Voluntary sector interventions to address loneliness and mental health in older people: taking account of emotional, psychological and social wellbeing

DAYSON, Christopher <http://orcid.org/0000-0003-2402-1183>, HARRIS, Catherine and WOODWARD, Abigail

Title

Voluntary sector interventions to address loneliness and mental health in older people: taking account of emotional, psychological and social wellbeing

Accepted for publication in Perspectives in Public Health 23/04/2021

Authors

Chris Dayson, Catherine Harris and Abigail Woodward

Centre for Regional Economic and Social Research, Sheffield Hallam University

Correspondence

Chris Dayson
Associate Professor
Centre for Regional Economic and Social Research,
Sheffield Hallam University
Sheffield
S1 1WB
Tel: 0114 225 2846
Email: c.dayson@shu.ac.uk

Abstract

Aims

(A) To explore the relationship between loneliness and mental health in older people accessing interventions delivered through the voluntary sector. (B) To understand how these interventions can take account of mental health, discussing the relative strengths of a number of different one-to-one and group-based interventions.

Methods

Qualitative case study of Age Better in Sheffield (ABiS), an initiative to address loneliness and isolation amongst older people (aged over 50). 37 beneficiaries of voluntary sector interventions participated in the study: 17 had accessed a one-to-one intervention and 20 had accessed group-based activities.

Results

One-to-one therapeutic interventions are beneficial when loneliness is associated with low psychological and emotional wellbeing stemming from trauma and other complex pre-existing issues that have left individuals unable to build social relationships and networks. *One-to-one peer-to-peer interventions* are beneficial for individuals whose loneliness is linked to low psychological and emotional wellbeing but for whom their issues are less complex. *Group-based* interventions are beneficial when loneliness is linked to social wellbeing and individuals want to build social networks and relationships and contribute to their community. Participants should be supported to access other forms of support if the benefits of the initial intervention are to be sustained.

Conclusions

There is an inter-connected relationship between loneliness and the emotional, psychological and social components of mental health that should be taken into account in the design of interventions. A range of one-to-one and group-based interventions are necessary to meet the varying needs and circumstances of older people experiencing loneliness. Public health commissioners should invest in an ecosystem of voluntary organisations providing different types of loneliness intervention if the epidemic of loneliness is to be addressed.

1. Introduction

Loneliness is one of our most pressing public health issues of our time (1). Feeling lonely often is linked to early death (2), increased risk of coronary heart disease and stroke (3), depression, cognitive decline and an increased risk of Alzheimer's (3, 4). Surveys have estimated that five per cent of UK adults feel lonely 'always' and a further 16 per cent 'some of the time' (5).Addressing loneliness is increasingly being prioritised by public sector bodies and independent funders who have, in recent years, commissioned a wide range of interventions to address the issue and learn more about 'what works'. Voluntary sector organisations are often commissioned to deliver these interventions but there remains a lack of high-quality evidence to demonstrate their impact (6). The Campaign to End Loneliness has also highlighted the contested nature of what constitutes a 'loneliness intervention'. They suggest that some of the approaches which show most promise are not the lunch clubs, social groups, and befriending schemes that receive most evaluative attention, but other types of approach that work with individuals at a stage before they begin start to access community activities, such as counselling and other types of therapeutic support.

Understanding the relative strengths of a number of different voluntary sector loneliness interventions in addressing the complex factors which affect individuals' loneliness and mental health is the focus of this article. We draw on evidence collected through a case study of the Age Better in Sheffield (ABiS) programme to address two broad aims:

A. To explore qualitatively the relationship between loneliness and mental health in older people accessing interventions delivered through the voluntary sector.

B. To understand how interventions to address loneliness in older people can take account of mental health needs and circumstances; and identify implications for policy and practice.

2. Understanding mental health as flourishing emotionally, psychologically and socially

The Government Loneliness Strategy (1) emphasises the link between loneliness and wellbeing and the need to improve people's social support, connections and relationships if loneliness is to be addressed. For this article we extend the concept of wellbeing to cover mental health, including the presence or absence of mental health conditions, and employ a definition of mental health that encompasses emotional, psychological, and social 'flourishing.'

The idea of mental health as flourishing has emerged from the field of public mental health, which has struggled to embed asset-based philosophies of care (7) within services (8), which still seek to focus treatment on perceived deficits associated with mental ill-health (9). Advocates of mental health as flourishing argue that full mental health, when defined from the viewpoint of individuals, requires a salutogenic focus alongside pathological considerations (10). This means epromoting positive mental health and quality of life so that people can flourish emotionally, psychologically and socially (table 1).

Table 1: The factors and dimensions of mental health as flourishing

Factors	Dimensions
Hedonia (emotional wellbeing)	1. Positive affect: cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
	2. Avowed quality of life: mostly or highly satisfied with life overall, or in domains of life
Positive psychological functioning (psychological wellbeing)	3. Self-acceptance: holds positive attitudes toward self, acknowledges, likes most parts of personality
	4. Personal growth: seeks challenge, has insight into own potential, feels a sense of continued development
	5. Purpose in life: finds own life has a direction and meaning
	6. Environmental mastery: exercises ability to select, manage and mould personal environs to suit needs
	7. Autonomy: is guided by own, socially accepted standards and values
	8. Positive relations with others: has, or can form, warm, trusting personal relationships
Positive social functioning (social wellbeing)	9. Social acceptance: holds positive attitudes towards, acknowledges, and is accepting of human differences
	10. Social actualisation: believes people, groups and society have potential and can evolve or grow positively
	11. Social contribution: sees own daily activities as useful to and valued by society and others
	12. Social coherence: interest in society and social life, and finds them meaningful and somewhat intelligible
	13. Social integration: a sense of belonging to, and comfort and support from, a community

Source: Provencher and Keyes, 2011

Applying this framework to loneliness interventions enabled us to take account of the following factors:

- *Emotional wellbeing:* how an individual's positivity, quality of life and life satisfaction is related to loneliness.
- *Psychological wellbeing:* how an individual's sense of themselves, their sense of purpose and autonomy is related to loneliness.

- *Social wellbeing:* how an individual's involvement in social groups and networks is related to loneliness.

The rationale for applying a broader understanding of mental health is supported by other research in this field which has highlighted the potential of voluntary sector led interventions to increase self-esteem and self-efficacy through development of support networks whilst also reducing symptoms of mental ill-health (11). Recent studies of social prescribing, for example, identify the contribution community-based interventions make to the emotional, social and psychological components of wellbeing (12); and how opportunities to meet and socialise in the community reduce social isolation and help improve confidence, self-esteem and mental health (13, 14).

3. Methods

This article draws on a case study of Age Better in Sheffield (ABiS) , a six-year £6 million programme to reduce loneliness and social isolation amongst older people (aged over 50) in the city of Sheffield (Yorkshire, UK) between 2015-21. . ABiS commissioned local voluntary organisations to develop and deliver interventions to 'test and learn' about 'what works' in reducing loneliness and isolation for older people. This enabled the delivery of 16 different interventions providing a combination of group-based, peer-to-peer and therapeutic support. The interventions were based on the principles of the 'Five Ways to Wellbeing', a set of evidence-based actions to promote people's wellbeing: Connect, Be Active, Take Notice, Keep Learning and Give. This article focusses on four interventions that received the largest amounts of funding and were delivered over the longest period.

Table 2. Overview of ABiS interventions covered by this article

Intervention	Type	Summary
Wellbeing Practitioners	Therapeutic	Counselling and therapeutic support, through individual or group sessions for people over 50 whose low mental wellbeing is the main cause of loneliness. Support can be provided at home or in a community venue and is delivered by professional counsellors from Sheffield Mind.
Age Better Champions	Peer-to-peer	Linking people aged 50+ who have experience of loneliness with people aged 50+ who are currently experiencing loneliness.
Peer Mentoring	Peer-to-peer	Linking people aged 50+ with those at risk of loneliness due to a life transition or life changing experience.
Start-up	Group-based	Financial and practical support for people aged 50+ who are interested in setting up a social group in their local community that aims to reduce loneliness. Through Sheffield-based arts charity Ignite Imaginations, a range of groups have been set up, including dementia cafes, martial arts groups, and creative doodle classes.

The study utilised a nested qualitative case study design (15). ABiS provided the overall case, with four interventions described in table 2 serving as nested cases within it. 37 intervention beneficiaries participated in the study (table 3): 17 had accessed a one-to-one intervention and 20 had accessed group-based activities. For the Wellbeing Practitioners, Age Better Champions and Peer Mentors interventions, semi-structured interviews with beneficiaries were undertaken. Participants were sampled purposively from the ABiS database using the following criteria: age, gender, ethnicity; pre-intervention loneliness score. For Start-Up interventions, which did not collect routine data on beneficiaries, participants were sampled

opportunistically by members of the Research Team attending events and activities organised by three groups: the Asian Women's Group, Tuneless Choir, and High Five Group.

Data were collected through a combination of semi-structured one-to-one and group interviews, and focus groups, based on researcher judgement about the most appropriate method for each setting. A common topic guide was used across the different interventions.

Ethical approval was provided through the (HEI) Research Ethics Committee. All participants were informed about the purpose of the study, issued with a participant information sheet and agreed to participate prior to interview. A member of the Research Team confirmed that participants understood the purpose of the evaluation before signed consent to participate was obtained.

Table 3: Overview of research participants by intervention and method

Intervention	No of interview participants	No of focus group participants	No of Group interview participants	Total*
One-to-one	**21**	**n/a**		**17**
Wellbeing Practitioners	9	n/a		9
Age Better Champions	6	n/a		6
Peer Mentoring	6	n/a		6
Group (Start-up)	**11**	**7**	**6**	**20**
Asian Women's Group	6	7	n/a	7
Tuneless Choir	4	n/a	4	8
High Five Group	1	n/a	2	3
All interventions*	**32**	**7**	**6**	**37**

*Note that the columns and rows do not always sum to the total figure as five participants engaged with more than one ABiS intervention, and some of the focus group participants also participated in interviews.

Interviews were digitally recorded and transcribed verbatim and transcripts were anonymised. NVivo was used to collate and manage data and to facilitate thematic analysis. Following a re-reading of each transcript by two members of the Research Team to ensure inter-coder reliability, a coding framework was developed iteratively based on a process of induction and deduction (16) to generate common themes and sub-themes according to the structure of the topic guide. A further phase of analysis was undertaken to integrate our mental health as flourishing analytical framework, with the original themes and sub-themes

compared against the factors and dimensions set out in table 1, followed by a re-reading and re-coding of relevant data under those themes and dimensions.

4. Findings

a. The relationship between loneliness and mental health

Although one of ABiS' core aims is to reduce loneliness amongst older people, we found that many participants did not access ABiS interventions primarily for this reason. They often hoped that interventions would help them to address more immediate issues, frequently related to mental health, which were in turn linked to loneliness, with one often reinforcing the other over an extended period.

Emotional and psychological wellbeing

Older people who sought help from ABiS often had long-term mental health issues which contributed to their need for support. In these cases, loneliness was often a result of complex psychological issues such as agoraphobia or previous trauma. For example, Richard suffered with PTSD following a career in the army and police . His physical health then began to decline after being diagnosed with Parkinson's leading to a further decline in his mental health and a lack of confidence in leaving the house, all of which contributed to and compounded his loneliness:

> *'I lacked a lot of self-confidence at that time cos in 2016 I had major brain surgery which was supposed to eradicate this and it hasn't.'* (Richard, Wellbeing Practitioners and Peer Mentoring)

For others, loneliness resulted from changes in family or personal circumstances and led to deteriorations in mental health. Retirement from work or a decrease in caring

responsibilities, following children leaving home or the death of a partner or family member, were common causes of loneliness:

> *'Up until four years ago I was looking after my mother cos she developed cancer so up until then I've always had people to look after, I looked after my brother, his father died early, he was seven, and I looked after my mother when she was ill for many years, but now she's not here I've got no-one to look after so it seems like I don't belong anywhere'.* (Philip, Wellbeing Practitioners and Peer Mentoring)

Social wellbeing

The responsibility of caring for a partner or relative could result in a person becoming isolated from wider social networks leading declines in mental health:

> *'Well, you are quite isolated when something like this happens to you. I'm not a lonely person as such, I do have family and friends and do things but it is an isolating thing when something happens to someone else and you are alone with it and there isn't a lot of help from the NHS or anyone, the doctor, nobody is there to help you really and eventually this is why I came here, cos there actually isn't anybody else.'* (Jane, Wellbeing Practitioners)

This mutually reinforcing relationship between loneliness and mental health often resulted in negative cycles: worsening mental health often led to increased isolation and then loneliness, and loneliness then had a further detrimental impact on mental health, and so on. The following sections discuss how different types of interventions can support emotional, psychological and social wellbeing to reduce loneliness.

b. How interventions to address loneliness can take account of emotional, psychological and social wellbeing

One-to-one interventions

What are the strengths of different one-to-one approaches?

The Wellbeing Practitioners intervention provided therapeutic support and was set up to reduce loneliness by addressing mental health needs. Therapy could be tailored around physical or mental health issues and was sometimes carried out in people's own homes. For one participant, Mary, therapy was an effective way of helping her to process and cope with the caring responsibilities that she had for her husband:

> *'I felt good that I'd been able to talk to somebody about what had happened in the week because…at that time [my husband] wasn't well in the home and...then he fell and was in hospital, then he died, so it was a big thing for me to have somebody to talk to.'* (Mary, Wellbeing Practitioners)

Where possible, ABiS support was tailored to the needs of the individual. One-to-one support was favoured by some participants such as Philip, who experienced high levels of anxiety in 'social situations', acting as a barrier to accessing group-based interventions:

> *'The group work seems to be stressful cos without that one-to-one first I feel like I'm like a fish being thrown into cold water, it feels very strange being in a group'.* (Philip, Wellbeing Practitioners and Peer Mentoring)

Matching individuals with a Peer Mentor was another beneficial intervention for people experiencing loneliness and mental health issues. Having a Peer Mentor provided regular social interaction and an opportunity to leave the house.

Overall, one-to-one interventions offered participants the chance to talk to someone detached from their personal life; an important factor since many did not wish to burden their family or friends or felt they did not fully understand. This often had the benefit of improving existing relationships with family and friends:

> *'So, having someone to talk to and discuss things, you can't talk to family, I've never been able to since I were 18, they don't understand your mental health problems and I know it says on television to talk about it but people don't understand and to talk to somebody that's knowledgeable or that's seen this before is a great help to everybody.'* (Helen, Wellbeing Practitioners and Peer Mentoring)

What are the limitations of different one-to-one approaches?

Targeted support through ABiS was time limited. One-to-one therapeutic support ended after a fixed number of sessions but before some participants felt ready to move on to other forms of support. This meant that once an intervention ended, levels of loneliness sometimes returned to where they were prior to accessing support:

> *'I've gone back to being isolated as I was before cos there's been no follow up, nothing to go on from that'.* (Philip, Wellbeing Practitioners and Peer Mentoring)

For Philip, one-to-one support provided him with the only source of social contact that he had *'apart from going to the shop and saying hello to the shop assistant'*. The death of his mother four years earlier led to him experiencing feelings of loneliness and having previously taken on the role of her primary carer, he became increasingly isolated over time with nothing to structure his life around. As such, while participants experienced positive

effects of therapy such as increased confidence and decreased levels of anxiety and stress, they struggled to maintain this once therapy ended.

It was also important that participants felt a connection with the person they received support from. Richard, who accessed the Peer Mentors programme, stressed the importance of being matched to someone he could have a meaningful conversation with:

> *'I had a lady that used to come and see me and she drove me to distraction…she was out of work obviously and every Thursday I saw it and it was all about her benefits and I thought I don't need this, every week and she'd just repeat herself over and over and I thought I can't cope with this anymore.'* (Richard, Wellbeing Practitioners and Peer Mentoring)

Peer mentoring was therefore about more than being placed with someone who had the time to volunteer. Fortunately, Richard was later matched with someone more suitable who he got along well with and who supported him with developing computer skills. He described being able to watch TV programmes online and communicate with his brothers over email as a result of this support as a *'lifeline'*.

Group-based interventions

What are the strengths of different group-based approaches?

Our research highlighted that some group-based approaches were particularly effective in supporting people whose mental health had deteriorated due to loneliness created by changes in personal circumstances. These changes included retirement, relationship breakdowns, or changes in caring responsibilities. One participant, Claire, who volunteered

in the Ageing Better Champions programme had experienced this herself, as well as observing it in the people she supported:

> *'A lot of people do get depressed cos they think there's nothing. When I first retired you think "what can I do next?" and until you know about these things […] initially it's someone telling them about it or someone saying "I've started this, do you want to come and join in?"'* (Claire, Ageing Better Champions)

Group-based approaches had the potential to offer long-term opportunities for social interaction for older people, reducing loneliness in those participating and providing ongoing support systems via connections and friendships built through the groups.

Having a group of peers and friends to socialise with often gave participants a social and emotional outlet, giving them space and time to switch off from external pressures and responsibilities:

> *'What we say here stays here, it's confidential, that's very important. We talk about our aches and pains and this and that and sometimes even a shoulder to cry on. So that's why this is very important, about our health, families, everything, it's not just exchanging recipes and other things. Sometimes when we talk to our friends that sort of inner peace you get after you talk to somebody, you can sort of breathe, you feel much better when you go back home, so to offload.'* (Focus group participant, Start-up, Asian Women's Group)

Groups set up through Start-up tended to focus on a particular activity or hobby, meaning that those attending met people with similar interests, increasing the likelihood of them enjoying the groups and continuing to attend and contribute. Many participants reported

that they had grown in self-confidence as a result of attending group activities, with some even progressing to volunteering or sharing their own skills. For example, a number of *'spin-off'* groups had emerged from the High Five social group based on the skills and interests of people attending, including a patchwork group and a choir. Others had formed friendships and had started to meet outside of the group socially:

> *'We've made friends with a small group of people very well but we've got to know a lot of other people that we can chat to, but the three, four, five of us that have really made friends, we all have similar interests other than singing, we're all crafters, we all knit, crochet, paint, we all are creative people.'* (Kate, Start-up, Tuneless Choir)

What are the limitations of different group-based approaches?

The benefits of group support can be limited by the availability and proximity of suitable activities in the local area. For some participants, not being able to access support locally could serve to compound their loneliness.

> *'I tried ABiS because I knew there'd been this mentoring and the champions and so I did contact them […] you could go to coffee mornings and things and none of it was in my area cos the funding for this scheme in Gleadless Valley had come to an end last year, so there was nothing I could access apart from the coffee morning that was already going on in the library that I'd been running anyway for years.'* (Rebecca, Ageing Better Champions and Peer Mentoring)

For people with more severe mental health issues, group-based support may not be appropriate or beneficial initially, and one-to-one tailored support may be required.

Depending on their needs, some may then move on to group activities to broaden their social connections, although this is not always appropriate or needed.

5. Discussion

Our study has identified clear links between loneliness and the emotional, psychological and social components of mental health and provides important learning about how interventions can be tailored for different circumstances. Foremost, our findings suggest that when developing an intervention, it is important to recognise that individuals may not identify or recognise themselves as lonely, and their absence of meaningful social ties is a consequence of wider physical, psychological and mental health problems. Support to address these problems can be a fundamental first step in addressing someone's loneliness and interventions should take time to understand the causes and other factors associated with an individual's personal circumstance if they are to be effective.

One-to-one therapeutic interventions, such as the counselling provided through Wellbeing Practitioners, can be beneficial for individuals whose loneliness is associated with low psychological and emotional wellbeing stemming from trauma and other complex issues or adverse life experiences. These issues have often led to mental ill-health and left them lacking in the confidence, self-esteem, and sense of purpose necessary to build the social relationships and networks that would enable them to overcome their loneliness. *One-to-one peer-to-peer interventions*, such as the mentoring provided by Age Better Champions and Peer Mentors, can be beneficial for individuals whose loneliness is linked to low psychological and emotional wellbeing but whose trauma and mental ill-health is less severe. These individuals often need some initial close support to improve their confidence and self-esteem before accessing other types of intervention, including community-based

groups. *Group-based interventions,* such as those developed at a community level through Start-up, are likely to work best for individuals whose loneliness is linked to their social wellbeing and who may be looking to build social networks and relationships, and contribute to their community, through an interest or hobby. For these individuals a lack of availability of, or awareness about groups in their area is the main barrier to support.

For some individuals, there can be transition from therapeutic support, through peer-to-peer support, and on to group-based activities in the community. But this pathway might not be linear, and a range of emotional and psychological factors will result in some people struggling to access community activities. This means that funders, public health commissioners and providers developing loneliness interventions should ensure participants are supported to develop personalised strategies that enable them to access a variety of forms support if the benefits of the initial intervention are to be sustained.

6. Conclusion

This article has explored the relative strengths of several heterogeneous individual and group-based loneliness interventions delivered by the voluntary sector in addressing the complex factors which affect individuals' loneliness and mental health. Although we do not cover the full range of loneliness interventions provided within the voluntary sector, our findings reveal that the relationship between loneliness and the emotional, psychological and social components of mental health should be considered when developing and implementing these interventions. For many Age Better participants loneliness was not the primary motivation for seeking support and we suggest that a combination of one-to-one (therapeutic and peer-to-peer) and group-based interventions is necessary to account for the varying needs and circumstances of older people experiencing loneliness. Interventions

do not necessarily need to be 'badged' as addressing loneliness to achieve this goal but should aim to reach as far as possible into populations in which loneliness may be prevalent and employ a range of engagement strategies to achieve this.

Our findings will raise questions for policy makers about which types of voluntary organisations should provide loneliness interventions loneliness. We suggest that a variety of organisations have a key role to play within an 'ecosystem' of provision. Larger charities operating in a specialised field (such as Mind, who delivered Wellbeing Practitioners) may be best placed to provide therapeutic support, such as counselling, which should adhere to the necessary professional standards. However, smaller community development organisations (such as Ignite Imaginations, who delivered Start-up) can also play a key role developing and supporting group-based activity at a community level. Programmes such as Ageing Better have catalysed the development of this type of ecosystem whilst the COVID 19 pandemic has demonstrated the vital role that voluntary organisations can play addressing loneliness at times of crisis (17). However, there is a risk that some of this capacity will be lost once the programme ends in 2021 and as public health systems are forced to focus resources on acute care. Moving forward, public health commissioners, working with the NHS and social care, should prioritise investing in a range of voluntary organisations providing different types of loneliness intervention, if the epidemic of loneliness that has been exacerbated by the COVID 19 pandemic is to be addressed.

3,989 words

Acknowledgements

Ethical approval for this study was provided by the (HEI) Research Ethics Committee.

This study and the wider Evaluation of ABiS was funded by South Yorkshire Housing Association as the lead partner for ABiS using funding provided by the National Lottery Community Fund.

The authors have no conflicts of interests to declare.

References

1. HM Government. (2018) *A connected society A strategy for tackling loneliness – laying the foundations for change*. London: Department for Digital, Culture, Media and Sport
2. Holt-Lunstad, J. Smith, T. Baker, M. Harris, T. and Stephenson, D. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science*, Vol 10, No 2, pp. 227-237
3. Valtorta, K. Kanaan, M. Gilbody, S. Ronzi, S. and Hanratty, B. (2017) Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. *Heart,* Volume 102, No 13, pp. 1009-1016
4. Hawkley, J and Cacioppo, L. (2009) Perceived social isolation and cognition. Trends in Cognitive Sciences, Vol 13, No 10, pp. 447-454
5. Pyle, E and Evans, D. (2018) *What characteristics and circumstances are associated with feeling lonely?* Office for National Statistics.
6. Joplin, K. (2016) *Promising approaches to addressing loneliness and isolation in later life*. London: Campaign to End Loneliness/Age UK.

7. Pilgrim, D. and McCranie, A. (2013). *Recovery and mental health: a critical sociological account*. Basingstoke: Palgrave Macmillan
8. Burns-Lynch, B. Brusilovskiy, E. and Salzer, M. (2016) An Empirical Study of the Relationship Between Community Participation, Recovery, and Quality of Life of Individuals with Serious Mental Illnesses. *The Israel Journal of Psychiatry and Related Sciences*, Vol 53, pp. 46–55
9. Barker, P. and Buchanan-Barker, P. (2011), Myth of mental health nursing and the challenge of recovery, *International Journal of Mental Health Nursing*, Vol 20, pp. 337–344.
10. Provencher, H. and Keyes, C. (2011) Complete mental health recovery: bridging mental illness with positive mental health. *Journal of Public Mental Health*, Vol 10 No 1, pp 57–69.
11. Kilgarriff-Foster, A. and O'Cathain, A. (2015), Exploring the components and impact of social prescribing, *Journal of Public Mental Health*, Vol 14 No 3, pp. 127–134
12. Dayson, C., Painter, J., & Bennett, E (2020). Social prescribing for patients of secondary mental health services: emotional, psychological and social wellbeing outcomes. *Journal of Public Mental Health,* Vol 19, No 4, pp. 271-279
13. Moffatt, S. Steer, M. Lawson, S. Penn, L. and O'Brien, N. (2017), Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ Open*, 7:e015203
14. Kellezi, B. Wakefield, JRH. Stevenson, C (2019) The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *BMJ Open,* 9:e033137.
15. Yin, R. (2003), *Applications of Case Study Research*, 2nd edn. CA: Sage

16. Langley, A. (1999). Strategies for theorizing from process data. Academy of Management review, Vol 24 No 4, pp. 691-710.

17. Dayson, C. Bimpson, E. Ellis-Paine, A. Gilberston, J. and Kara, H. The 'resilience' of community organisations during the COVID 19 pandemic: absorptive, adaptive and transformational capacity during a crisis response. *Voluntary Sector Review* (In press)