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RESEARCH ARTICLE

SOCIAL ACTION APPROACHES TO REDUCE THE INCIDENCE OF DEPRESSION WITHIN SOCIO-ECONOMIC DEPRIVED COMMUNITIES IN SCOTLAND

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ABSTRACT

This article will review the ways in which public health practitioners can utilise social action approaches to address health inequalities. A critical analysis and evaluation will present on how the social determinants of health are capable of impacting health and wellbeing and will discuss the ways in which the principles and practice of community development can be utilised to tackle depression at a community level. The relationship between public health theory and its application to social action will also be examined focusing on community development approaches to support communities to address health inequalities in relation to depression. Public health theory and public health practice development will be explored and the relationships between communication and public involvement in public health service provision will be presented.

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INTRODUCTION

This article will review the ways in which public health practitioners can utilise social action approaches to address health inequalities. A critical analysis and evaluation will present on how the social determinants of health are capable of impacting health and wellbeing and will discuss the ways in which the principles and practice of community development can be utilised to tackle depression at a community level. The relationship between public health theory and its application to social action will also beexamined focusing on community development approachesto support communities to address health inequalities in relation to depression.Public health theory and public health practice development will be explored and the relationships between communication and public involvement in public health service provision will be presented.

Depression: More than 300 million people globally are affected by mental illness and depression (World Health Organisation, 2020).

This figure was accrued from a systematic analysis for the Global Burden of Disease Study (2017) providingdata on multiple specific diseases from 195geographical areas across the globe. The incidence of depression signifies a worldwide serious public health problem. The World Health Organisation (2017) attribute depression to being the most predominant factor contributing to global disability. Depression is acknowledged as being the foremost diagnosedmental disorders amongst adults (Richards, 2011).In the UK, approximately 1 in every 4 adults will experience a mental health problem each year (McManus et al, 2009). Depression is noted to "impair normal functioning, cause depressive thoughts, and adversely affect quality of life" (Liu et al, 2020). As well as the cost on the individual and their personal circumstances, depression places an economic burden on society (Greenberg, 2015). During a recent study on the financial strain of depression, the World Economic Forum (2018) surmise depression costs the global economy £651 billion each yearand is attributable for 6% of the burden of all diseases in Europe in terms of disability adjusted life years (DALYs).

The Five Year Forward View for Mental Health(2016)concedesthe social and economic cost of poor mental health equates to £105 billion a year in England. In Scotland, mental health attributes to approximately £10.7 billion per year (Scottish Government, 2016). These figures necessitate the need for public health action. Within Scotland, depression affects 1 in 10 people over the course of their lives (National Health Service Scotland, 2020).Poor mental health is a significant public health challenge which has become further evident since the swift global spread of COVID-19 (Campion et al. 2020). Prior to the COVID-19 pandemic, mental health attributed to 20% of the global disease burden (World Health Organisation, 2016). Since the pandemic began, the mental health population has become more widely affected resulting in reduced wellbeing and increased vulnerability (Panchal et al, 2021). Social isolation has been recognised as a key attribute todeclining mental health. Supportive relationships with friends, family and neighbours arerecognised as being beneficial to individuals and population mental health (Economic and Social Research Council, 2013). However, this has been increasingly difficult to attainin the midst of a pandemic when required to adhere to social distancing. A marked reduction in the delivery of mental health services through imposed quarantine and lockdown measures are alsoconsidered to be attributable to deteriorating mental health and depression (Department of Health and Social Care, 2020).

The social determinants of health: Research has highlighted a direct correlation between mental health problems and social and health inequalities suggesting there is a strong socioeconomic gradient within mental health and people of lower socioeconomic status (World Health Organisation, 2014; Williams et al, 2020; Hodgson et al. 2020). This 'social gradient' implies that mental health problems are more common further down the social ladderwhere it has been argued that the greater the income inequality in a society, the worse the social outcomes for that society as a whole (Wilkinson, 2018). The social determinants of health according to the World Health Organisation (2011) are "the conditions in which people are born, grow, live, work and age". These conditions areaffected by the "distribution of money, power and resources which can be at local, national or global levels" (World Health Organisation, 2011). Social determinants of health are understood to create health inequalities. Health inequalities as suggested by the National Health Service England (2019 p.1) are "unfair and avoidable differences in health across the population and between different groups in society". There are many attributing factors to social inequalities including poverty, financial strain, race, gender, sexual orientation, homelessness, mental health and wellness, disability and social exclusion (McDaid and Kousoulis, 2020). The social determinants can operate at macro, individual or micro levels. Different models exist to determine how the social determinants influence health such as the Bio-ecological model developed by Bronfenbrenner and Ceci (1994). For the purpose of this assignment however, the social model of health by Dahlgren and Whitehead will be discussed.

Although seminal, the influential social model of health by Dahlgren and Whitehead (1991), maps the relationships between an individual, their environment and health. Within this model, the individual is central and surrounded by varying influences on their health including lifestyle factors, living and working conditions and community influences. This model advocatesaddressing interventions to improve health. Dahlgren and Whitehead (2007) proposetheir framework supports the exploration of different determinants and their impact on health, and endeavours to tackle inequalities in healthwhich are central to public health. Applying this model to practice intends to enable public health agencies to enrapturepolicies of varying levels to target specific health needs and concerns such as depression. The diagrammatic form enables the practitioner to organise interventions to reduce illness and promote health, allowing a consistent approach to be maintained. Due et al, (2011)proposes depression can be correlated to each of the social determinants of health when applying this particular model of health.Nevertheless, many considerDahlgren and Whitehead's model to beoutdated as a result of the digital revolution which has fundamentally changed everyday life as well as the global economy (Turkle, 2012; Schmidt and Cohen, 2014).Information and communications technology (ITC) has been perceivedas a major determinant of health due to affordability (Rice and Sara, 2018). A systematic review completed by Best et al, (2014) denotes ICT as one of the many factors which contribute to mental health and views it as having a negative outcome on depression. However, this opinion is contrasted, with many other professionals who viewICT as positively contributing to mental health(Thomée, 2012).

The Black Report (1980) published by the Department of Health acknowledgeswidespread inequalities in the distribution of ill health and death, highlighting a gradient of mortality down the social classes. This report suggests four theories as the root cause of health inequalities as: artefact, selection, behavioural and cultural (Donaldson, 2017). However, as part of selection theory, these were extended to include meritocracy and intelligence. McCartney et al, (2013) when expressing the relationship between cause and effect of health inequalities advocates structural theory as the most proficient explanation for the fundamental reasons forhealth inequalities. Marmot (2008) within the 'Fair Society Healthy Lives' review advises the most effectual strategies for reducing health inequalities, identifying the social determinants of health as being the conditions which contribute to the overall physical, mental and social well-being of people at local, national and global levels. In the more recent Marmot reportpublished in 2020, 'Tackling Social Inequalities to Reduce Mental Health Problems', identifies persistent social factors (such as poverty, low quality employment, housing) asthe important drivers of mental health problems. In a summary report on 'Scottish Mental Health Profiles for Adults', Millard and McCartney (2015) emphasizeadults who live in the most disadvantaged areas of Scotland are almost twice as likely to have common mental health problems as those living in the more affluent areas. The report which features at the most robust level within the hierarchy of evidence concludes there are inequalities in mental health outcomes by age, sex and deprivation. Their work highlights those living in the most deprived communitieswithin Scotland, particularly young adults, are more susceptible to poorer mental health. They conclude men are more likely to misuse drugs, be alcohol dependent and commit suicide. They also acknowledge within their survey, women reported worse mental health and lower wellbeing than men.

Measuring deprivation within Scotland: The Scottish Index of Multiple Deprivation measures deprivationthrough the domains of income, education, health, employment, crime and

housing, and access to services. This approach from theScottish Government,aims to identify areas of high deprivation,improve the consequences and circumstances of people living within the most deprived areas and provide effective targeting of policies and funding to reduce levels of deprivation (The Scottish Index of Multiple Deprivation, 2016).

Community development: MacQueen et al, (2001) classify community as "a group of people with diverse characteristics who are linked by social ties and share common perspectives who engage in joint action in geographical locations or settings."Community development has been identified by the Scottish Community Development Centre (2019) as "a process where people come together to take action on what is important to them". Community development supports communities to utilize their own assets to improve their services facilitating the process to implement change through undertaking a programme of specific activities to achieve a desired outcome (Buck and Wenzell, 2018). Community development adopts the ideology of action in which to restructure normative, economic and social order (Robinson and Green, 2011; Scottish Community Development Centre, 2019). The aims of community development are to aid communities to identify their own issues and needs, facilitating their community capacity to act, through a process of change. This process fosters understanding and learning, promoting collaborative partnerships between health professionals and the community. Community development aims are akin to the health promotion approach outlined in the Ottawa Charter (1986), advocating the creation of essential conditions for health enablement and pursuit of health. Public Health England (2018) advocate participatory approaches, viewing them to be "more effective than professional led services in reducing health inequalities as they directly address marginalisation and powerlessness that underpin inequities".

Public involvement: In order to foster positive health outcomes, community-led approaches are frequently advocated within health improvement policies and practice. Public involvement can act as a modification tohelp achieve improvements of the health of the public and strengthen public confidence in the NHS. Taylor (2007) supports public involvement as it provides a better understanding of issues which impact individuals and communities which can then be acted on. Similarly, the House of Commons propose public involvement improves the quality of services and enhances the accountability within public spending. Engaging in public involvement is acknowledged to identify new priorities for investigation that would previously not have been recognised by professionals. Utilising public involvement fosters grater understanding of the factors which elide to health inequalities. From an economic perspective, employing public involvement can reduce costs by utilising existing resources. Active public involvement is also denoted to engage better community participation thus ultimately improving individual health and well-being (Coulter and Ellins, 2011). Similarly, partnership working can empower individuals and communities to foster greater responsibility for their own health and well-being through active involvement in the planning, implementation and evaluation of health improvement initiatives. There are a variety of pathways in which community engagement can be formed. Varying methodological approaches can be utilised to demonstrate worth. One such programme is the 'Community Driving Change (CDC)' which supports residents in improving their health and wellbeing. Public health programmes such as this, enable local residents to be the drivers in defining their needs within their locale, identifying what works best for them and their community. There are numerous benefits from involvement at both individual and community level. For someone suffering from depression, this may evoke confidence, self-esteem, and self-efficacy. For a community, engagement fosters social support and connectiveness, cohesion and resilience amongst others.

Assets based approach to health: Inequalities are primarily addressed by a pathogenic model of health where much of the reliance is placed on health professionals and resources. However, an assets model promotes community involvement so there is less reliance on professional services. As such a salutogenic theory and approach "can strengthen society's organised efforts to prevent disease, promote health and prolong life" (Lindstorm, 2018). Utilising asset mapping enables health professionals to understand what commodities they have to offer in terms of existing knowledge, skills and capabilities (McKnight, 1995). From this, individual skills, physical and organisational resources already within the community can be utilised. This process is also thought to enhance trust between professionals and the community.

Arneisten's Ladder of Participation: The theoretical framework of Arnestein's 'A Ladder of Citizen Participation' published in 1969, depicts different participation levels and powers when making decisions. This typology of citizen participation is arranged as rungs on a ladder, where each rung connotates to a level of citizen participation and control. From perusal of literature, three main criticisms are apparent of this theory, namely from Tritter and McCallum (2006 p161) who acknowledge the model to be "missing rungs, snakes and multiple ladders", Arneisten's model.

Community partnerships: Within Scotland, the Community Empowerment (Scotland) Act came into power in 2015, "to help empower community bodies through the ownership or control of land and buildings, and by strengthening their voices in decision about public services" (Scottish Government, 2017).With power devolved to a local level, the focus can be placed on local priorities and 'Single Outcome Agreements'. These lay the foundations which support the development of community partnerships (The Commission on Strengthening Local Democracy, 2014). This has enabled Scotland to take on an asset-based approach to community development and public services,where the focus has been placed on the application of resources to individuals and communities (Markantoni et al, 2018). Through this approach, the Scottish Governments willingness to work with the communities through services co-design and co-production, aids to empower communities to contribute to local service development and asset management. However, this Scottish Government approach has received criticism from academics who express that research has shown marginalised communities participate less in local development processes (Meader and Skerratt, 2017). There are other challenges to community led development programmes. Bock (2016) stipulatesthat a shift in power from government to communities can conceal the withdrawal of the state from its duties thus increasing community vulnerability which are less engaged with civic activity.

Public health practice: "Public health aims to protect and improve the health of people and their communities by

promoting healthy lifestyles;researching disease;injury prevention; and detecting, preventing and responding to infectious diseases"(The Centre for Disease Control Foundation, 2018). Public health necessitatespower relationships between varying stakeholders, practitioners and their clients. Public health programmes are designed to be professionally driven, talk down pre-packaged and with a focus on the biomedical approach. To build an empowering public health practise means readdressing the constraints placed on the profession by its bureaucratic nature, through an ideology of top-down interventions and by the powerlessness of its practitioners. The public health practitioner enables the clients to take greater responsibility and control of their lives. Sheehy (2017) when discussing the bridge perspective within partnership working in health and social care, advocate uniting separate organisations to benefit from pooled expertise, resources and power sharing. On evaluation of successful public health partnerships, the World Health Organisation (2010) found the key to successful partnerships where clearly added values for public health and clear goals in line with public health policies. However,Glasby and Dickinson (2008) in their expertise of social policy, highlight that "there is no universal definition of partnership and is often used rhetorically to encourage organisations to work together".

Communication: Corcoran (2007) states "effective communication is a pre-requisite to any action which improves health". There are a variety of communication channels which are used to convey health information and public health policies and lifestyles. These include entertainment media, social marketing and interpersonal communication. Actively involving community participation and engagement can facilitate support, information, advice and training for community groups which can foster long term sustainability.

Diversity in public health: Reducing the incidence of depression and mental health issues requires direction action to address the social, economic, cultural and environmental adversities. In order to address these factors, a variety of different levels of approach can be utilised through imposing structural measures, strengthening assets within a community, increasing resilience of individuals and groups, and from employing structural methods to change social and economic influences which precede mental health problems is recommended within the Mental Health Foundation Report, 'Tackling social Inequalities to reduce mental health problems' (2020). Ways in which this could be established include reducing poverty, unemployment, income inequality, discrimination, homelessness and domestic violence, all of which would have a beneficial effect on depression. Proposed means to fortify community assets include tackling socio-economic inequalities to reduce health inequalities, facilitating social connectiveness through advocate community participation in decision making, and increasing community resources to support mental health and well-being. Individual measures for addressing mental health include providing education on ways to care for their own mental health and wellbeing as well as those in their family and community. Providing opportunities through different methods of peer support is recognised as being fundamental in improving depression and mental health (MIND, 2019).

Evidence-based services in a community-wide strategyfor depression: Improving mental health and wellbeing within Scotland has been outlined as a priority by Public Health Scotland. The Good Mental Health for All (2016)publication by Public Health Scotland, outlines a variety of strategy commitments and national priorities to address mental health inequalities. This plans to be facilitated by adopting a systematic and co-ordinated approach to prevention and promotion across sectors, through improving social and environmental circumstances and ensuring more equitable access to services and developing individual capacity(Public Health Scotland, 2016). Applying outcome focused planning can help the health practitioner to identify desired achievement, outlining steps to expedite this. This may support the identification of interventions where there is evidence to endorse investment in the promotion and prevention of mental wellbeing.The Scottish Government's Mental Health Strategy adopts health promotion and prevention strategies which outline a number of commitments including inpatient and crisis mental health services, integrated community,improved responses to common mental health problems and more accessible child and adolescent mental health. However, these strategies cannot be achieved solely by the National Health Service and require input from third sector organisations, Integrated Joint Boards and Community Planning Partnerships to reduce mental health inequalities.

Conclusion

It is evident that the poorer an individual's socio-economic position, the greater their risk is of poor health and depression. Depression is attributed to a complex interaction of social, psychological and biological factors. Health inequalities can be reduced through government policies and on a wider level, global health strategies. Through involvement and empowerment, community led approaches can support communities to use their own assets which can contribute to improving the health and wellbeing of its members, ultimately reducing health inequalities.

REFERENCES

Bronfenbrenner, U. and Ceci, S., 1994. Nature- Nuture reconceptualized in developmental perspective: A bioecological model. *Psychological Review*, [online] 101(4), pp.568-586. [Accessed 13 April 2021]. Available at: <https://www.semanticscholar.org/paper/Nature-nurture-reconceptualized-in-developmental-a-Bronfenbrenner-Ceci/147f215c79b21e 07998c6ceac 9c2ffc 5b7b0592a>

Bradford, E., 2016. *In the Mind: Key facts about mental health in Scotland*. [online] BBC News. [Accessed 21 February 2021]. Available at: <https://www.bbc.co.uk/news/uk-scotland-35576995>

Buck, D. and Wenzell, A., 2018. *Shared responsibility for health*. [online] The King's Fund. [Accessed 13 April 2021].Available at: <https://www.kingsfund.org.uk/publications/shared-responsibility-health>

Campion, J., Javed, A., Sartorius, N. and Marmot, M., 2020. Addressing the public mental health challenge of COVID-19. *The Lancet Psychiatry*, [online] 7(8), pp.657-659. [Accessed 16 February 2021].Available at: <https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30240-6/fulltext#>

Centers for Disease Control and Prevention, 2018. *CDC Works 24/7*. [online] Centers for Disease Control and Prevention.

[Accessed 13 April 2021].Available at: <https://www.cdc.gov/>

Commission on Strengthening Local Democracy. 2017. *Commissioning on Strengthening Local Democracy*. [online] Cdn.ps.emap.com.[Accessed 13 April 2021]. Available at: <https://cdn.ps.emap.com/wp-content/uploads/sites/2/2014/04/Scotland-Commission-on-Strengthening-Local-Democracy.pdf>

Corcoran, N., 2013. *Communicating Health*. London: SAGE Publications.

Coulter, A. and Ellins, J. 2006. Patient-focused interventions: A review of the evidence. London, UK: The Health Foundation and the Picker Institute Europe.

Dahlgren, G. and Whitehead, M., 2007. *European strategies for tackling social inequities in health: Levelling up Part 2*. [online] Euro.who.int. [Accessed 7 April 2021].Available at: <https://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf>

Dahlgren, G. and Whitehead, M., 2007. *Chapter 6: wider determinants of health*. [online] GOV.UK. [Accessed 7 April 2021].Available at: <https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-6-wider-determinants-of-health>

Department of Health and Social Care, 2020. *Coronavirus bill: summary of impacts*. [Accessed 16 February 2021]. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/coronavirus-bill-summary-of-impacts/coronavirus-bill-summary-of-impacts>

Donaldson, L. and Rutter, P., 2017. *Donaldsons' Essential Public Health*. 4th ed. New York: CRC Press, p.153.

Due, P., Krølner, R., Rasmussen, M., Andersen, A., TrabDamsgaard, M., Graham, H. and Holstein, B., 2011. Pathways and mechanisms in adolescence contribute to adult health inequalities. *Scandinavian Journal of Public Health*, [online] 39(6_suppl), pp.62-78. [Accessed 7 April 2021].Available at: <https://journals.sagepub.com/doi/pdf/10.1177/1403494810395989>

Economic and Social Research Council. 2013. *Mental health and social relationships - Economic and Social Research Council*. [online] Esrc.ukri.org. [Accessed 3 April 2021]. Available at: https://esrc.ukri.org/news-events-and-publications/evidence-briefings/mental-health-and-social-relationships/

Glasby, J. and Dickinson, H., 2008. *Jon Glasby and Helen Dickinson on interagency co-operation - Community Care*. [online] Community Care. [Accessed 13 April 2021].Available at: <https://www.communitycare.co.uk/2008/05/16/jon-glasby-and-helen-dickinson-on-interagency-co-operation/>

Global Health Data Exchange, 2017. *Global Burden of Disease Study 2017 (GBD 2017) Burden by Risk 1990-2017 | GHDx*. [online] Ghdx.healthdata.org. [Accessed 13 April 2021].Available at: <http://ghdx.healthdata.org/record/ihme-data/gbd-2017-burden-risk-1990-2017>

Greenberg, P., 2015. *The Growing Economic Burden of Depression in the U.S.*[online] Scientific American Blog Network. [Accessed 3 April 2021].Available at: <https://blogs.scientificamerican.com/mind-guest-blog/the-growing-economic-burden-of-depression-in-the-u-s/>

Hodgson, K., Stafford, M., Fisher, R., Docherty, M. and Deeny, S., 2020. *Inequalities in health care for people with depression and/or anxiety | The Health Foundation*. [Accessed 16 February 2021]. [online] The Health Foundation. Available at: <https://www.health.org.uk/publications/long-reads/inequalities-in-health-care-for-people-with-depression-and-anxiety>

Katz, R., 2017. *GSR-17 Discussion paper and Economic Impact of Digital Transformation of the Economy*. [online] Itu.int. [Accessed 7 April 2021].Available at: <https://www.itu.int/en/ITUD/Conferences/GSR/Documents/GSR2017/Soc_Eco_impact_Digital_transformation_finalGSR.pdf>

Liu, Q., He, H., Yang, J., Feng, X., Zhao, F. and Lyu, J., 2020. Changes in the global burden of depression from 1990 to 2017: Findings from the Global Burden of Disease study. *Journal of Psychiatric Research*, [online] 126, pp.134-140. [Accessed 26 March 2021].Available at: <https://www.sciencedirect.com/science/article/pii/S0022395619307381>

MacQueen, K., McLellan, E., Metzger, D., Kegeles, S., Strauss, R., Scotti, R., Blanchard, L. and Trotter, R., 2001. What Is Community? An Evidence-Based Definition for Participatory Public Health. *American Journal of Public Health*, [online] 91(12), pp.1929-1938. [Accessed 8 April 2021].Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446907/>

Man, F., 2016. *The hierarchy of evidence: Is the study's design robust?* [online] The Logic of Science. [Accessed 26 March 2021]. Available at: <https://thelogicofscience.com/2016/01/12/the-hierarchy-of-evidence-is-the-studys-design-robust/>

McCartney, G., Collins, C. and Mackenzie, M., 2013. What (or who) causes health inequalities: Theories, evidence and implications? *Health Policy*, [online] 113(3), pp.221-227. [Accessed 9 April 2021].Available at: <https://www.sciencedirect.com/science/article/pii/S0168851013001590>

McDaid, S. and Kousoulis, A., 2020. *Resilience across the UK during the coronavirus pandemic*. [online] Mentalhealth.org.uk. [Accessed 13 April 2021].Available at: <https://www.mentalhealth.org.uk/sites/default/files/MHF%20The%20COVID-19%20Pandemic%203.pdf>

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. The NHS Information Centre for health and social care.

McKnight, J. (1995). The Careless Society: Community and Its Counterfeits. New York: Basic Books.

Meader, E. and Skerratt, S., 2017. *National Rural Mental Health Survey Scotland: Report of Key Findings*. [online] Uhi.ac.uk. [Accessed 13 April 2021].Available at: <https://www.uhi.ac.uk/en/t4-media/one-web/university/research/srhp/RuralMentalHealthSurveyReportScotland_April2017_RPC.pdf>

Millard, A.D, McCartney, G. 2015. *Scottish Mental Health Profiles for Adults: Summary Report. Edinburgh*: NHS Health Scotland.

MIND, 2019. *About peer support*. [online] Mind.org.uk. [Accessed 8 April 2021].Available at: <https://www.mind.org.uk/information-support/drugs-and-

treatments/peer-support/about-peer-support/#WhatIsPeerSupport>

MIND, 2021. *Symptoms*. [online] Mind.org.uk. [Accessed 3 April 2021].Available at: <https://www.mind.org.uk/information-support/types-of-mental-health-problems/depression/symptoms/>

National Health Service England. 2016. *The Five Year Forward View for Mental Health*. [online] England.nhs.uk. [Accessed 13 April 2021].Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

National Health Service England. 2019. *NHS England » Definitions for Health Inequalities*. [online] England.nhs.uk. [Accessed 7 April 2021].Available at: <https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/>

National health Service Scotland, 2020. *Depression symptoms and treatments*. [online] Nhsinform.scot. [Accessed 16 February 2021].Available at: <https://www.nhsinform.scot/illnesses-and-conditions/mental-health/depression>

Panchal, N., Kamal, R., Cox, C. and Garfield, R., 2021. *The Implications of COVID-19 for Mental Health and Substance Use*.[Accessed 16 February 2021] [online] KFF.Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

Public Health England, 2018. *Health matters: community-centred approaches for health and wellbeing*. [online] GOV.UK. [Accessed 13 April 2021].Available at: <https://www.gov.uk/government/publications/health-matters-health-and-wellbeing-community-centred-approaches/health-matters-community-centred-approaches-for-health-and-wellbeing>

Pulford, A., Richardson, E., Agbato, D. and Anand, N., 2019. *Informing Interventions to reduce health Inequalities (Triple I) National overview report 2019*. [online] Healthscotland.scot. [Accessed 9 April 2021].Available at: <http://www.healthscotland.scot/media/2523/triple-i-overview-report-apr2019-english.pdf>

Rice, L. and Sara, R. 2018. Updating the determinants of health model in the Information Age, Health Promotion International, Volume 34, Issue 6, December 2019, Pages 1241–1249, https://doi.org/10.1093/heapro/day064

Richards, D., 2011. Prevalence and clinical course of depression: A review. *Clinical Psychology Review*, [online] 31(7), pp.1117-1125. [Accessed 26 March 2021]. Available at: https://www.sciencedirect.com/science/article/pii/S0272735811001127

Robinson, j. and Green, G., 2011. *Introduction to community development: theory, practice, and service-learning*. Los Angeles: Sage.

Schmidt, E. and Cohen, J., 2015. The New Digital Age. *Asia-Pacific Journal of Rural Development*, 25(2), pp.119-122.

Scottish Community Development Centre, 2019. *SCDC - We believe communitiesmatter*. [online] SCDC - We believe communities matter. [Accessed 13 April 2021].Available at: <https://www.scdc.org.uk/>

Scottish Government, 2018. *Scotland's public health priorities - gov.scot*. [online] Gov.scot. [Accessed 5 April 2021].Available at: <https://www.gov.scot/publications/scotlands-public-health-priorities/pages/12/>

Sheehy, R., 2017. *Partnership Working in Health and Social Care: The Bridge Perspective - Recovery College Greenwich*. [online] Recovery College Greenwich. [Accessed 12 April 2021].Available at: <https://www.therecoveryplace.co.uk/partnership-working-in-health-and-social-care-the-bridge-perspective/>

Sobocki P, Jönsson B, Angst J, Rehnberg C. Cost of depression in Europe. J Ment Health Policy Econ. 2006 Jun;9(2):87-98. PMID: 17007486.

Thomée, S., 2012. *ICT use and mental health in young adults Effects of computer and mobile phone use on stress, sleep disturbances, and symptoms of depression*. [online] Gupea.ub.gu.se. [Accessed 9 April 2021].Available at: <https://gupea.ub.gu.se/bitstream/2077/28245/1/gupea_2077_28245_1.pdf>

Tritter, J. and McCallum, A., 2006. The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy*, [online] 76(2), pp.156-168. [Accessed 13 April 2021].Available at: <https://research.aston.ac.uk/en/publications/the-snakes-and-ladders-of-user-involvement-moving-beyond-arnstein>

Turkle, S., 2012. *Alone together*. New York: Basic Books.

Wilkinson, R.G. 2018. *The inner level: how more equal societies reduce stress, restore sanity and improve everybody's wellbeing*. Wilkinson RG, Pickett K, editors. Allen Lane, an imprint of Penguin Books; 2018.

Williams, E., Buck, D. and Babalola, G., 2020. *What are health inequalities?* [online] The King's Fund. [Accessed 16 February 2021].Available at: <https://www.kingsfund.org.uk/publications/what-are-health-inequalities>

World Economic Forum, 2018. *Depression is the no. 1 cause of ill health and disability worldwide.* [online] World Economic Forum. [Accessed 13 April 2021].Available at: <https://www.weforum.org/agenda/2018/05/depression-prevents-many-of-us-from-leading-healthy-and-productive-lives-being-the-no-1-cause-of-ill-health-and-disability-worldwide>

World Health Organisation, 2011. *WHO | Social determinants of health*. [online] Who.int. [Accessed 12 April 2021].Available at: <https://www.who.int/gender-equity-rights/understanding/sdh-definition/en/>

World Health Organisation. 2014. *Social Determinants of Health*. [Accessed 21 February 2021]. [online] Available at: <https: www.who.int/teams/social-determinants-of-health>

World Health Organisation. 2014. CalousteGulbenkian Foundation. Social Determinants of Mental Health. Geneva; 2014.

World health Organisation. 2017. *World Health Statistics 2011*. [online] Who.int. [Accessed 12 April 2021].Available at: <https://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Full.pdf>

World Health Organisation. 2018. *Global health estimates 2016: disease burden by cause, age, sex, country and region, 2000-2016*. [Accessed 16 February 2021]. [online] Available at: https://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html

World Health Organisation. 2020. *Depression*. [Accessed 10 February 2021].[online] Available at: https://www.who.int/news-room/fact-sheets/detail/depression.

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