Branch Out Project

Evaluation Report

A report completed for

East Lancashire Community Restart Service

And

Pennine Lancashire Community Farm

This evaluation report was commissioned by East Lancashire Community Restart Service on behalf of the Branch Out project consortium, led by Pennine Lancashire Community Farm.

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Data was provided by the Branch Out project partners:

East Lancs Community Restart Service – Lancashire Care NHS Foundation Trust

Pennine Lancashire Community Farm (Registered Charity No 1140498)

Offshoots Permaculture Project – Groundwork Pennine Lancashire

Lancashire Wildlife Trust

Lancashire Woodlands Project

Forest of Burnley Project

Garden Able (CIC)

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1.0 Introduction

This report is based on data collected from 202 service users referred to the Branch Out project by East Lancashire Community Restart service. East Lancashire Community Restart service utilises a stepped model of care. Step 1 relates to recognition of a problem by primary care services and results in assessment or watchful waiting. Step 2 relates to treatment for mild disorders managed through medication and low level psychological intervention including social prescribing. Step 3 relates to treatment for moderate disorders and is associated with more targeted psychological interventions for example CBT, EMDR, counselling and group therapy. Step 4 relates to patients requiring more complex non-inpatient interventions. Step 5 relates to complex intervention usually requiring inpatient services and/or crisis resolution.

The Branch Out project is a social prescribing partnership between third sector community organisations and statutory mental health services. The partnership is led by Pennine Lancashire Community Farm and provides opportunities for people accessing mental health support services in East Lancashire to engage in Ecotherapy or green activities in order to improve their wellbeing.

2.0 Background

Prior to the setting up of the Branch Out project, the East Lancashire Community Restart Service and Pennine Lancashire Community Farm worked in partnership on delivery of a Care Farm project. This pilot project was funded by East Lancs PCT and enabled service users who were being supported by the East Lancashire Community Restart Service to experience farming and rural activities as part of their personal recovery journeys. The aim of the project was to provide socially inclusive activities in the natural environment thereby maximising the holistic health benefits said to be gained from such nature-based interventions. This local pilot provided some early indicators of the benefits of “Ecotherapy” in terms of improved wellbeing, and created a foundation on which the Branch Out concept was based.

The Branch Out project is led by Pennine Lancashire Community Farm in partnership with East Lancashire Community Restart Service and embraces a consortium approach whereby a variety of provider organisations work together to offer a wider mix of knowledge,

experience and opportunity. Finance for the project was secured via a successful bid for Big Lottery monies, which was administered by MIND under the Ecominds (MIND 2013) funding stream. The amount of the award was £250,000 and was one of only five awarded nationally. The Project began in March 2010 and accepted referrals until end of March 2012, with all sessions being delivered by end of June 2012. Branch Out has provided people with mental health conditions with the opportunity to engage in a choice of green activities which have been facilitated by a project coordinator who both sought to elicit individual preferences and then linked service users up with appropriate activity providers. Participants were able to access up to 12 sessions of various activities including dry stone walling, beekeeping and outdoor photography. The cost of delivery of 12 sessions = £720, based on unit cost per full day session (6hrs) = £60, ½ day sessions (3hrs) = £35.

Following the funded Ecotherapy sessions, on-going volunteering opportunities are available to service users within the partner organisations and the Project also operates a Peer to Peer employment model, providing paid work to a small number of services users on twelve month contracts with PLCF. These roles are supported by the East Lancs Community Restart Employment Team.

2.1 Ecotherapy

Ecotherapy denotes schemes in which participants become physically and mentally healthier through contact with nature (Friedli, 2009). This can include gardening and horticulture, walking in the countryside, green gyms, and developing community green spaces and the Branch Out project provides opportunities for several of these activities and more. Green exercise has been associated with increases in self-esteem and mood (Pretty, 2005) and an evaluation of green gyms (Yerrell, 2008) demonstrated a range of physical and mental health benefits (though neither of these studies considered the needs of mental health service users specifically and Pretty (2005) used images of green spaces rather than actual green spaces. A report presented by MIND (2007) supports the use of Ecotherapy having conducted 2 qualitative surveys of people with anxiety and depression, one focusing on green exercise and one comparing indoor and outdoor exercise. Participants in the first study reported significant benefits in relation to well-being, and in the second study the

outdoor environment compared more favourably than indoors in relation to improvements in self-esteem, depression and tension (self-reports). These findings can be considered encouraging, and the intervention worthy of further evaluation.

2.2 Social Prescribing

Branch Out is based on a social prescribing model. Social Prescribing is a route to reducing social isolation and providing psychosocial and/or practical support to disadvantaged, isolated and vulnerable populations (Keenaghan et al, 2012). It is most often discussed in relation to supporting those with mental health conditions, particularly anxiety and depression and benefits are reported to include emotional, cognitive and social gains. The National Institute for Health and Clinical Excellence (NIHCE) recommends the use of some activities which fall within the remit of social prescribing including, exercise, bibliotherapy and social support (NIHCI 2004a, 2004b) and Frideli (2003) suggests that green activities such as those provided by the Branch Out project are legitimate activities to be included in social prescribing schemes. There is limited information as to the value for money of these schemes, particularly in comparison to other interventions, however a cost benefit analysis (Marsh et al 2011) of a Be Active project in Birmingham UK determined that the (Be Active) scheme was cost effective and generated a return on average of £21.30 in quality of life related benefits (to the NHS and Local Authority) for every £1.00 invested in the scheme.

Social prescribing can take a range of forms, but there are a number of common elements to what has been described by Friedli (2003) as “best practice” in social prescribing and the Branch Out project achieves most of these elements. The primary care team should be a central component, acting as referrers or sometimes co-ordinators of care. In this case it is the statutory funded Community Restart teams who sit across primary and secondary care that are the key referrers. Activities to which people are referred must be non-medical and are located in the local mainstream community, often provided by voluntary and community organisations as is the case with Branch Out. There may be an information resource or directory of services made available to people, to facilitate their choice of activity and Branch Out has this via its promotional literature and referral form, which

contains a menu of activities on offer through the project. Furthermore it is suggested that social prescribing schemes should be user led with service users involved as key stakeholders from the offset which again has been a key component of the Branch Out project. Perhaps the only way in which this project does not quite meet the ideal for best practice is in relation to care co-ordination. It is recommended that there should be a care coordinator who acts as a link between health professionals and the community services, and to date this role has been undertaken only on an ad-hoc basis by a member of the Branch Out project team.

3.0 Evaluation

Evaluating the impact of social prescribing is complex. Commentators have suggested that impact should be measured in relation to the service user (symptoms, wellbeing, social determinants), the service provider (economic, waiting times, attendance, frequency) and the community (prescription behaviours, increased social capital, community inclusion) (Keenaghan 2012). This project mainly evaluates the impact of the intervention on the wellbeing of the service user.

NB: It should be noted that this is a practice evaluation, rather than a research study and the findings should be considered accordingly. There has been no attempt to secure a representative sample for this evaluation, nor has consideration been given to sample size calculations or control for variables during the course of the intervention. This means that any increase in wellbeing cannot conclusively be attributed to the intervention though it is very reasonable to consider that there MAY be a relationship between intervention and outcome.

3.1 Method

3.1.1 Participants were referred to the Branch Out project by East Lancs Community Restart teams. Descriptive data relating to age, sex, diagnosis and source of referral was collected at the point of referral.

3.1.2 The main source of evaluative data relates to improvements in well-being as measured by the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), which was administered pre and post intervention (the intervention was of 12 session's

duration). The WEMWBS is a scale for assessing positive mental health (mental well-being) and was developed in 2007 following a UK evaluation of a longer mental wellbeing measure (Affectometer 2), a review of the literature and the support of a multidisciplinary expert panel (Tennent et al 2007). The full version of the WEMWBS is a 14 positively worded item scale with five response categories. It covers most aspects of positive mental health (positive thoughts and feelings) currently in the literature, including both hedonic and eudemonic perspectives (Stewart Brown et al 2009). Initial validation using student populations was followed up by the inclusion of WEMWBS in two national Scottish surveys (2006 September wave of the Health Education Population Survey (HEPS) and the 2006 Well? What do you think survey?) and data analyses showed that WEMWBS performed equally well in the general population as in student groups. It is also sensitive to change in psychiatric populations and is therefore suitable for use in this context (Tennent et al 2007).

3.1.3 This evaluation uses the abbreviated 7 item scale, which has also been judged to be a valid and reliable tool for measuring mental wellbeing with the advantage of being quicker to complete.

3.1.4 Some qualitative data was also captured in the format of video diaries in order to provide feedback on the intervention to the Branch Out co-ordinator however the quality of these was too poor for detailed analysis.

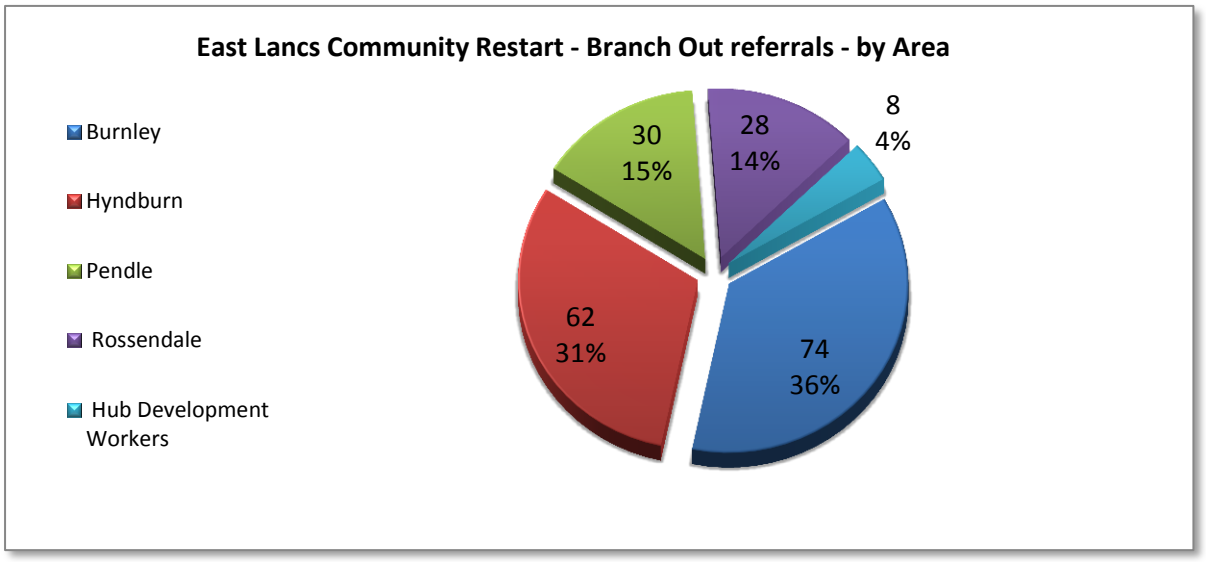
3.1.5 There is a small amount of data that has been collected from participants who did not complete the intervention and this has been considered as appropriate.

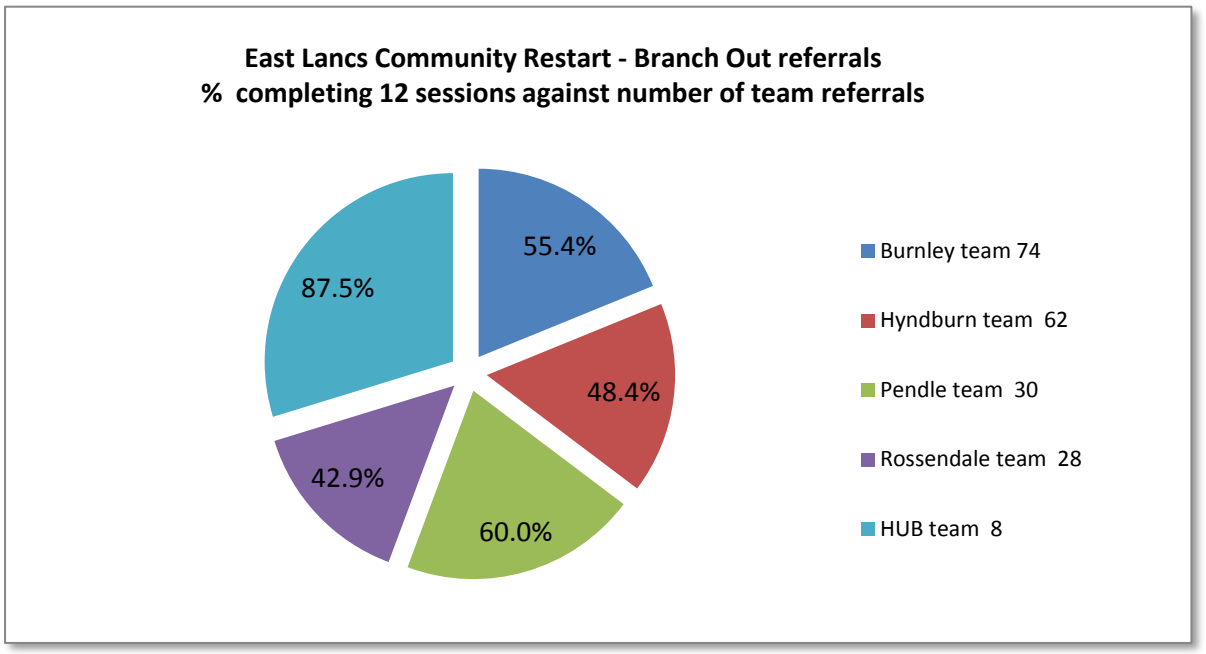
3.2 Results

NB. East Lancs Community Restart service operates a hub and spoke model for its teams and the hub teams are not primarily involved with making referrals into Branch Out. The data in the charts relating to hub referrals was collected purely a means to differentiate a small group of people who accessed Branch Out through the development workers, but did not require full social inclusion support from the STR teams. This data is not therefore appropriate to include in the analysis, however it remains included in order to give a complete picture.

3.2.1 Overview

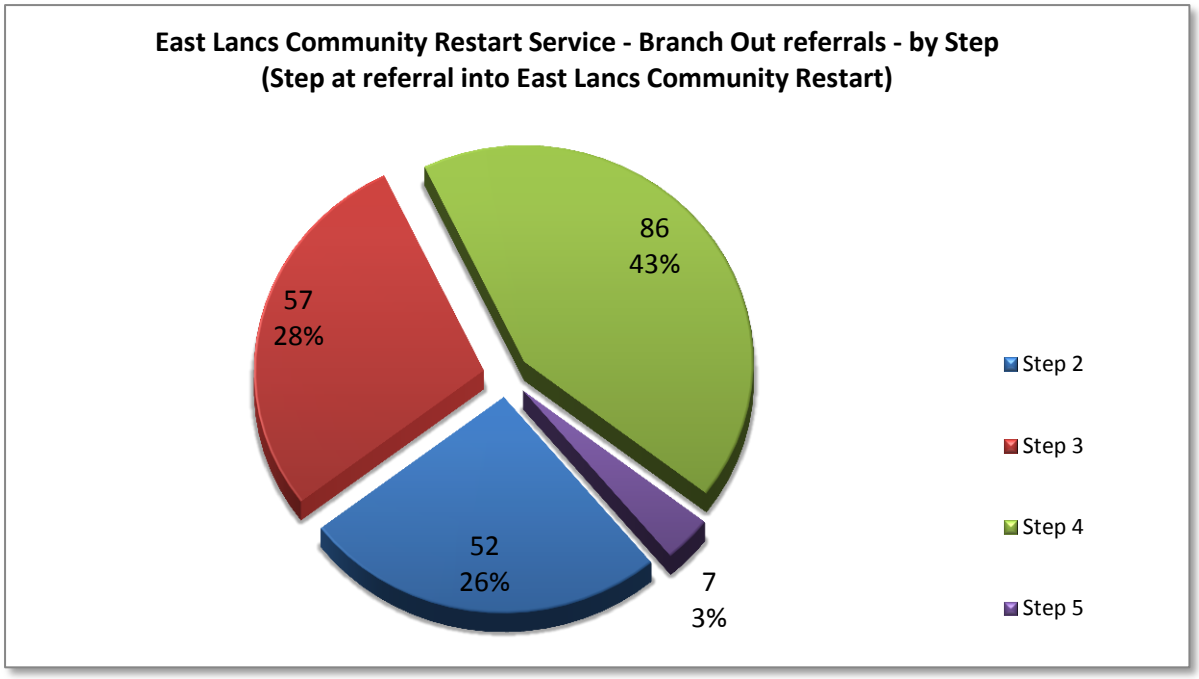
202 people were referred to the Branch Out project by East Lancs Community Restart Service and in total 106 service users completed the 12 sessions. The majority of referrals came from the Burnley area team.





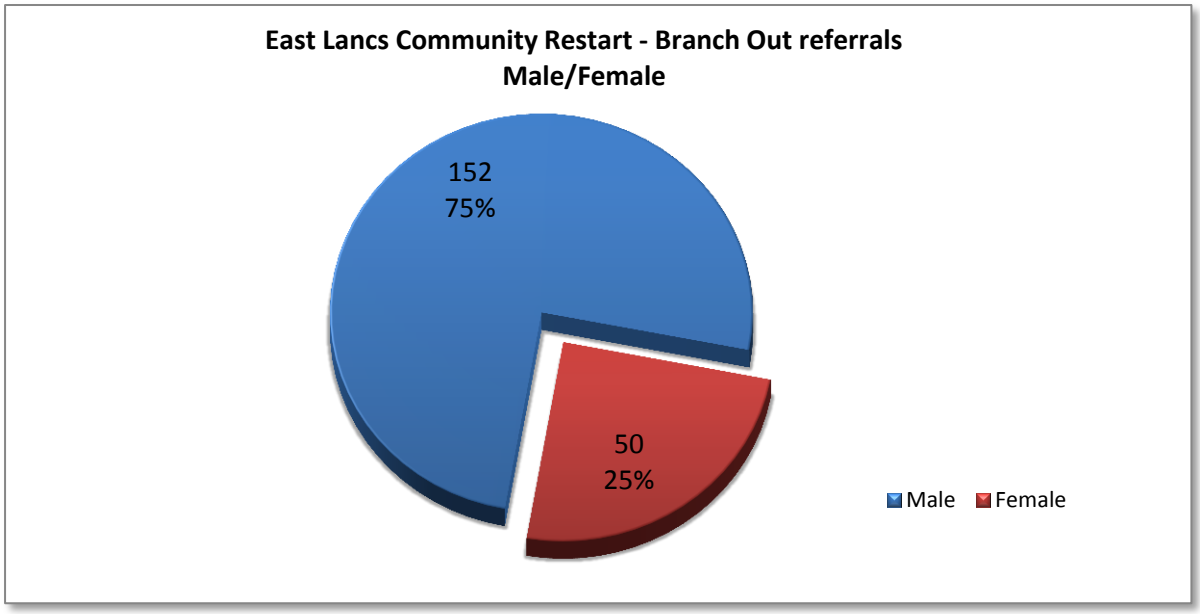
3.2.2 Referral by Step

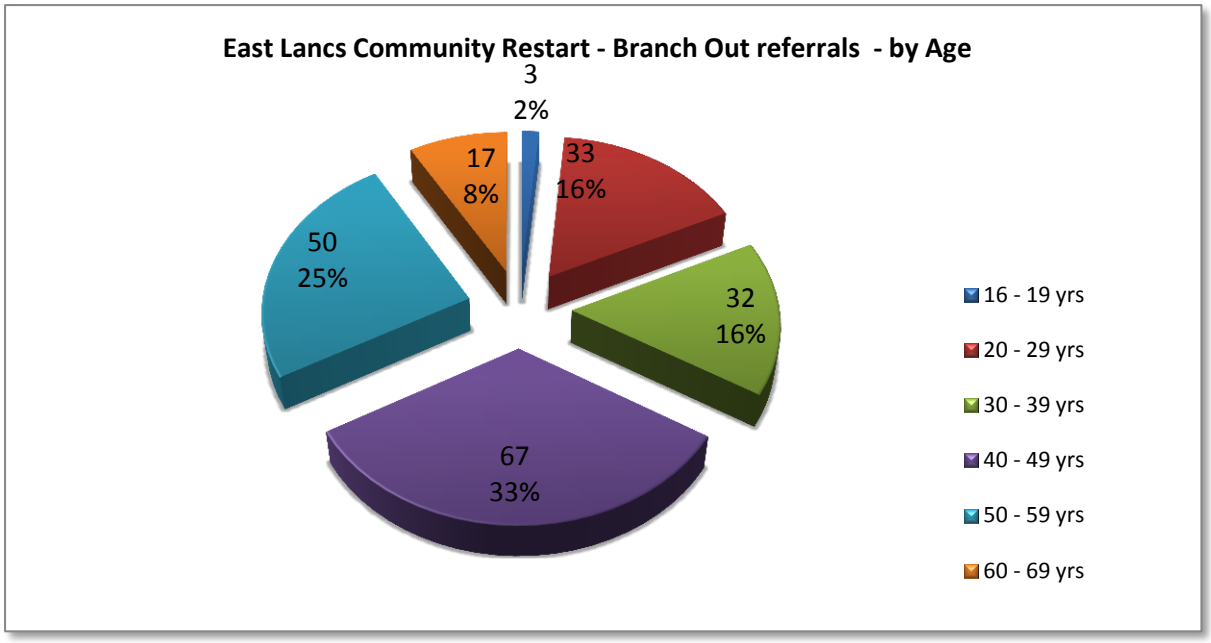
The referral scheme is based on a stepped model of care prevalent across LCFT. The biggest group of referrals 86 (43%) were from Step 4, followed by Step 3 at 57 referrals (28%), then Step 2 at 52 referrals (26%) and Step 5 at 7 referrals (3%).



3.2.3 Referral by gender and age

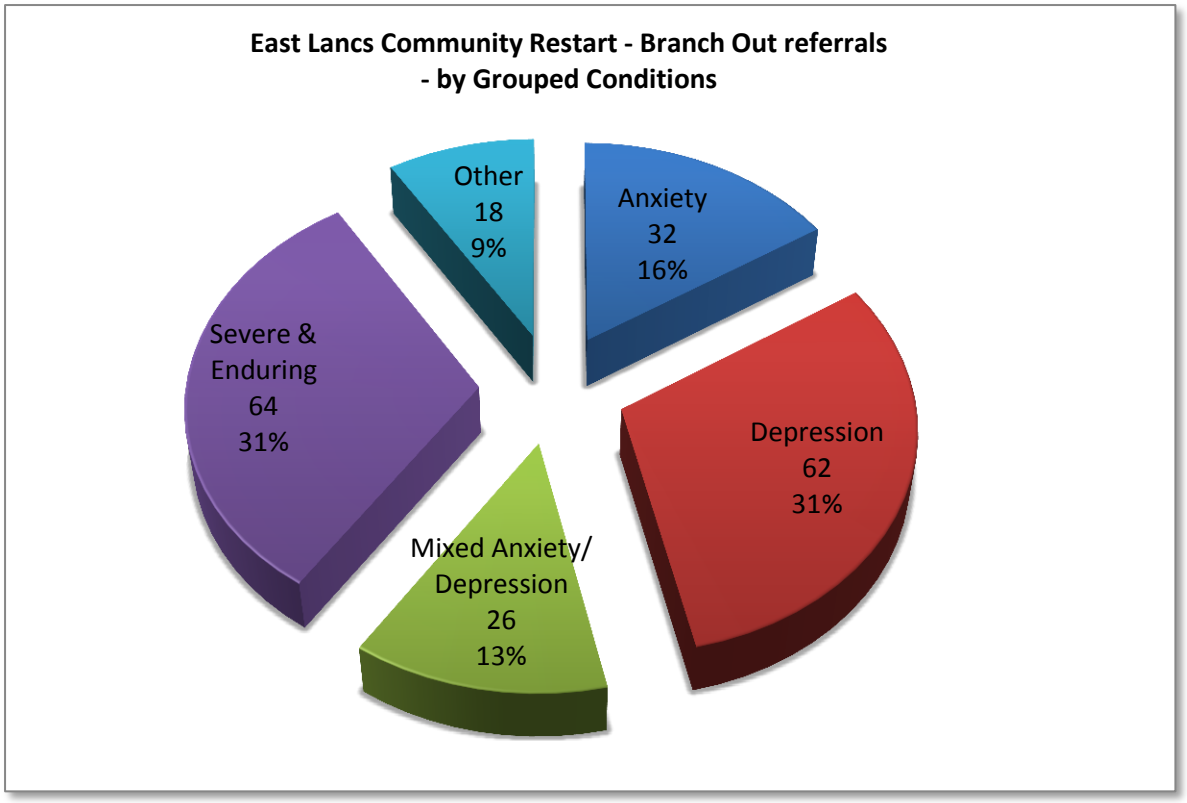
75% of all referrals were male and 25% female. Most (33%) of referrals fell into the 40-49 age group and all referrals were adults of working age.





3.2.4 Referral by diagnosis

The two most common diagnostic categories for referrals are severe and enduring mental health conditions and depression, each making up 31% of referrals (62% in total). The highest number of referrals to Branch Out came from the Burnley area Community Restart team.



3.2.5 Non engagement

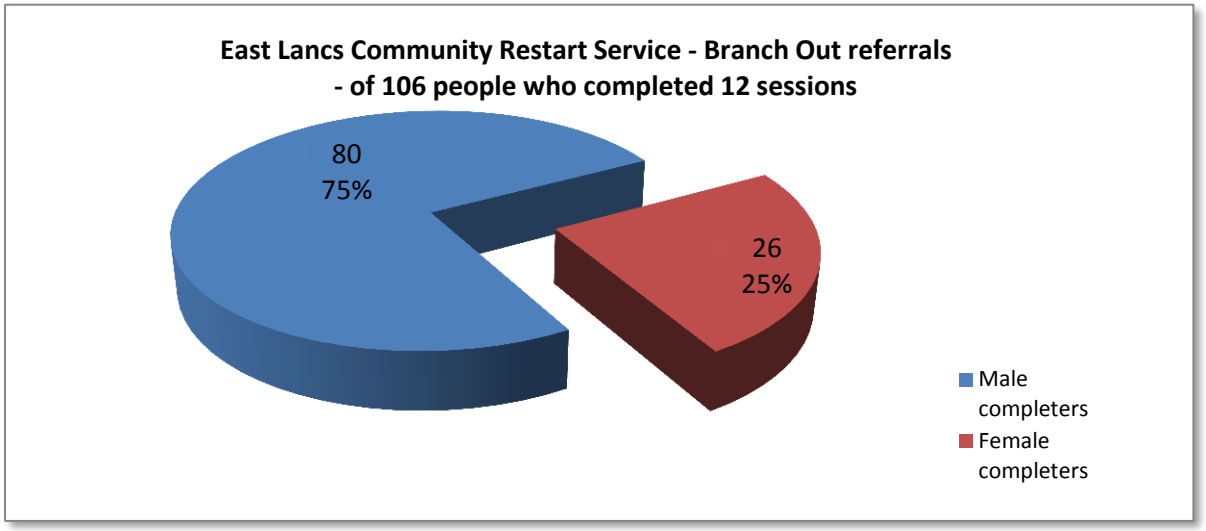
50 (24.8%) of those referred to the project did not engage at all. A small number of those who did not engage went into education or relapsed, and one patient moved house. The remainder (36 service users) failed to respond to follow up and the reasons for their non - engagement are not known.

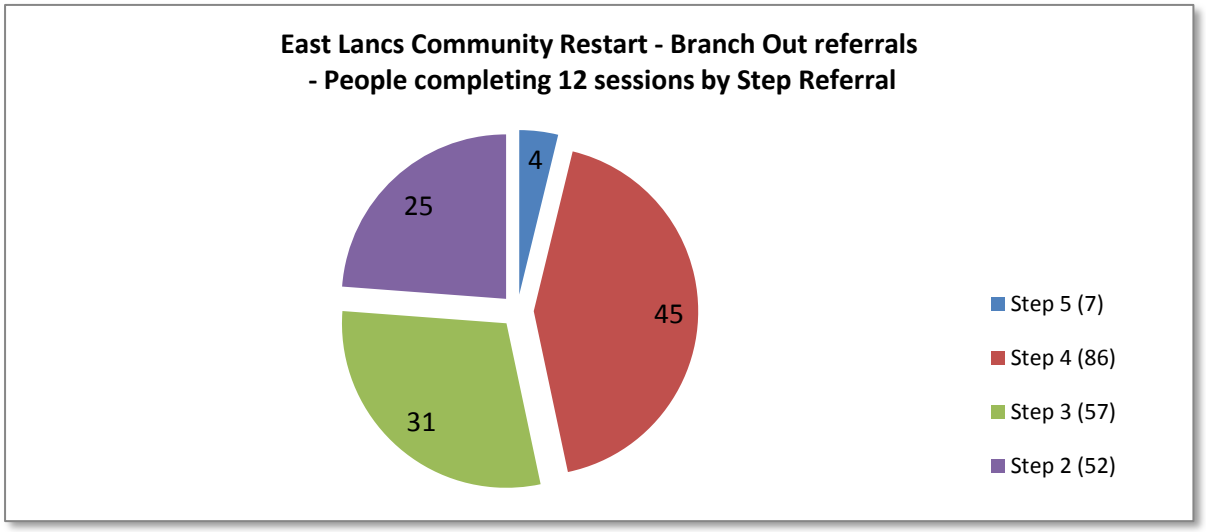
3.2.6 Non completion

46 (22.8%) did not complete the intervention. Of those who did not complete again a small number went into education, relapsed or relocated however the majority of non-completers (31 service users) did not complete for reasons unknown.

3.2.7 Completers by gender and step

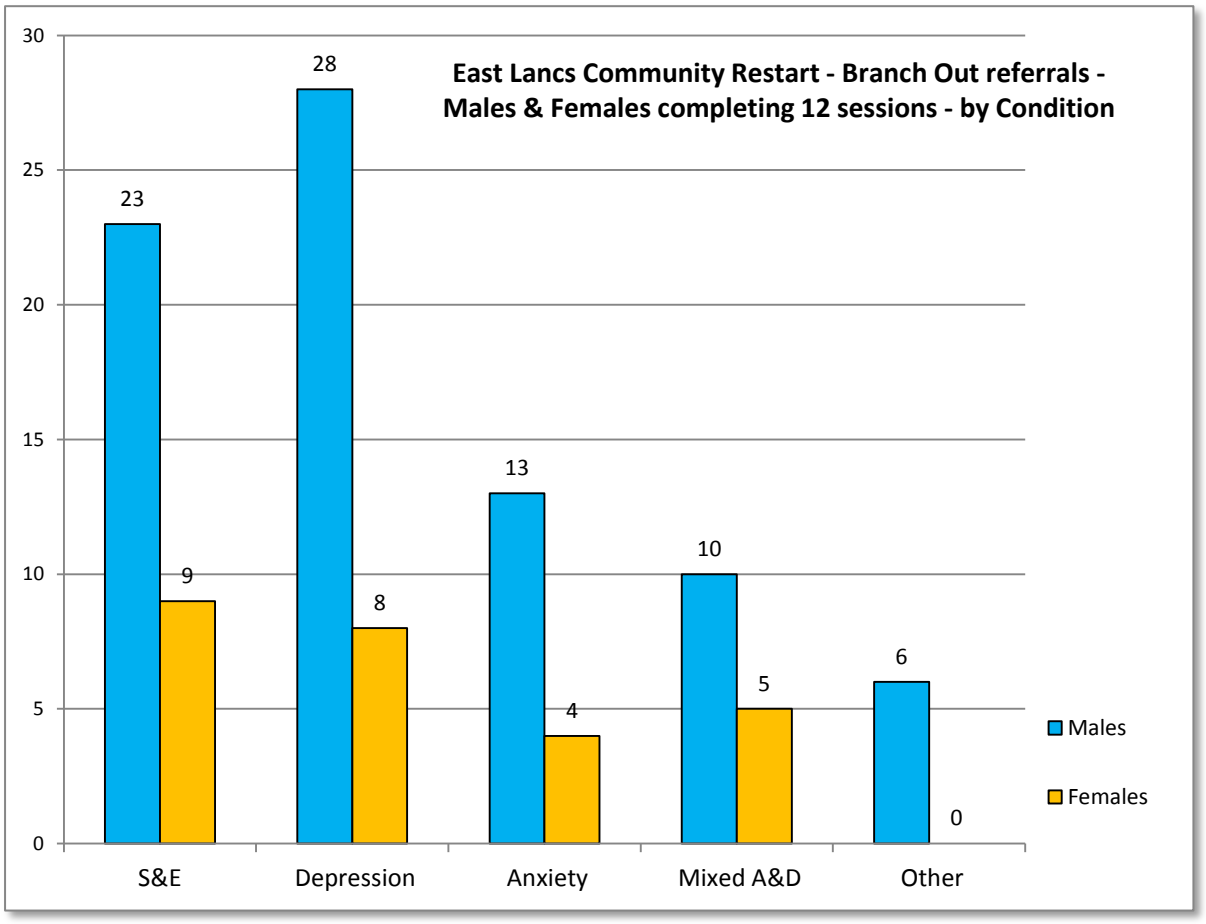
106 service users (52.4%) completed the full twelve session's intervention. Of these, 80 (75%) were male and 26 (25%) were female.





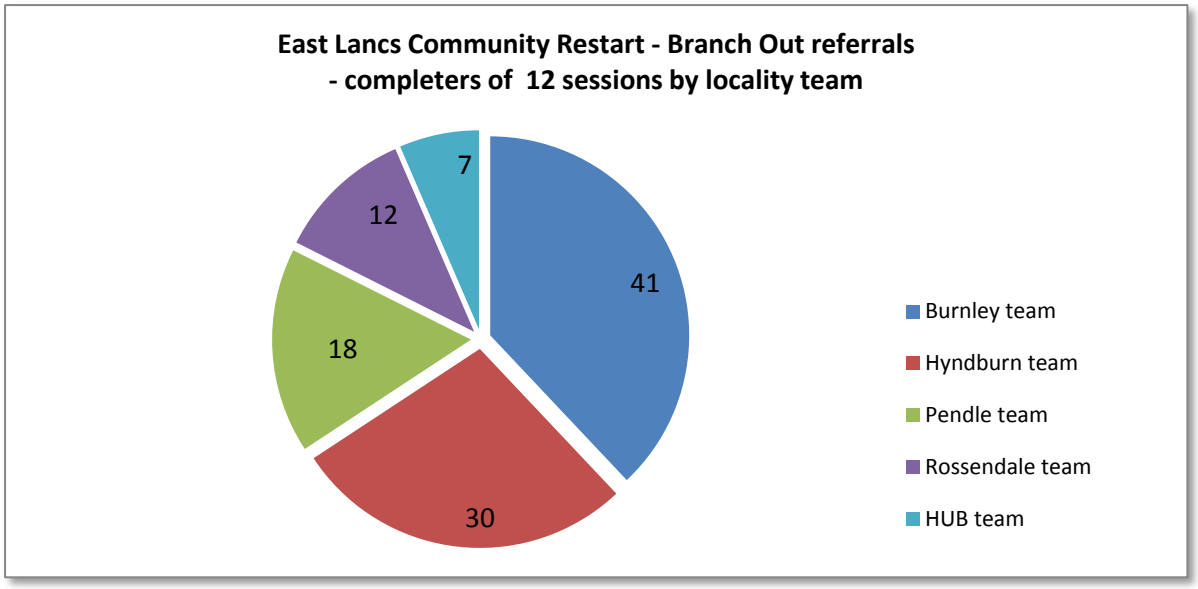
3.2.8 Completers by condition

The highest number of completers by condition are those with depression (36 service users), followed by those with severe and enduring conditions (32 service users). Half of the total number of people referred with severe and enduring conditions completed the intervention and 58% of the referrals for people with depression completed the intervention.



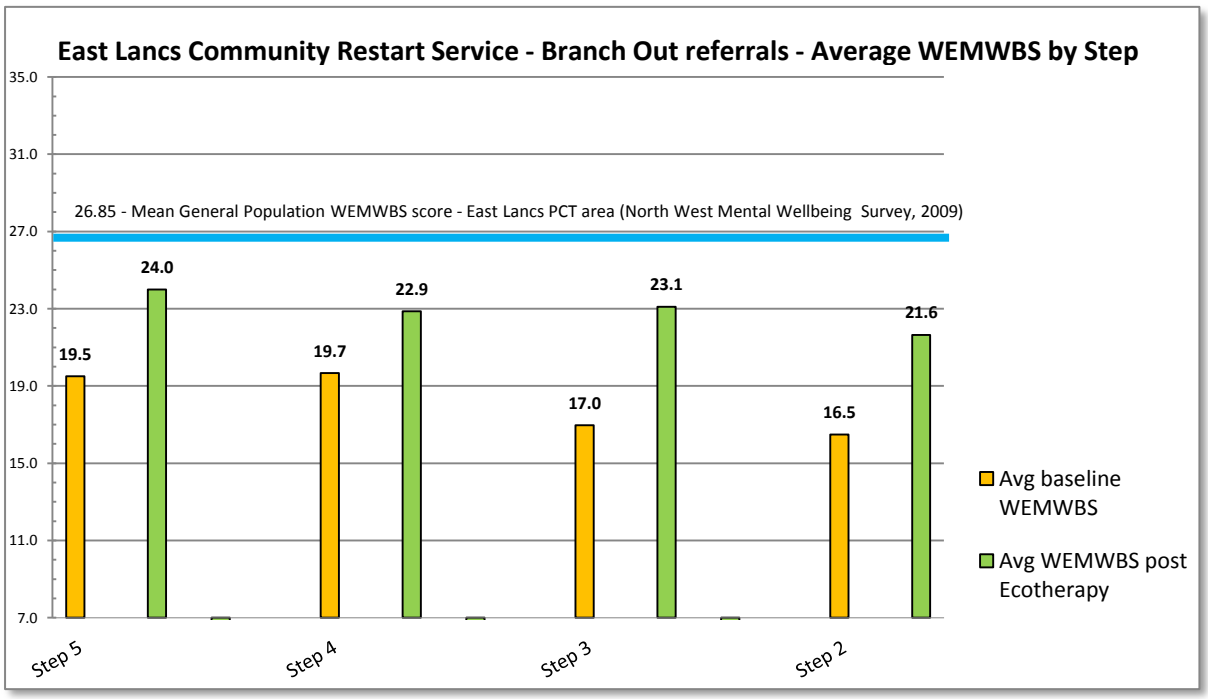
3.2.9 Completers by area

55% of those referred from the Burnley area completed the intervention and 48% from Hyndburn area completed. It is interesting to note that 60% of referrals from the Pendle area completed even though referrals from this area are a relatively small amount of the overall referrals to the project (15%)



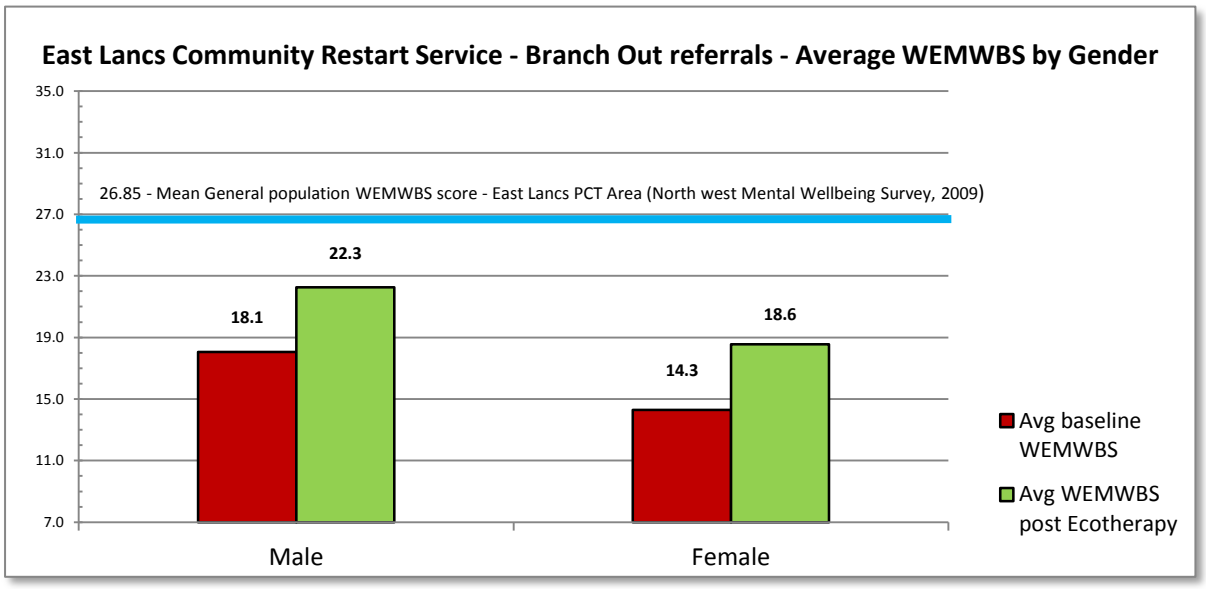
3.2.10 Impact of Ecotherapy in relation to step

Step 2 (mild disorders) shows the lowest baseline measure of wellbeing at 16.5, with step 4 (complex disorders) showing the highest baseline at 19.7. Post intervention sees an increase in wellbeing across all steps, however it is step three (formal psychological interventions) that sees the largest increase of 6.1 points and step 4 showing the smallest increase (3.2 points). Step two (most commonly recognised as benefiting from social prescribing) and step 5 (inpatient services) both show the same increase of 4.5 points.



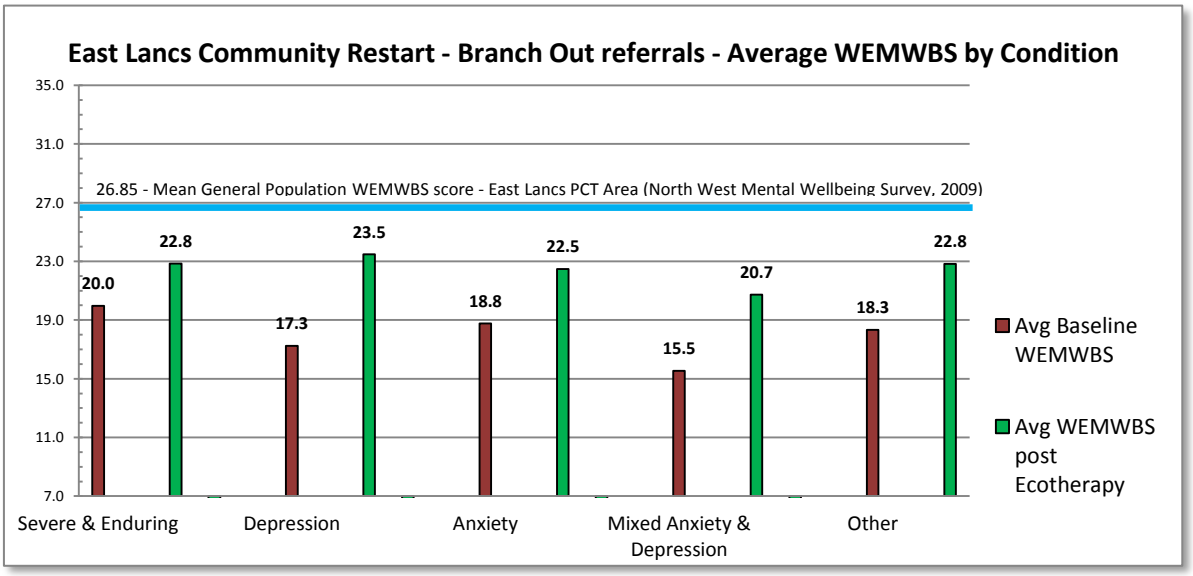
3.2.11 Impact of Ecotherapy on wellbeing in relation to gender

The mean wellbeing score for males pre-intervention is 18.1 which is higher than the same score in females. Post intervention sees a mean increase to 22.3 in males and 18.6 in females. Despite scoring their wellbeing as lower overall, females see a slightly bigger post intervention improvement than the males (4.3 points as opposed to 4.2 points).



3.2.12 Impact of Ecotherapy in relation to diagnosis

The most significant increase can be seen amongst those who have depression (6.2 points) followed by those who have mixed anxiety and depression (5.2 points). The smallest increase in wellbeing is in those with severe and enduring mental health conditions (2.8 points)



4.0 Analysis

4.1 At first glance it may seem that the attrition rates for this project are high, however this should be considered in light of the client group. It is well documented that engaging people with mental health problems in treatment is difficult (Mitchell and Selmes, 2007) and (Richards and Borglin, 2011) and there is no reason to suggest that the Branch Out project attrition rates are inconsistent with the general picture.

4.2 Given the overview of the stepped care model and associated interventions it would have been reasonable to assume that the majority of referrals to the Branch Out Project would have come from step 2 (mild disorders managed through medication and low level psychological intervention including social prescribing) but this was not the case, with the 71% of total referrals indicating a higher level of complexity than that which is normally associated with social prescribing.

4.3 It is interesting to note that the majority of referrals came from Burnley, closely followed by Hyndburn and would be interesting to understand if this reflects different communities and incidence and prevalence of mental illness within them, or if it is something related to the referral process specifically which may be precluding referrals.

4.4 Overall those most likely to take up this initiative and to complete it have anxiety and/or depression. Higher levels of engagement and completion amongst this population is congruent with the literature and may be because this group are more likely to have some insight into their condition, to be motivated to seek help and able to better understand the potential benefits of a social prescribing scheme or Ecotherapy specifically. Having said that, 50% of those referred with severe and enduring conditions completed the programme and this is very positive given the challenges in engaging this particular group in social prescribing initiatives.

4.5 The majority of referrals to Branch Out were for men (75%), which may be unusually high, and this is also reflected in the completion figures. It could be hypothesised that referrers view the Branch Out project and activities as an acceptable intervention for men (hence the number of referrals) and it can also be suggested

that a lot of those men who are referred to the service feel the same way. Given that engaging men in psychological therapies is challenging, this adds an interesting dynamic to the project and it would be useful to explore WHY men in particular find this an acceptable intervention. The men who completed were most likely to have depression, which is concurrent with other literature; however they are closely followed by men with severe and enduring conditions who are again a difficult to engage group due in part to the chaotic nature and poor volition sometimes associated with this of this type of illness.

4.6 Overall though, approximately half of the people referred to the Branch Out project did not take up the referral or complete the project. In the absence of significant qualitative data it impossible to know for sure why this was the case, though it could be speculated that it may be due in part to the nature of the various conditions and to the appeal and availability of the various activities on offer as well as their perceived potential benefit. There may also be resource issues to consider in relation to the level of follow up and assertive outreach provided to non-engagers and non-completers. The non-engagers and non-completers remain a useful source of learning though, and this could be exploited in order to further develop the services in relation to reducing attrition.

4.7 The mean general population WEMBWS score for East Lancs PCT area (North West Mental Wellbeing Survey 2009) is 26.85. The mean pre or post scores for those who completed this intervention did not reach this level, however it can be noted that the gap between this population's wellbeing and the general population has narrowed. This is consistent across step, gender and diagnoses.

4.8 The stepped model of care is complex in and of itself and so these findings must be considered with this in mind. It should be noted that patients move through steps, and this data reflects the step allocated to the patient at the time of referral, although given the timeframe of the intervention it is reasonable to assume that most patients would have remain within the same step for its duration.

4.9 The data seems to indicate that this may be a useful intervention for all steps, including step 3, 4 and 5 service users who have more complex needs than would

usually be associated with this type of intervention. This is where it is very important to acknowledge the limitations of this evaluation. Those people in steps 3, 4 and 5 are more likely than step two service users to be having concurrent psychological therapies and medical intervention which may assist them in being able to benefit from this one, or which may have skewed the data as extraneous variables. It is not possible here to know exactly which of these interventions has generated the increase in wellbeing, particularly as there is no control group. It is however reassuring that an increase in wellbeing is seen in step two as expected, given that social prescribing is an integral part of this step.

4.10 The next element of the analysis is gender. Men and women may have different perceptions of wellbeing, or may have difference in overall wellbeing however it would seem that both men and women have shown a very similar level of improvement following intervention. This is interesting given that women make up a small percentage of completers (25%), yet the intervention seems to have some benefit to them. It is reasonable to assume that this intervention may benefit more women than those who have availed themselves of it.

4.11 Consideration of impact by condition is important. It could be surmised that this may be a particularly useful intervention for people with depression; one of the most common referral conditions. It seems less useful for severe and enduring conditions (the other most common referral condition) however in the absence of comparative data it is impossible to really understand the significance of either of these increases other than to note that there ARE increases.

5.0 Conclusion

The Branch Out project has been successful in delivering Ecotherapy interventions to a wide range of service users. It can be concluded that the Consortium have developed an effective model for social prescribing, and have been able to deliver an intervention which is acceptable to male and female service users across a range of steps, geographical areas and clinical conditions. There are some issues with non-engagement and attrition, and whilst the reasons for this remain unknown due to lack of data, it is considered that they may be due to issues typically experienced by the client group. It is extremely encouraging that every

person who did complete the programme reported improvements in their perception of wellbeing and whilst this cannot be conclusively attributed to the intervention it must be considered as a very real possibility. The encouraging data arising from this evaluation justifies the need for further research in order to understand more conclusively the impact of Ecotherapy on the wellbeing of people with mental health problems.

6.0 Recommendations

6.1 At a strategic level it would be extremely useful to establish beyond probability the relationship between the intervention and the outcome and to better understand the service user's *experience* of the project, including non-completers. The most effective way to establish the impact of the intervention would be a randomised clinical trial (RCT), however other scientific methodologies may also be considered. This should be supplemented by qualitative studies focusing on some of the issues generated in this report. To undertake research at this level would involve considerable investment and a very specific skill mix. Research funding opportunities should be considered and collaboration with an academic partner is recommended.

6.2 Given the ratio of engagement to non-engagement and completion to non-completion generally, it would be useful to understand this more fully in order to be able to take action to improve these ratios.

6.3 There is a need to understand the issue of non-uptake and non-completion by those with enduring mental health issues more fully in order to be able to provide services that are useful and acceptable to this priority population.

6.4 It may be necessary to consider alternative engagement strategies, for example adopting an assertive outreach approach to complement the social prescribing model and investing more time in key working the at risk individuals.

6.5 This intervention could be promoted as particularly appealing to men generally and specifically to men with depression closely followed by men with severe and enduring conditions. It would be useful to further understand the reasons why fewer women than men were referred to the service, or completed the intervention in order to examine if it would be possible to take action that would engage women

in an intervention that seems to indicate a positive impact on wellbeing. This may involve discussion with the referrers, the non-completing women, those that did complete, and the service providers. The findings should be considered in relation to relevant research literature.

6.6 Consideration must also be given to evaluating the economics of this intervention in relation to value for money and added benefit over, for example, medication or other interventions provided within the steps. Again, this would be a complex initiative but one for which research funding could be sought and which may provide useful data to inform the commissioning process.

6.7 Assuming the project were to continue in its current format consideration should be given to a number of operational issues including to the reasons why referrals from Burnley are higher than other areas and then action may be taken to emulate good practice if appropriate.

7.0 Sources of potential research funding

7.1 National Institute for Health Care Research:
http://www.nihr.ac.uk/research/Pages/programmes_research_programmes.aspx

7.2 Research for Patient Benefit (inspired by patients and practice)
http://www.ccf.nihr.ac.uk/RfPB/Pages/home.aspx

7.3 NHS National Innovations Centre http://knowledge.nic.nhs.uk/

7.4 Mental Health Research UK http://www.mhruk.org/

7.5 The Big Lottery http://www.biglotteryfund.org.uk/funding/funding-finder

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