

Culturally sensitive social prescribing and frailty prevention: a co-produced community research project - final report

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1. Introduction

This project aimed to co-produce and pilot a methodology for researching the role of social prescribing within frailty prevention. Funded by Sheffield Hallam University (SHU) Research and Innovation Fund (SHRIF), the project brought together the expertise of researchers from SHU from different disciplines, practitioners from Darnall Well Being (DWB) – a community health organisation – and Community Researchers – residents of Darnall trained in qualitative research skills to research people from their own communities. Community Researchers were supported to explore patient experiences of, and views on, frailty prevention services and activities provided by the voluntary and community sector in Sheffield. Any gaps in service provision, and the potential role of social prescribing in frailty prevention were also researched.

The term social prescribing is used to describe various systems, processes and pathways which enable professionals and practitioners within health and social care settings to connect patients and/or service users with non-medical support, typically at a community or neighbourhood level. Recently, an internationally accepted conceptual and operational definition of social prescribing was published:¹

(Social prescribing is) a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to

improve health and well-being and to strengthen community connections (Muhl et al., 2023, p. 9).

In practice, social prescribing is ‘a holistic, person-centred and community-based approach to health and well-being that bridges the gap between clinical and non-clinical supports and services’ which requires an ‘identifier’ – such as a link worker – to identify an individual’s unmet non-medical, health-related social need and make an onward referral to activities and services (Muhl et al., 2023, p. 9).

In England, social prescribing has been embedded within primary care since 2019. Primary care-based social prescribing involves a link worker, which is one of three key personalised primary care roles, alongside Health and Wellbeing Coaches and Care Coordinators, funded by NHS England. The social prescribing link worker (SPLW) takes referrals from health and care professionals – usually the GP – and starts with a ‘what matters to you’ conversation to understand the individual’s needs and preferences. The SPLW then makes an onward referral to the activities and services, typically provided by the voluntary and community sector.

Referral activities tend to fall into four broad categories: creative activities linked to art, culture or heritage; physical activities; activities in nature; or information, advice and guidance in relation to financial issues. Practical examples of social prescribing referrals include helping someone who is isolated join an art class or a community gardening project; connecting someone struggling with their finances to a debt management service; supporting someone with dementia to join a specialist choir; or helping someone with high blood pressure to take up a community exercise class.

¹ The study used a Delphi method - a way to generate consensus on concepts by bringing together a group of experts to discuss and refine key ideas over several rounds of discussion and evaluation.

2. Methodology

Before embarking on the research, SHU worked closely with DWB, our community partner, to recruit and train a cohort of Community Researchers – engaging with diverse and underserved communities to build their research capability to carry out research competently and responsibly. Certain criteria were assessed when determining the suitability of residents to the Community Researcher role, including the following:

- Eighteen years and over, understand and or have experience of frailty, or care for someone affected by it.
- The ability to speak English at a moderate level and be able to read and write in English due to the training being delivered in English. Formal education was not a prerequisite for involvement.

DWB set about recruiting potential trainees for the Community Researcher role from diverse communities within the geographical areas their service covered. Various methods were used for recruitment:

- DWB team members provided information to Development Workers, Activity Workers, Link Workers and Health and Wellbeing Workers to share with the public. Project information was also distributed in DWB's weekly and monthly support groups.
- Sending out a mass text message to local partners including patients of Seven Hills Primary Care Network to gauge interest.
- Designing and circulating posters to key organisations (local surgeries, places of worship,

food banks and local organisations) to promote the training.

- Contacting existing DWB service users through phone calls, text messages, home visits and word of mouth.

Each potential recruit was provided with a Community Researcher Role Profile to share information on what the role and training would involve, the research aims and their potential level of involvement. Apart from a requirement to attend all the training, the level of involvement ranged from conducting interviews, data analysis, report writing, and dissemination of research findings – as little or as much involvement as individuals wanted.

Sixteen residents from diverse ethnic groups of various ages were recruited by DWB, and of these, 15 completed the full training programme. To be inclusive, the training was delivered flexibly (outside the core training sessions) for two trainees whose work commitments prevented participation in the core sessions. Other gaps in training, due to absences, were addressed in the same way.

Following advice from DWB's Health and Wellbeing Manager regarding the specific needs of each trainee in relation to their disabilities and/or long-term health conditions, regular breaks were built into the training programme. Lunch and refreshments were also provided which enabled the cohort time to socialise, get to know one another and build rapport.

The training was delivered from mid-September 2023 and after an additional practise session Community Researchers began their research (semi-structured interviews) in late October. The interviews continued into December supported by SHU researchers. Two focus groups – facilitated



Table 1: Core content of the Community Researcher training

Session	Content
Session 1	Introduction to the Social Prescribing and Frailty project; about the Community Researcher role; what is qualitative research; key interviewing skills.
Session 2	An introduction to focus groups; key research skills; participation and reflection exercise; ethical considerations, including gaining informed consent; researcher safety and wellbeing.
Session 3	Arranging the research; introducing yourself and the research; the research fieldwork pack; the topic guide; using the topic guide.
Session 4	Interview practice.
Research begins	
Session 5	Debrief session: Community Researchers reflect on their experiences of conducting the research, discussing any issues which emerged during their research.

by Community Researchers – were undertaken in the new year. Community Researchers were encouraged to conduct the research in community languages where necessary and to play a role in interpreting the data for transcription purposes – to engage those in research who are seldom heard. One Community Researcher was employed by SHU on a short-term contract as a Casual Transcriber to widen their access to higher education and employment opportunities within the university.

Although some research participants were recruited by the newly trained Community Researchers drawing on their own contacts in the community, many participants were recruited through DWB contacts. DWB’s service users who had previously expressed an interest in research were mobilised by DWB practitioners with key information imparted word-of-mouth.

To celebrate the achievements of our Community Researchers, an event was organised, where researchers enjoyed a celebratory lunch together and received a gift voucher to show appreciation for their contribution to the research project. This event was followed by the presentation of certificates during a project dissemination event in April 2024. Community Researchers played an active role presenting the research findings and sharing their experiences of, and motivations for, being a Community Researcher.

3. Research findings

This section provides an overview of the findings from the community research. It describes the characteristics of the research participants before presenting findings in relation to the research aims and questions.

Age, gender, ethnicity, and cultural background of research participants

The people who contributed to this research were a variety of different ages, spanning from 31 years to 90 years inclusive. The wide mix of ethnic and cultural backgrounds was representative of the Darnall community and included African Caribbean, White British, Somali, British Pakistani, Bangladeshi, Asian, Black African, and Irish. There were 28 research participants in total, including:

- Five men and eight women involved in one-to-one qualitative semi-structured interviews.
- One man and one woman in a focus group discussion.
- Twelve men in a focus group discussion.
- One reflective piece on social prescribing and frailty written by one of our newly trained Community Researchers with prior experience as a Social Prescribing Community Practitioner.

Ten women and eighteen men engaged with our research – whilst it was far from an equal split with almost double the men to women represented in our research, we welcomed the participation of more

men, because rarely do we hear the voices of men, on issues related to health, particularly from those of minority ethnic backgrounds.

Health problems and impact of them

The participants who contributed to the interviews and focus groups as part of this research suffered with a wide range of health problems that impacted upon their day-to-day lives. Heart failure and arthritis were most cited, closely followed by loss of balance, muscle weakness, hearing issues, failing eyesight, shortness of breath, reduced mobility, fatigue, and ME (Myalgic Encephalomyelitis). David, over 70, shared that working in the steel industry had led to tinnitus which *'can be really destroying, until you get used to it, it can be debilitating'*. One participant with arthritis (amongst other health conditions) explained that arthritis caused her hands and legs to shake and make her *'feel very weak'*. This prevented her from being active, which had led to stress and unwanted weight gain (Mary). After suffering with COVID-19, Patrick explained that although he was only 48 years old, he struggled *'with brain fog, memory issues and cognitive ability to understand things'*. He also felt that he was *'quite incapable of doing most normal things due to a weak heart and weak muscles'*. In addition to the health complaints already mentioned, other participants also stated that they suffered from asthma, psoriasis, sciatica, anxiety, diabetes, stroke, and back problems.

Experiences of frailty

General weakness was reported by participants when exploring their experiences of frailty. Patrick, for example, was too weak to stand up, and struggled to cook due to problems with his hands and using knives. The disabling impact of feeling weak and being restricted in what she could do made Mary feel anxious and stressed. She reported staying at home *'when the weather is cold and icy'* in fear of slipping. Age-related mobility issues were underscored in our research. A deterioration of eyesight had led to Fatima having increasing falls in the home, and outside – she reported, *'I fell at home and hurt my whole face, my eye at one side was bruised (blue)'*. This resulted in a week-long stay in hospital. Over time, the frequent falls and fear of falling led to depression and loneliness.

Like Fatima, Annette often experienced *'loss of balance and dizziness'*. She recounted feeling agonising pain after dislocating her hip following a hip replacement operation and consequently

developing a fear of falling. The fear of falling left her too frightened to attempt any household chores – a disabling impact, mentally. Again, Anna expressed a fear of falling:

I tend to fall a lot and get a lot of fractures... I don't really do any of anything now, I just stop at home because it's safer for me cos if I were to fall outside its worse than falling inside.

The vulnerability and care needs related to frailty placed a burden on those providing the care. During a focus group discussion, Stephen shared that caring for his mum had left him feeling isolated. He commented, *'she won't let me out of her sight, I can't leave the house, if I do, I've got to be back within the hour, or she starts getting really anxious so I'm pretty isolated'*. Mike described his caring responsibilities to his brother as *'a full-time job because I daren't leave him because you don't know what's going to happen'*.

Where do people with frailty or at risk of frailty go to get help and support?

Our research found that people with, or at risk of, frailty accessed several services locally for support. DWB was most cited for provision which included, chair aerobics, crafting, yoga, and men's group for health information and social interaction. Mary shared that she felt, *'happy as there are other people to talk to'* when participating in DWB activities. Several community members reported that they had participated in the walking group and in one example, an elderly man commented that he had *'benefitted from the health walk at DWB'* (Barrington). During a focus group discussion, we learnt that the organisation had provided a man (with severe health impacts from COVID-19) with practical support obtaining a Blue Badge, which permits people with mobility problems to park in disabled bays. Fatima, who is visually impaired, and has no support from family, reported that she had received help reading her letters. Another woman with rheumatoid arthritis (and other health conditions) explained that she often went to DWB, participating in the walking group, chair aerobics and crafting. She also attended a day centre twice weekly at St Lukes to access activities but confined herself to her home after increasingly suffering falls (Anna).

Other local community assets such as churches offered services, for example, luncheon club to address loneliness which characterised the



lives of old and frail people. A couple of people highlighted that a support group was available locally for both carers and people with dementia – giving both parties some respite. A dementia café, welcoming the carers of people with dementia, was also identified. During a focus group discussion, Simon shared that Sheffield Churches Council for Community Care (SCCCC), a local charity, were offering him a befriender to help address his loneliness. Age UK, Help the Aged, Mind, Social Services, NHS walk in service, NHS phone services, and Sheffield’s two major hospitals were mentioned when asked where people experiencing frailty went for support. Notably, one local person (Annette) was aware of numerous services but did not access them due to her dependence on others for lifts to and from support services – raising a question about the potential role of community transport in facilitating the uptake of services.

What type of frailty support did people get and who provided it?

The research revealed a **lack of awareness of frailty support services amongst some people**, for example, a research participant caring for her grandparent commented that she did not know of a paid service provided for the elderly by a carer / nurse. Similarly, Dean questioned why health information was not readily available. He stressed, *‘when it’s a diagnosis of dementia, you shouldn’t have to dig for this kind of information’*. In Joseph’s experience there was no support for his son from birth. Unable to get him a wheelchair from the NHS or Social Services, he purchased one privately. Further, Frank recalled leaving hospital after

losing his leg and moving into a council bungalow. Receiving no support, he made the adaptations to his home himself to be able to move around more comfortably. A key finding to emerge from our research is that some people were aware of services and how to access them, whereas others received little or no information and consequently no support.

Healthcare equipment to support and aid balance and movement, including walking sticks, walking frames, white cane for the blind / visually impaired, and crutches were accessed by those that we researched. Several people recalled being referred to an occupational health therapy team who assessed their needs and arranged for relevant provision. In many cases, adaptations such as grab rails and handrails were installed in homes. A GP referral to Age UK helped Bilquis to have internal and external adaptations to her home, including installing a wet room, which she required due to her frailty. In another example, Anthony described the type of support gained from Age UK – *‘they’ve helped me with everything, got all me benefits sorted out, they got me an electric wheelchair, they’ve been brilliant’*. Wheelchairs were also acquired through occupational health, although in a few cases, information on how to access such equipment came through informal channels, for example, friends:

I found out about that, a friend had to tell me that, nobody actually gave me that information, a friend said my grandma got a wheelchair, it won’t cost you nowt, it come from adult services, and that’s how I found out about things like that (Mike).

Only one person (Jim) reported obtaining a medical device – a pendent alarm for the elderly. Family members and friends routinely played significant roles supporting those with frailty, either as formal carers or informally. General Practitioners (GPs) were cited by a few people as providing medical advice and prescriptions. The narratives about accessing GPs and receiving support were positive apart from in one case where Patrick expressed disappointment at not being listened to by his GP who readily prescribed antidepressants. Wellbeing calls from the DWB team were more valued by him. Barrington, in his 80s, recognised the help received from a friend at home, but also getting him out and about by providing lifts. Indeed, transport (accessibility and cost) surfaced as a dominant theme in our research – substantiated in the following accounts:

Community transport now comes and picks me up and drops me off and then pick me up to take me home and it's cheaper than having a taxi, it's good (Annette).

I have physio once a week at Hallamshire, the ambulance picks me up and fetched me back but that's it (Anna).

I think the main thing we use is hospital transport to get us from hospital to home and back, that's weekly (Stephen).

We used to go swimming but of course you lose your funding and so we lost the swim bus that used to take us swimming (Annette).

The type of support important to participants and why

Our research found that people with, or at risk of frailty valued the support that was available to them. Community transport was considered an essential asset as it enabled participants to access services in their local community that they otherwise may not be able to access. Annette, an 86-year-old woman explained *'they pick me up from home and take me back home, the drivers are brilliant'*. However, she did not know that community transport was available until a Link Worker at DWB made her aware of it. Whilst Annette found community transport to be a valuable asset, during a focus group discussion, Simon stated, *'I looked into that (community transport) but it's not so easy cos there's a time limit, they can only come at certain times, and you've got to plan round it'*. On a number of occasions, a DWB Link Worker was identified as having made

participants aware of various services that they were otherwise unaware of. It was explained *'since I've come in touch with XXXX [name of DWB Link Worker], it's been quite helpful, coming to various different groups like pain group, diabetes group, things like that'* (Bilal).

Another well regarded community asset was the Men's Group that takes place weekly at DWB. During a focus group, Simon explained *'at Men's Group we do exercise, communicate with one another, that's the best thing, support one another, friendship'*. Another participant added *'a lot of us are of an age where we worked in steelworks and industry, and it were a male environment, and you had a lot of camaraderie which you don't get now, and we come in (Men's Group) and we have a laugh and a giggle'* (Dean). It was also identified that there was a need to see an increase in some services including: befriending services, services that provide help with daily activities both inside and outside the home, and respite care services. An increase in these services would be much valued by participants within the local community. Also, it was suggested that it would be helpful to receive *'some sort of leaflet'* (Dean) or access to a *'central organisation'* (Joseph) upon receiving a diagnosis. It was understood that this would help participants to identify all the relevant services available to them.

Where should frailty support be provided?

When asked where frailty support should be provided, most of our research participants **expressed that it should happen in the community**. Further, all, but a couple of focus group participants concurred that they would want frailty support at DWB. Simon commented, *'it is only this local community hub here that's got me the support'*. However, focus group participants stressed, that in sharing premises with a medical centre, some people, especially men, unaware of DWB's services, might be reluctant to take up services in a GP setting. In several interviews, participants shared that whilst the community was preferable, **those with limited mobility required support in the home**. Jim, a carer for his mother, relayed that she would prefer support at home, which in turn could relieve some pressure off him to pursue his own interests. Aziza who had limited mobility expressed that she would continue to access provision in the local community while she had the energy to do so but would require exercise sessions in the home if she could no longer muster up the strength to get out and about.



did express that *'you have to appreciate that they have commitments so you might have to rely on professional help'*. In contrast, Anna believed that **community workers were best placed to offer frailty support** *'it doesn't have to be like anyone medically or anything'*. Similarly, David stated that the doctor was too far away from where he lived making access difficult. Due to this, he believed that community workers or social workers were the most appropriate people to offer frailty support within the local community.

What other types of support are needed to help with frailty or risk of becoming frail?

Only a few participants articulated the need for other types of support to help people experiencing frailty – mainly for those people who were heavily dependent on others for transport and or confined to their homes. During a focus group, Rachel explained that she was a carer for an elderly man who was largely isolated and, in his case, it *'would have been better if someone could have gone in and sat with him'* other than her. A few participants suggested that a 'befriender' or similar, visit people in their homes and or take people experiencing frailty out for a walk, coffee, or shopping:

Someone to act as a befriender to speak to and then someone who can meet you and then you can go together to these activities (Anna).

Also, someone who could come to your house and just walking with you around the block or something just to get out for half an hour (Timothy).

All I want is someone to spend a little bit of time with me, talking to me (Fatima).

Two participants expressed the need for help with mental health. Patrick requested, *'access to talking therapies because people who suffer with frailty can become really depressed'* and current waiting lists were deemed to be too long. Additionally, Anna described carer visits as being so brief that the isolation resulting from not speaking to anyone all day, every day, necessitated mental health support. In the focus group discussion, Colin proposed that a creative community hub would improve social interaction and help keep the minds of those experiencing frailty engaged and stimulated – *'somewhere to keep your mind active, like a community hub where we could make stuff, do stuff, help each other out, just sit and have a brew'*.

Evidently, those who were not entirely housebound wished to get out and about rather than be supported at home, although they recognised that community transport was necessary to do so – *'someone to take me where I can have socialising... maybe to take swimming... it's very far'* (Bilquis). One participant recalled attending an activity at DWB previously, but emphasised that when provision went online, her difficulty using technology prevented her from participating:

I know they do a keep fit class as well but I think it's online...they used to do it here [at DWB] and I used to do that as well for a while... When we used to have meetings at Wellbeing online and I never joined in, well I tried once and I got myself in a right mess with it (Annette).

Ideally who would you like frailty support to be provided by?

Our research highlighted that ideally, frailty support would consist of **a combination of medical services, community services and help offered by friends and family**. Darnall Wellbeing was most cited as being an appropriate place to provide frailty support. Barrington, shared, *'I talk to professionals and doctors here, I'm very comfortable coming to DWB and speaking to people'*. Similarly, Annette, a woman over 50 explained, *'it should be a doctors and the wellbeing centre as well because I can walk here. I know everyone here and I'm more confident'*. Additionally, it was detailed that DWB are *'very well known within the community'* and that they are *'representative'* and *'reputable'* which might make people more willing to take up the services that they offer (Hafsah). It was understood by Mary, a woman over 50 that neighbours and friends were best placed to offer frailty support. However, she

What do you think about social prescribing, and do you think it could help?

When research participants were asked what they thought about social prescribing and whether it could help with issues related to frailty, we found that **several participants had a limited understanding, if any, of what social prescribing was**. However, Bilquis articulated needs that could be met through social prescribing – *‘I really wish we have some[one] to take us swimming... I like gym, walking also, or maybe friends to go somewhere and sit and drink tea’*. Similarly, Mary’s understanding was basic yet the social and emotional benefits of getting together, doing exercise and activities was consistent with definitions of social prescribing. Jim described social prescribing as *‘non-medication cures’* and identified the benefits of it, recalling how he started practicing tai chi through DWB, attributing his mother’s *‘stability and stuff down to having practiced [tai chi too]’*. Another participant, Anna, recounted being referred by her GP to a social prescriber at DWB who connected her to various activities – some of which (e.g. chair aerobics) were recognised as being particularly beneficial to less mobile people.

Many participants in our focus group shared a thorough understanding of social prescribing and the mental health benefits of social interaction – *‘the minimum someone listening to you, it makes me feel*

now much better. I come here, I share it, everybody when he talk, he feel better’ (Simon). Aziza, for example, discussed the mental health benefits of seeing people – *‘at my home there is no one. My son goes to work, my husband goes out, and my granddaughter goes to work. For that reason, to distract myself, I come out so not only I will do exercise but also, I will see someone so my mind will be fresh’*. The facilitator of a social prescribed group summarised the feedback he had received from group members when asked what the group meant to them:

The group serves as somewhere for you to go and like a respite, to forget about the day-to-day things happening in your life, it also helped in terms of educating people on how to keep themselves well, to manage their health condition and also, we do physical exercise, we focus on the ways we can keep ourselves well and live better (Benjamin).

Notably, a Community Researcher recollected her prior experiences as a social prescribing community practitioner, offering insights on how frail people and their carers benefited from specific provision, the barriers, and potential solutions. Her thoughts are conveyed in the boxed example below:

Reflections from a social prescribing community practitioner

As a social prescribing community practitioner, I have engaged deeply with different initiatives designed to support community members, particularly those who are frail. One social prescribed health activity entailed providing assistance at dementia cafes. These cafes are vital social outlets to stimulate valuable conversations and engaging activities which can help slow the progression of symptoms. A relative of one participant shared how these sessions have significantly brightened her mother’s routine bringing more joy to her life. However, many participants struggled to consistently attend and access provision, for example, due to a lack of transport to the cafes - limiting regular participation which was integral to the sustainability of provision.

Another activity involved coordinating sports activities like chair aerobics, ball games etc and adapting them to the capabilities of frail individuals. These activities were inclusive and enhanced community bonding whilst improving physical and mental health. I also led health walks for the elderly and isolated frail individuals, combined with mindfulness practices in a safe group setting. This helped participants to manage feelings of stress and anxiety whilst being aware of the present moments.

I found that local health and wellness hubs can help frail individuals access a wide range of health services tailored to their specific needs. Further, educating both frail people and caregivers by designing programs about managing health conditions and utilising community resources could enhance the quality of life.

4. Recommendations from the research

Whilst our research participants did not explicitly mention cultural competence when sharing their preference for DWB to deliver social prescribed services for frailty, through our nuanced understanding and participant observation, we could infer that DWB practice embraced diversity and drew local people together based on their commonalities. Language skills and cultural knowledge clearly engaged those usually deemed difficult to reach. Hence, the provision of frailty services in ethnically diverse communities should be based in local communities and provided by practitioners with a deep understanding of cultural competence – reflected in their routine practice.

Our research revealed a lack of services, if any, for people experiencing frailty restricted to their own homes. Yet, our participants mentioned that befriending services in the home could perhaps help address the isolation experienced by those unable to access social prescribed activities and services within the community.

A strong recommendation based on our research is the need for a database that holds information about the frailty provision available in local communities. Participants suggested that if local community organisations that they utilised were able to access such information and share with those requiring support, the health and wellbeing outcomes would be improved.

Closely connected to the issue of awareness of services was the availability of transport to access those services. A significant need for community-focused transport solutions emerged from our research. The benefits of affordable (perhaps subsidised) community transport were emphasised in this research and no doubt the provision of such transport across different communities would enable the uptake of frailty prevention activities and services, enhance community integration, reduce social isolation, and improve health outcomes.

A notable finding was the participation of men in this study, particularly those from minority ethnic backgrounds which is less common in most typical health related studies. This perhaps demonstrated

the success of the outreach and engagement strategy of DWB in a demographic that often under-participates in health discussions. Adopting community partnership approaches to future research might ensure better representation of those groups and/or populations underrepresented.

A recurring theme across the study was the low awareness and utilisation of social prescribed health services. This underutilisation underscores the need for enhanced communication strategies to reach all community segments effectively. To address this, we would propose using local media, social media platforms, community networks and outreach work whereby information is shared, publicising the available services. The type of information should be tailored to meet the diverse needs and preferences of the community, ensuring it is both accessible and engaging. Such strategies would be expected to drive an increase in awareness and engagement with services, potentially leading to better health outcomes.

A further recommendation is to broaden the scope of social prescribed services and activities to increase diversity and be appealing and engaging to a wide variety of interests. Diversifying the options available through social prescribed health activities could cater to broad community demographics, leading to enhanced holistic health outcomes. We suggest this could be achieved by implementing a community driven research programme that investigates what local people truly want and enables social prescribed services to be tailored to authentically meet interest and need. This approach has the potential to increase participation rates, promote lifelong learning, enhance social interaction, and ultimately lead to an increase in mental and physical health.



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