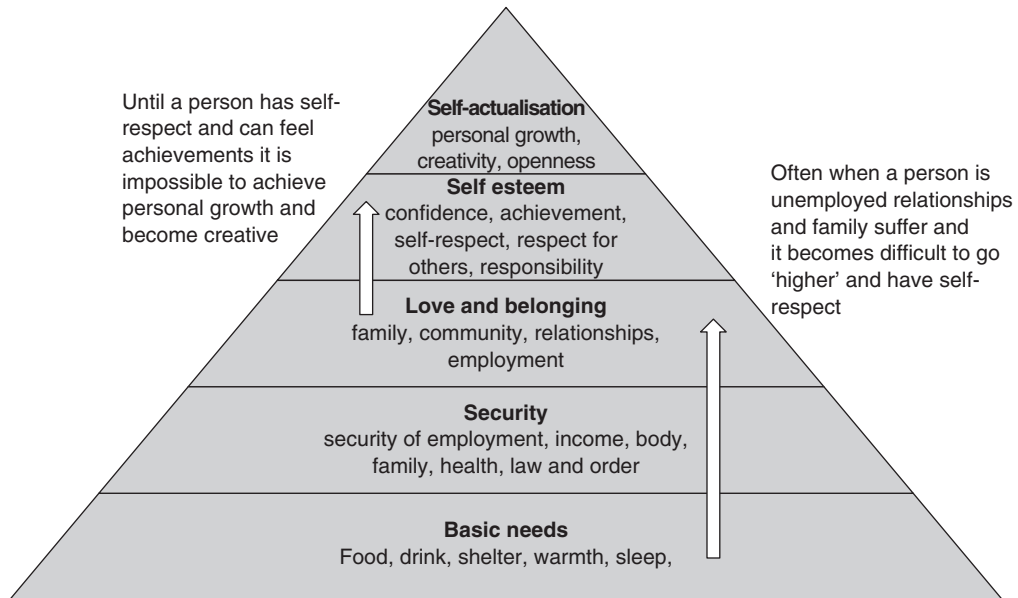


**Figure 1.3** The inter-relationship of the three aspects of health and wellbeing

## d) Social justice and promoting equalities

One of the most important arguments supporting a focus on public mental health is the value of social justice in promoting equity and equality. Prevention and health promotion are two of the most significant aspects of health and social care. Why is it so difficult for politicians to recognise the value of prevention instead of treatment? This is especially true in relation to mental health. Mental health, and by that we mean positive mental health for all, is the other side of the coin of social justice. Being mentally healthy means that our basic needs have been met and we have been accorded autonomy, resources, and acceptance. For example, it is immensely difficult to get people to become engaged in the higher order features of their lives (e.g. as described by Maslow's hierarchy of needs – see Figure 1.4) if their more basic needs are not being met or are likely not to be met.

The Secretary of State for Health, the NHS Commissioning Board (NCB) and Clinical Commissioning Groups have legal duties under the Health and Social Care Act 2012 (HM Government, 2012) in relation to reducing health inequalities. In Chapter 3 we consider equity in health and social care and recognise the value of the social determinants of health. By focusing on food, road transport and air pollution, global warming, decent housing and so on we will prevent many of the deprivation-borne disorders from forming. In Chapter 6 we demonstrate how poor parenting leads to poor child rearing, perhaps as a result of alcohol-driven intimate partner violence, and will almost certainly mean a life of lower opportunity and poorer achievement. But it doesn't have to be like that. By making social justice our aim we can ensure that everyone's life is improved; and incidentally we ensure as well that the resources are spread between people in spaces of deprivation (Popay, 2012) rather than being spent sometimes in too bureaucratic a manner by well-heeled professional staff.



**Figure 1.4** Maslow's hierarchy of need (redrawn by the authors from Maslow, 1943)

## e) The moral argument

Health promotion, illness prevention and wellbeing generation should draw on evidence and ethics as two related systems of reasoning. At the same time values (of individuals, groups, communities and the general population) are a crucial aspect in taking a 'full-field' standpoint (see Fulford et al., 2012; Heginbotham, 2012). The evidence and values should be made explicit as should the ethical basis of the way health promotion and prevention are implemented (Carter et al., 2011). Amartya Sen (2002), for example, advocates capabilities as an alternative to a utilitarian approach to welfare, opening up opportunities; recasting disability as '*capabilities deprivation because it interferes with a person's ability to make valued choices and participate fully in society*' (Hopper, 2007: 874). Much commissioning is currently based on a deficit model and we explore the implications for an assets-based approach for transformational change below. Commissioning is thus a moral endeavour, with assumptions about humanity constructed and reproduced through our policies and commissioning intentions.

## 1.5 Improving mental wellbeing

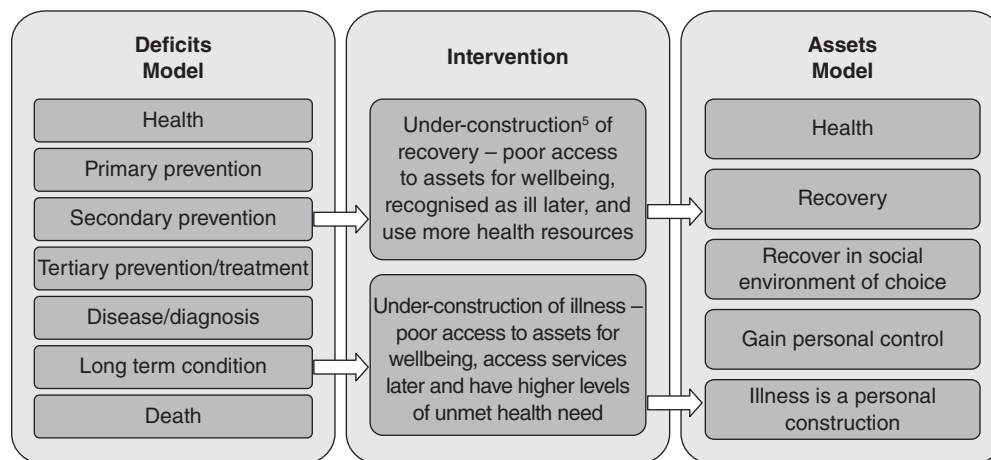
Critical decisions will need to be made about ways of focusing effort in those areas which are most likely to reap benefits. Clear direction will be required concerning where resources should be invested and focusing efforts on initiatives that are known to be effective and have been tried and tested. This does not mean stifling local innovation but rather balancing creative local practice with a commitment to implementing and scaling

up evidence-based programmes that have been clearly shown to have worked across different settings. For example, there is a very robust evidence base concerning the effectiveness of interventions in the early years with families and young children. We will see in Chapter 6 how early years interventions and parenting skills can improve life chances, and in Chapter 8 how, if those interventions were applied, they could help to improve diabetes self-management.

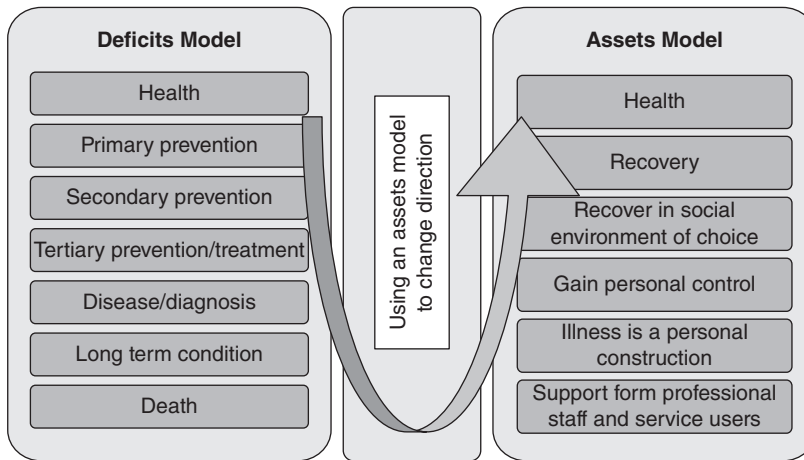
The assets approach to health offers the opportunity for citizens to take control of their lives and to access a range of assets in doing so. The deficits model considers illness and death as inevitable and defines a pathway as shown on the left of Figure 1.5. Conversely the assets model recognises the value of personal control and that the use of assets in the community (or social environment in which the person lives) can help to identify disease earlier, reduce the need for health care resources and support recovery. In this way we can see that the deficits model and the assets model are not mutually exclusive (Pavlekovic et al., 2011).

Personal and community assets, on their own, will not resolve serious disease or offer appropriate treatments; but similarly, the deficits model on its own condemns many people, usually those living in deprived communities, to existing with curable or at least modifiable disease. By constructing disease (failure of function) or illness (failure of agency) (Fulford, 2004) in new ways, we can see what assets we need to improve function and agency; by constructing recovery as personal control over life (or treatment) objectives, it is possible to identify those aspects of the environment that will assist in achieving a healthy life.

One of the main tenets of the assets approach is to emphasise connectedness and co-production. Enabling people to connect (the first of the nef five wellbeing steps) will encourage an interest in asset finding and designation. There is in communities an ‘asset unconscious’, which can be found through dialogue with others. Assets ‘emerge’ in the interplay of language about community: often people are unaware of the physical or personal assets until they describe them during facilitated discussions. These assets have probably been there all along and simply need identification and ‘permission’ to be used. In Chapter 5 we consider ways of engaging communities authentically to empower local



**Figure 1.5** From a deficits model to an assets model



**Figure 1.6** Transformative action in changing from a pathology focus to a health focus

people and to identify the assets that they have locally, which they may never have noticed, or if they did they thought would not be of value for health and wellbeing.

The model proposed above does not absolve professional or community staff – concerned with inequities in health access or disturbed by the prevalence of health inequalities borne of many years of neglect and discrimination – from tackling inequalities through determined access to the best technology and the most applicable care. The assets model does not readily achieve change for those already suffering the effects of inequity – for example, social deprivation, lack of access to health resources, early onset long-term conditions made worse by insufficient or ineffective treatments – but by developing an inclusive community-oriented assets base it will be possible to ensure an improving environment for the future. Tackling existing inequalities, however, requires some old-fashioned focus on those with disease, and the establishment of transparent targets that are used to identify the proper interventions that will bring the numbers down in line with the targets set.

## 1.6 Our approach

We unashamedly take a life course approach to health and wellbeing. Many of our recommendations are focused on ways in which early life experiences, both risks and protective factors, affect the health trajectory of the individual, usually adversely, later in life (see, for example, Halfon and Hochstein, 2002). In this model, health is a consequence of many factors operating through genetic, biological, behavioural, social, psychological, familial, economic and political contexts. Health adapts as the contexts in which it is ‘expressed’ change and develop over the life of the individual (which is one reason why wellbeing is such an intangible and slippery subject!) In this model ‘health’ ‘takes on a trajectory that results from the cumulative influence of multiple risk and protective factors that are programmed into an individual’s bio-behavioural regulatory systems during critical and sensitive time periods in development<sup>6</sup> (Halfon and Hochstein, 2002). Similarly, a life course approach to the epidemiology of long-term conditions is the study of the effects on chronic disease risk of physical, mental, psychological and social exposures during pregnancy,

childhood, adolescence, young adulthood and later adult life. It includes studies of ‘the biological, behavioural and psychosocial pathways that operate along an individual’s life course ... to influence the development of chronic diseases’ (Kuh and Ben-Shlomo, 1997: 285; see also Ben-Shlomo and Kuh, 2002).

Consequently, we hope this book will help to:

- assist the development of a life course approach to health and wellbeing;
- promote those interventions that are known to work or have a good chance of providing improvements in (mental) health and wellbeing;
- provide benefits for physical and mental health promotion and suggest preventive measures that will stop or attenuate those behaviours that lead to physical and mental problems;
- assist in building social capital within our communities;
- address inequalities in society and offer ways to address and challenge those inequalities in the way they arise and are sustained;
- achieve better outcomes for public health interventions;
- enable communities to understand and obtain improved health and social care outcomes;
- support people to take greater responsibility for improving their own health and wellbeing.

We will, in the course of the book, develop four arguments for the suggested interventions we propose. Reflecting those above, these are:

- **economics** – wellbeing makes economic sense and is cost-effective, as has been shown by nef and others;
- **equalities** – wellbeing helps to tackle health and social inequities and inequalities – it offers a vehicle for an assets-based approach to public health;
- **ethics** – promoting wellbeing through an assets-based approach (that ameliorates but does not emasculate a deficits approach) is morally the right thing to do, as is promoting the best possible psychological health available;
- **evidence** – it works where it works! (and we will try to offer the best evidence of the interventions available).

Mental wellbeing is influenced by a complex interplay of factors at an individual, social and community level (Ryan and Deci, 2001). Although wellbeing is dependent on many factors, and in an ideal world would be based on inter-sectoral and inter-departmental action across national and local government, in practice this is very difficult to achieve. Place-based approaches are one way to bring resources together to focus on wellbeing and facilitate a shared vision across organisations. Whilst it is important to recognise the inter-sectoral aspects of wellbeing, there is little purpose served in idealistic pipe dreams about the best, which then becomes the enemy of the practical and achievable. We, therefore, focus unashamedly on what health and social care commissioners can do now whilst recognising and reflecting the role of other sectors, notably housing, education, transport and the role of local government, government agencies and the third sector.

## 1.7 Overview of the book

Commissioning for health and wellbeing of a local population means understanding the factors that build and strengthen individual and community resilience, that enable local

communities and individuals to stay healthy, independent and interdependent and anticipating the risks that might jeopardise this. That requires a full understanding of local health inequalities, their social, physical and socio-economic determinants and their implications for mental wellbeing, and finding ways to tackle those inequalities identified. Commissioning also means promoting health and social inclusion and supporting independence through the mainstream policies and activities of different sectors including health and social care, education, housing, leisure, employers and the third sector. In Chapter 2 we explore the different dimensions of mental wellbeing from a theoretical perspective with a view to using key ideas about flourishing, proportionate universalism and assets-based approaches in developing practical approaches to commissioning for mental wellbeing.

The current context for commissioning is changing and arguably locating public health within local authorities will enhance the opportunity to take action to address some of the inequalities faced by different groups and thus promote population mental wellbeing (see for example, Howarth, 2012, Appendix 1). Whilst this context is somewhat fluid at the time of writing, the principles and process underpinning effective competent commissioning are well understood and thus Chapter 4 considers the commissioning process from the perspective of improving population mental health. Using the rapidly developing evidence base on the protective, risk and environmental factors associated with mental wellbeing and the interventions that can promote mental wellbeing at an individual and social level should assist in targeting effectively the interventions that are known to work. This will demand the alignment of outcomes measures and information systems with strategies and the goals of programmes and interventions, and in turn this requires a more explicit focus on commissioning the mental wellbeing component of existing provision, better strategic coordination of exiting activities and aspirations to improve mental wellbeing, and support for additional community activities and increased upstream investments.

Commissioning requires active engagement with the public and targeted groups, giving them a voice to influence the availability of and access to interventions for physical and mental wellbeing. Community engagement is also essential in tackling health inequalities and to determine what assets are available in the community that can be used to ameliorate the process of turning the deficits model around and we explore different models for community engagement in Chapter 5. Understanding and recognising diversity within communities and developing appropriate methods for engagement to determine interventions to strengthen mental wellbeing will be essential. Too often in the past interventions that have been shown to work in one place are slavishly copied somewhere else without sufficient recognition of age, disability, ethnicity, religion or other important factors. Wellbeing for black and minority ethnic communities may be constructed differently from that for the majority community, and only by developing locally relevant interventions will we get cost-effective, clinically relevant, psychologically appropriate and socially acceptable solutions.

Integration is a difficult concept, especially now (at the time of writing in January 2013) as the government's attitude towards the market in health and social care may undermine the best opportunities to integrate both vertically and horizontally around the citizen (the patient, service user or client). Paradoxically health and wellbeing will only be fully secured once systems and procedures are developed with the service user at the centre. This is one of the contradictions of a public health approach in which the citizen is paramount: it demands a universal focus on health and wellbeing whilst recognising the importance of personalisation.

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an



individual or group must be able to identify and to realise aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. In Chapters 6 to 9 we will consider in detail the interventions that lead to improved health and wellbeing in a number of areas and in Chapter 9 we consider promoting wellbeing for people with ‘particular vulnerabilities’, including people with a diagnosis of mental illness. And in the final chapter we will discover the population effects of all these interventions.

Whilst there is increasingly robust evidence for improved outcomes as a consequence of wellbeing interventions, much hangs on how these are implemented in real-life contexts. There is a tension between fidelity to the intervention as provided by the evidence base and the day to day contingencies that will influence outcomes at a local level. This is the focus for Chapter 10, where we explore how to implement best practice in local settings. In Chapter 11, we consider accountability for outcomes and approaches to evaluating and measuring outcomes including cost-effectiveness and the effectiveness of interventions measured against either professional or service user expectations. Our final chapter provides a synthesis and concludes with a starting point in using this book as a resource to support improvements in population health and wellbeing.

## 1.8 Conclusion

Promoting health and wellbeing demands a composite strategy that draws on assets models to generate solutions to individual health or illness problems, and recognises the value of a range of solutions for generating improved wellbeing from (in some cases) relatively complex multi-disciplinary interventions. Health, whether drawing on a deficit model or an assets model, is a foundation for flourishing but does not, of itself, generate wellbeing. A minimally adequate health is a necessary foundation for maximising wellbeing, but it is not sufficient. As we have discussed, wellbeing derives for a range of social, psychological, emotional, spiritual, economic and familial contexts. Only by getting those right (or at least maximising them depending on circumstances) in the context of a health strategy that seeks equity of access and ability to benefit will it be possible to offer the best health and wellbeing available.

## Notes

- 1 [www.neweconomics.org/publications/measuring-well-being-in-policy](http://www.neweconomics.org/publications/measuring-well-being-in-policy); [www.neweconomics.org/projects/five-ways-well-being](http://www.neweconomics.org/projects/five-ways-well-being) (accessed 25 July 2012).
- 2 For further information see [www.grossnationalhappiness.com](http://www.grossnationalhappiness.com) for a discussion of Bhutan’s GNH index.
- 3 And interdependence!
- 4 See for example Public Health England at [www.lho.org.uk/LHO.Topics/Analytic\\_Tools/Health\\_InequalitiesInterventionToolkit.aspx](http://www.lho.org.uk/LHO.Topics/Analytic_Tools/Health_InequalitiesInterventionToolkit.aspx)
- 5 i.e. is not fully constructed or determined by the intervention.
- 6 See also Zero to Three, at [www.zerotothree.org](http://www.zerotothree.org) (accessed 11 March 2013).