Developing Social Prescribing and Community Referrals for Mental Health in Scotland

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Authorship and Acknowledgements

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Summary

This report, commissioned by the Scottish Government’s National Programme for Improving Mental Health and Wellbeing, considers the case for using non-medical interventions, sometimes called community referrals or social prescribing, to improve mental health\(^1\). It is intended primarily as a resource for colleagues working in primary health care, Community Health Partnerships and Community Planning Partnerships, although it will also be of interest to community and voluntary sector organisations and those working in sports, leisure, arts and education.

Social prescribing is a valuable complement to other recent and on-going developments within the NHS to promote access to psychological treatments and interventions. It is now widely understood that social, economic and environmental factors have a significant influence on the mental health and wellbeing of people in Scotland. Social prescribing aims to strengthen the provision of, and access to, socio-economic solutions to mental health problems, linking people (usually, but not exclusively, via primary care) with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as support with, for example, benefits, housing, debt, employment, legal advice or parenting.

Social prescribing has the potential to become fully integrated as a patient pathway for primary care practices in Scotland and the potential to strengthen considerably the links between health care providers and community, voluntary and local authority services that influence the wider determinants of mental health, such as for example, leisure, welfare, education, culture, employment and the environment.

The link between these factors and mental health is already widely recognised and there are many examples of community projects which place a strong emphasis on improving wellbeing, as well as a range of local alternatives to mainstream mental health services. There are also a number of primary care-based initiatives that offer exercise, arts or learning referrals to patients with mental health problems across the spectrum of disorders. Nevertheless, there are a number of steps which need to be taken to establish social prescribing as a more widely available option, including increasing public awareness and much greater support for both primary care and voluntary and community groups.

\(^1\) Although the term ‘social prescribing’ is widely used in the literature, it has been criticised because ‘prescribing’ has medical connotations and may imply that exercise, arts, leisure and learning activities should be accessed via primary care. ‘Community referrals’ is an alternative term.
Efforts are also needed to explore how referrals from primary care can preserve and extend the diversity of what is available in different communities and increase the potential for working together.

**Increasing public awareness**

Although there is baseline data on public attitudes to mental illness, tracked through the Scottish Government national survey of public attitudes towards mental health (Braunholtz et al, 2004), we lack data on the extent of public knowledge about how to look after your mental health and effective ways of improving mild to moderate symptoms of depression and anxiety. Levels of awareness of the impact of physical activity, diet, alcohol, sleep patterns and other lifestyle behaviours on mental health are likely to be low when compared to awareness of other public health issues, such as smoking, sexual health, obesity, coronary heart disease and alcohol consumption. Knowledge and understanding of mental wellbeing may be very low.²

This has a number of consequences:

- People do not seek help; their symptoms may escalate and/or seriously impact on their quality of life and physical health. This is a particular issue for some groups, e.g. low income households, older people, young men, black and minority ethnic groups and asylum seekers and refugees
- The treatment and management of common mental health problems place a very high burden on primary care; treatment options are currently largely confined to medication (which may not be effective as a first line response for mild to moderate depression and anxiety) and talking treatments (where demand greatly outstrips supply).

**Supporting primary care to offer social prescribing**

Effective social prescribing will depend on the quality of partnership, joint working and co-operation between primary care staff and a wide range of voluntary and community groups, as well as statutory providers like local authorities. Cultural differences between medical and community development models emerged as a strong potential source of tension in compiling the data for this report. At the same time, social prescribing fits well within the Scottish Government’s commitment to increasing patient choice and a long tradition within community development of addressing the social and economic

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² This is recognised in the recent English White Paper *Our health, our care, our say* (Department of Health 2006) which makes a commitment to including simple messages about mental wellbeing in the social marketing strategy currently being developed to support Choosing Health. See also Appendix Four.
determinants of health. *Delivering for Mental Health* (Scottish Executive, 2006) aims to accelerate improvements in mental health services across Scotland, and its objectives include promoting access to a wider range of interventions options. There is, therefore, considerable potential for dialogue and overcoming barriers. Community Health Partnerships (CHPs) provide a real opportunity to develop links between primary care and the community and the voluntary sector to facilitate social prescribing. CHPs have a remit and responsibility for improving the health, including the mental health, of their local populations and ensuring access to effective interventions for people experiencing mental health problems. Social prescribing represents a means for CHPs to extend the range of options available to people who present to primary care practices with mental health problems and in doing so to make best use of specialist mental health resources.

Practical challenges in implementing social prescribing include:

- Maintaining up to date information on sources of voluntary and community support
- Agreeing referral criteria
- Recording and evaluating impact and outcomes
- Accountability and liability for referred patients.

Other problems raised include concerns about voluntary sector capacity, concerns about increased GP workload at least initially and identifying resources for a skilled link worker (referrals facilitator).

**How will we know we’ve made a difference?**

The overall aim of social prescribing is consistent with the goal of the Scottish Government’s National Programme, namely to improve mental health and wellbeing for all and to improve quality of life for people with mental health problems. The specific objectives of increasing the availability of and access to social prescribing are:

- Increase public knowledge of positive steps for good mental health e.g. exercise, sensible drinking, eating well, stress management, building and maintaining social networks, talking things over
- Increase social prescribing as first line treatment for symptoms of mild to moderate anxiety and depression and other common mental health problems
- Reduction in inappropriate prescribing of antidepressants for mild to moderate depression, in line with guidelines from the National Institute for Health and Clinical Excellence (NICE)
- Reduction in frequent attendance (defined as more than 12 visits to GP per annum).
The monitoring of outcomes for social prescribing might be done at primary care practice, CHP and/or health board level, and be measured through, for example, improved General Household Questionnaire (GHQ) Social Functioning (SF) or Patient Health Questionnaire (PHQ) scores or through the recently developed Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).³

Short and medium-term outcomes which could provide a basis for assessing whether social prescribing has made a different might include:

- Increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at risk groups, including people using psychiatric services
- Increased levels of social contact and social support among marginalised and isolated groups
- Reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression
- Reduced waiting lists for counsellors or psychological services.

In the long-term, the mental health benefits of the widespread adoption of social prescribing, together with greater public awareness of and commitment to taking steps to improve mental health and wellbeing, could be measured through public mental health indicators currently being developed as part of the Public Mental Health Indicators Project (http://www.healthscotland.com/understanding/population/mental-health-indicators.aspx).

³ The Warwick-Edinburgh Mental Wellbeing Scale has been developed specifically to measure positive mental health. It has been piloted and is now being used in population surveys.
1.0 Background

This report was commissioned from the Scottish Development Centre for Mental Health (SDC) by the Scottish Government’s National Programme for Improving Mental Health and Wellbeing, to address the role and potential contribution of social prescribing or community referral in two principal areas of concern in mental health:

- Effective identification and response to people with common mental health problems presenting in primary care
- The role of primary care in supporting people with long term mental health problems.

It comes at a time of growing concern about potential overreliance on pharmaceutical treatments for common problems like anxiety and depression and growing evidence for the benefits of psycho-social interventions in promoting recovery across the spectrum of mental health problems. It is also part of a broader recognition of the contribution mental health improvement can make to public health and the importance of increasing public awareness of how to look after mental, as well as physical, health.

This report is based on an overview of the existing literature on social prescribing and case studies submitted from across Scotland in response to a questionnaire circulated by the SDC (Appendix 2). Thirty-five case studies were submitted.

2.0 Aims

The aim of this report is to provide information that could inform the future development, commissioning and design of social prescribing or community referral programmes in Scotland.

The report includes:

- What we know – an overview of the literature on social prescribing
- What works – a summary of the emerging evidence base
- How it might work in Scotland – an assessment of the policy and practice environment in which social prescribing could be developed further in Scotland
- Measuring success – some guidance on evaluation
- Challenges, opportunities and recommendations.

Social prescribing is an emerging field. This report is intended to enable key partners to work with what is already known about alternative responses to
common mental health problems and improving quality of life for people who use mental health services. It also aims to contribute to the debate about how Community Health Partnerships can most effectively meet their mental health care responsibilities, as well as providing a basis for the development of pilot social prescribing projects.

The report:

- Complements the broader aims of the National Programme to improve mental health for all and quality of life for people with mental health problems, the aims of the *Doing Well by People with Depression* programme and *Delivering for Mental Health*, notably improving access to community based support
- Supports key themes in the Kerr Report *Building a health service fit for the future* (Scottish Executive, 2005b), in relation to enabling people to participate in looking after their own health, promoting preventative and anticipatory care and reducing waiting times
- Describes how social prescribing might contribute to the responsibility of CHPs, set out in *Principles and Guidance for Integrated Mental Health Services* (Scottish Executive, 2004b) to:
  - promote mental health and wellbeing in their resident populations
  - promote good physical health in those with mental illness and their carers
- Explores the information, tools and procedures that CHPs might need to make social prescribing for mental health viable and sustainable, and to extend the range of options for those who present in primary care settings with mental health needs
- Reinforces and complements key messages from the *Doing Well by People with Depression* programme, which aimed to improve access to psychological interventions for people with common mental health problems, as described in more detail below
- Examines the potential of social prescribing to assist in promoting recovery and in tackling exclusion, by facilitating access to mainstream opportunities and activities for people with long term mental health problems. This is consistent with Section 26 of the Mental Health (Care and Treatment) (Scotland) Act (2003) which requires local authorities to:
  - provide services to promote wellbeing and social development
  - help people who have or have had a mental disorder to live lives which are as normal as possible.
Doing Well by People with Depression

This three year programme (2003 – 06), funded by the Scottish Government, supported by the Centre for Change and Innovation, and evaluated by an independent research consortium, was designed to improve the quality of care and treatment for people with mild to moderate depression. Ten health board areas across Scotland took part in pilot work which aimed to:

- Build capacity for brief psychological interventions in primary care
- Improve the assessment of the symptoms that people present with and enhance the range of treatments and support available
- Improve access to community-based services and support.

(McCollam et al, 2006)

Further details about the Programme and its evaluation can be found at: http://www.scotland.gov.uk/Publications/2006/07/12090019/0

3.0 What is Social Prescribing?

Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning, volunteering, mutual aid, befriending and self-help, as well as support with, for example, benefits, debt, legal advice and parenting problems.

Social prescribing provides a framework for:

- Developing alternative responses to mental distress
- A wider recognition of the influence of social, economic and cultural factors on mental health outcomes across the whole spectrum of disorders
- Improving access to mainstream services and opportunities for people with long term mental health problems.

Primary care has a key role in the early identification and treatment of common mental health problems, notably anxiety, depression and phobias, as well as a wider role in promoting mental health and wellbeing, alongside the promotion of physical health. While both medication and psychological therapies have a role, social prescribing provides a further opportunity to strengthen the capacity of primary care to respond effectively and at an early stage, to symptoms of mental
distress, as well as initiating a more proactive approach to mental health improvement.

A study commissioned by the former Scottish Health Feedback in 1999 found a significant gap in services for people with psycho-social problems for whom referral to psychiatric or psychological services is not appropriate. They also found wariness and lack of knowledge of voluntary and community resources among GPs, together with a strong interest in forging ‘better links with local voluntary organisations’.

(Scottish Health Feedback, 1999)

"I have a general concern about the potential "medicalisation" of social prescribing, indeed the name itself suggests that it needs a doctor’s approval. Therein lies perhaps one of the major barriers as in general it is not easy to get medics to accept the value of social support."

(response to SDC consultation on social prescribing; see Appendix 2)

Social prescribing is also relevant to aspects of the National Waiting Times Initiative on Psychological Therapies, and the subsequent Doing Well by People with Depression Programme which examined the pathways in place and those required to improve the client journey through local care systems (SDC, 2002; McCollam et al, 2006). What social prescribing brings is a particular focus on the development of access to Tier 0 and Tier 1 community services as an alternative and as a complement to more specialist health care interventions.

The most common examples of social prescribing are primary-care based projects which refer at risk or vulnerable patients to a specific programme, for example Exercise on prescription, Prescription for learning and Arts on prescription (Aldridge and Lavender, 2000; James, 2001a,b,c; Friedli and Watson, 2004; Tyldesley and Rigby, 2003; Huxley 1997; Millin, 2003). However, it also includes a very wide range of initiatives in which primary care staff provide a signposting or gateway service, linking patients with sources of information and support within the community and voluntary sector.

Although a comprehensive mapping of social prescribing practice in Scotland is beyond the scope of this study, a questionnaire distributed by the Scottish Development Centre for Mental Health (Appendix 2) demonstrated considerable interest and elicited 35 examples of local projects.
4.0 Rationale for social prescribing

Current interest in social prescribing is based on its potential benefits in three areas: reducing prevalence of and improving mental health outcomes and therefore demands on health services; improving community wellbeing; and reducing social exclusion.

4.1 Reducing prevalence of mental health problems and improving mental health outcomes

Social prescribing can contribute to the prevention of common mental health problems and to the promotion of good mental health in the following ways:

- It recognises the importance of social support as a protective factor for both mental and physical health (Brugha et al, 1993; Cohen, 1997; Oxman et al, 1992; Rosengren et al, 1993; Berkman, 1995; Faulkner, 2004)
- It draws on evidence of the health benefits of participation, involvement and reciprocity, drawn from research on social capital (McKenzie and Harpham, 2006; Cooper et al, 1999; ONS, 2003; Department of Health, 2001b)
- It offers a wider range of treatment options to increase patient participation in the decision making process, which is known to improve concordance and, ultimately, clinical outcomes (NICE, 2004a).

4.2 Reducing incidence/improving community wellbeing

Social prescribing can also contribute to improved mental and wellbeing for communities by:

- Acknowledging the importance communities attach to social contact, social activity, opportunities to learn and develop skills, involvement and having a role as positive influences on mental health (SDC, 2003)
- Integrating mental health within broader strategies for regeneration, closing the opportunity gap and social justice (Cameron et al, 2003; SDC, 2003)
- Building voluntary and community capacity to promote mental health (Scottish Executive, 2004d).

4.3 Promoting social inclusion

Social prescribing is a valuable resource to promote social inclusion by:

- Increasing access to opportunities and activities within the community, notably for those with long term mental health problems (Bates, 2002; Friedli and Gale, 2002; Scottish Recovery Network, 2004; Social Exclusion Unit, 2004)
• Shifting the focus of treatment and management to a recovery model, which addresses the needs of the whole person in the context of a wide range of factors influencing their quality of life (Department of Health, 2001a; 2001d; NIMHE, 2003b).

**A holistic approach**

Social prescribing embraces a range of perspectives on the causes and treatment of mental health problems and different definitions of both mental health and mental disorders. The broader, holistic framework evident in social prescribing, with an emphasis on personal experiences, relationships and social conditions, may be more compatible with lay understandings of mental wellbeing and mental distress (Rogers and Pilgrim, 1997) than a medical model, although there is also considerable support for more holistic approaches among GPs. Some people, including GPs, do not like the term ‘prescribing’, seeing it as implying a medical model and prefer to use ‘referral’ e.g. exercise referral, or community referral schemes.

A postal study of 2,311 general practitioners in Scotland found that nearly nine out of ten thought a holistic approach was essential in delivering high quality care (Mercer et al, 2002).

Recent research by the Mental Health Foundation found that 78% of GPs have prescribed an antidepressant in the last three years despite believing that an alternative treatment might have been more appropriate. 66% have done so because a suitable alternative was not available, 62% because there was a waiting list for the suitable alternative, and 33% because the patient requested antidepressants. 60% of GPs surveyed would prescribe antidepressants less frequently if other options were available to them (Mental Health Foundation, 2005).

The model below, adapted from the World Health Organization’s *World Report on Violence and Health*, provides an ecological framework for understanding the factors that contribute to mental health and wellbeing and the role of social prescribing in strengthening links between the distressed individual and sources of support.

5.0 Outcomes

The long term aim of social prescribing is to improve mental health and quality of life and/or to ameliorate symptoms, measured through, for example, improved GHQ or SF scores or through a range of validated scales which may be used to measure key elements of mental health and wellbeing e.g. confidence, optimism, self-efficacy, hopefulness, life satisfaction, sense of purpose or meaning. Short and medium-term outcomes might include:

- Increased awareness of skills, activities and behaviours that improve and protect mental wellbeing
- Increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at risk groups, including people using psychiatric services
- Increased levels of social contact and social support among marginalised and isolated groups
- Reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression
- Reduced waiting lists for counsellors and psychological services.

6.0 Who is social prescribing for?

Social prescribing has been quite widely used for people with mild to moderate mental health problems, with a range of positive outcomes including enhanced self-esteem and reduced low mood, as well as social benefits. There is also a growing interest in social prescribing as a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with severe and enduring mental health problems (Bates, 2002; Gask et al, 2000).

Broadly, social prescribing is one route to providing psycho-social support for:

- Vulnerable and at risk groups such as, low income single parents, recently bereaved elderly people, people with chronic physical illness
- People with mild to moderate depression and anxiety
- People with severe and enduring mental health problems
- Frequent attenders in primary care.

(Frasure-Smith, 2000; Greene, 2000; Harris et al, 1999).

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4 A guide to mental health and wellbeing scales is to be published in 2007 by NHS Health Scotland as part of the Evidence into Practice/Practice into Evidence series.
Social prescribing may be particularly appropriate for isolated or marginalised groups and/or for groups whose needs may be best met from within the voluntary and community sector (VCS). Some women and lesbian, gay, bisexual and transgender people may find support from the VCS more accessible (Hutchison et al, 2003). Some black and minority ethnic (BME) communities have also expressed a strong preference for support provided within the BME voluntary sector (Mental Health Act Commission, 2001; Department of Health, 2003a). In these cases, social prescribing via a referral facilitator or link worker can facilitate understanding between primary care and ethnic minority communities (Gillam and Levenson, 1999).

7.0 Policy and practice environment for social prescribing in Scotland

A number of developments have created a potentially favourable policy environment for social prescribing in Scotland. These include a stronger policy emphasis on:

- Public participation and patient involvement e.g. Our National Health: a plan for action a plan for change (Scottish Executive, 2000) the Kerr Report (Scottish Executive, 2005b) and Delivering for Health (Scottish Executive, 2005c), public partnership forums, expert patients
- Partnership with the voluntary and community sectors, which is a requirement for community planning and CHPs, in health improvement
- Social inclusion, through the social justice agenda and integrating social inclusion and community planning partnerships
- Holistic definitions of health which recognise the impact of psycho-social and socio-economic factors, as well as the mental health impact of chronic physical disorders.

7.1 Expanding the boundaries

Expanding the boundaries of primary care is a recurring theme in a range of primary care guidelines, including stronger engagement with local authorities and closer links with, for example, Citizens’ Advice Bureaux, benefits and housing agency workers and partnerships developed through Healthy Living Centres and Health Demonstration Projects in disadvantaged and deprived communities.

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5 The Scottish Public Health Observatory provides a useful summary of key policy documents from the perspective of mental health and wellbeing
http://www.scotpho.org.uk/web/site/home/Healthwell-beinganddisease/MentalHealth/mental_keypolicy.asp
At a UK wide conference on social prescribing, the benefits for patients of greater involvement through partnerships between primary care and the voluntary and community sectors were summarised as follows:

- Builds networks
- Provides group support
- Increases confidence
- Develops transferable skills
- Fosters feelings of control.

(CCVS 2003)

**Healthy Living Initiatives**

A number of Healthy Living Initiatives use social prescribing models to support health improvement and address health inequalities.

**Aberdeen Healthy Living Network**

The Network has a very wide range of voluntary and statutory sector partners who refer people to Network activities, as well as supporting communities and groups wishing to establish particular initiatives. A range of activities are provided which aim to improve the financial circumstances, life choices, opportunities and skills of local people, in addition to developing opportunities for greater influence on local health policy and services. These include arts and creativity, parenting support and lifeskills, complementary therapies, benefits advice, credit union, volunteering and mentoring.

Primary care does not currently refer patients to Network activities, although the Network has strong links with health visitors and is currently trying to strengthen links with primary care with a view to encouraging their access to services offered through the Network.

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**Bute Healthy Living Initiative**

Bute Healthy Living Initiative (HLI) runs a variety of programmes including a garden project, a walking for health project, self-help groups, arts and crafts and complementary therapies. There is a formal referral process via GPs, community psychiatric nurses (CPNs) and other health professionals for exercise. For other projects, people self-refer. There are plans to develop a pilot project for referral to art therapy. After a slow start, Bute HLI now gets many referrals for its exercise programmes from GPs, however, for other programmes more knowledge and evidence based research, aimed at GPs, on the benefits of social prescribing is needed.

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7.2  Community health partnerships

Guidance for Community Health Partnerships also stresses the importance of transcending barriers between different levels of care and a multi agency approach to meeting health needs:

"the traditional view of primary care, secondary care and social care should change over time as professionals working within and across these areas remove barriers to joint working and design alternative models of care delivery based around patient pathways that are adapted to suit local circumstances."

(Scottish Executive, 2004b)

This includes greater recognition of the role of the voluntary sector and building on their long tradition of close working with local authorities. The ‘power to advance wellbeing’ provision in the Local Government in Scotland Act 2003 also gives quality of life a new significance for local authorities. *Quality of life* is a way of assessing levels of wellbeing, as opposed to illness. It includes economic, social and environmental factors, such as, employment, housing, quality of the natural environment, cultural and leisure facilities, noise, pollution and safety.

### Community Health Partnerships

CHPs have been given a pivotal role to work closely with local communities in making a direct and measurable improvement in local population health and to provide higher quality, accessible and joined up services, with a special focus on the management of chronic disease and addressing health inequalities. CHPs have an explicit community-based health promotion and health protection function which will involve forging stronger links with, and greater input from, community and voluntary sector organisations.

Community planning processes have the potential to be powerful vehicles to shape Joint Health Improvement Plans (JHIPS) and facilitate implementation of agreed priorities. JHIPS set out objectives, strategies and actions for each partner organisation within the community planning partnerships to improve health and reduce inequalities within their local populations. These plans are in turn reflected in local health plans developed by each NHS Board and subject to annual performance assessment. CHPs can ensure actions identified in JHIPS are based upon the best evidence of action that can best deliver health improvement for the community.
Expanding the boundaries of health care provision:

Building healthy communities (BHC) in Dumfries and Galloway

Through strong and effective partnership working with statutory and voluntary agencies this project aims to: build individual, organisational and community capacity in order to address health inequalities and to take action to tackle the root causes of these inequalities; and strengthen the infrastructure for health regionally. The project places emphasis on building healthy communities from the bottom up so that work carried out strengthens and influences existing services within the community.

The project, which takes a community development approach to health and wellbeing, focuses on first step social support and early intervention for those dealing with anxiety, stress, depression, isolation, lack of self-esteem and addiction. While it develops local health initiatives that address health inequalities, it also offers learning options for local people interested in becoming volunteers, capacity-building opportunities through engagement in local decision making, community planning and, most importantly, removing barriers to these opportunities such as the need for support with childcare and transport expenses. A range of activities are determined by local needs and are set out in local action plans.

The recruitment, support and deployment of Community Health Volunteers (CHVs) is a central feature of the project, aiming to create a graduated hierarchy of opportunities – i.e. from participating in the activities that the project generates to involvement in the facilitation of initiatives, at a pace that suits the individual. BHC staff work closely with the CHVs to help them develop their own ‘individual learning plans’ which are tailored and based on the individuals’ needs and the needs of their local communities. Host organisations work in partnership to provide work experiences for the Community Health Volunteers while benefiting from gaining some volunteering.

Other activities include: befriending and peer support groups e.g. Jills of all Trade (this provides women with children the opportunity to learn DIY skills and in doing so also promotes the development of peer support); groups for new parents and parents to be; arts based activities such as the Arts for Health initiative, writers’ groups, drama groups; and physical and relaxation activity groups, and access to complementary therapies.

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7.3  Making links with the wider policy agenda

The principles of social prescribing are relevant to and supported by Scottish Government policy on arts and culture, employment, lifelong learning, employability, volunteering, environment and conservation, health, sport and physical activity (Appendix 1).

The key activities which social prescribing involves (arts and creativity, learning, training and volunteering) access to the natural environment, sports and leisure therefore all rest on national strategies which highlight their contribution to:

- Health, wellbeing and quality of life
- Reducing inequalities
- Regenerating deprived communities
- Building the confidence that individuals and communities need to be able to thrive socially and economically.

Key themes across all policy areas include:

- Increasing participation among those most deprived and marginalised
- Reducing social exclusion
- Helping people to take more responsibility for actively managing their own health
- Promoting opportunities for physical activity
- Holistic views of health
- The relationship between the emotional wellbeing of individuals and communities and broader health and socio-economic goals for Scotland.

8.0  The case for social prescribing: why do it?

Primary care has a crucial role in promoting the mental and physical wellbeing of people with severe and enduring mental health problems, as well as those experiencing mild to moderate levels of distress (Jenkins and Ustun, 1998; Gask et al, 2000).

It is well known that within primary care around 30% of all consultations and 50% of consecutive attendances concern some form of psychiatric problem, predominantly depression or anxiety (Kessler et al, 2001; Scottish Executive, 2005a).
Prevalence of anxiety and depression in Scotland

44% of adults living in Scotland know someone who has experienced depression. 21% of Scottish women and 14% of Scottish men have been diagnosed by a doctor as having depression at some point in their lives (Scottish Executive, 2002). Depression was the commonest contributing diagnosis for people in Scotland visiting their GP in 2000, with GP consultation rates for depression and anxiety at 237 per 1,000 of the population (Philip et al, 2002). In Glasgow, depression and anxiety account for 73% of all mental health consultations in general practice. Women consult their GPs for depression around two and a half times more commonly than men, a proportion which increases amongst those living in the most deprived areas.

The mental health of young people is of particular concern. For ages 12-25 in Scotland, West and Sweeting (2002) found that a significant minority (up to one in three males, two in five females) of respondents had experienced psychological distress (malaise and high GHQ scores) and one in ten meet the criteria for psychiatric disorder, about half of whom have emotional disorders and half conduct disorders. Across the UK, rates of depression and anxiety among teenagers have increased by 70% in the past 25 years (Collishaw et al, 2004).

All local NHS organisations across Scotland should have protocols for managing anxiety, depression, postnatal depression and other common mental health problems within primary care. In practice, such protocols usually focus on the prescription of medication and referral to talking therapies, notably cognitive behavioural therapy. Initiatives like Doing Well by People with Depression have contributed to understanding how the evidence that supports a wider range of responses (NICE, 2004a; 2004b; 2006b; Bower et al, 2001; Jorm et al, 2002) can be introduced in a local context with good effect.

Interface between primary care and the community: summary

- Evidence is up and coming but there is growing support to show that non-medical or psychological approaches can improve outcomes in mental health and impact on people’s wellbeing
- Psycho-social needs and social inclusion can be better met by access to community and voluntary resources, and facilitated through models of service delivery between primary care and the community
- Appropriate voluntary and community resources should be available and accessible in local areas and improved links and joint working are needed between health and voluntary sector services.

(Scottish Executive, 2005a)
Given that primary care should also be contributing to local strategies for the improvement of mental health via Community Planning Partnerships, there is considerable scope for looking at how the development of mental health improvement within the community can assist a wider range of approaches to mental distress within primary care.

Social prescribing is therefore a potential mechanism for:

- Improving primary care provision for those with mental health needs across the spectrum of disorders
- Offering greater choice to patients
- Providing a gateway to community-based resources.

**Cost of treating common mental health problems in Scotland**

The major contributor to the cost of drugs associated with mental health problems in the community comes from antidepressants (now £44 million of the £60.6 million total for mental health drugs). The cost of antidepressants in Scotland rose rapidly until 99/00 (over £30 million increase in 8 years; £12.2 million to £44.5 million) but has now peaked. This is in large part because Prozac has come off patent and cheaper generics are available.

Between 1992 and 2001 the number of dispensed prescriptions for antidepressants more than doubled from 1.2 million to 2.8 million per year. The average cost per prescription for antidepressants also rose between 92/93 and 99/00 (£10.61 to £17.56) but has since fallen (to £15.93). About 40% more is spent per head on antidepressants and 30% more per head spent on anxiolytics in Scotland than in England. This is despite data from the Office of National Statistics that does not show significant differences in prevalence of neurotic disorders (mostly anxiety and/or depression) between Scotland and England. (Philip et al, 2002)
8.1 Common mental health problems

GPs have been the target of concerted efforts to improve the recognition and treatment of depression, and primary care is widely recommended as the first port of call for people experiencing symptoms. This poses problems because, while there are reliable diagnostic tools for severe depression, symptoms below that level are much harder to classify. They could represent the early or late stages of severe depression, reactions to life events or responses to adverse socio-economic circumstances (Goldberg et al, 1998; Freudenstein et al, 2001). In the absence of alternatives, GPs prescribe antidepressants at considerable cost and, for mild to moderate depression, with little robust evidence of effectiveness. In Scotland, the number of prescriptions for antidepressants has trebled over the decade to March 2003 (Scottish Health Statistics, 2003).

Concerns about potentially high levels of mental ill-health and the considerable proportion of people whose symptoms would reach the threshold for diagnosis, as well as concerns about the rapid increase in the prescription of antidepressants, have generated major debates about alternative responses to mental distress in primary care. In particular, concern has been expressed about attaching a diagnosis to what may be, in effect, manifestations of socio-economic problems (Shaw and Middleton, 2001). The crucial questions concern the determinants of mental health and the locus of responsibility for the mental health of individuals, families, organisations and communities. That these do not lie solely with the NHS is self evident. This suggests that primary care needs to work more closely with agencies which influence these broader determinants of mental health and develop links with alternative responses to, and sources of support for, mental distress.
NHS Borders Galashiels Wellbeing Project: minor mental health problems in primary care

This is a volunteer-based service offering a range of existing community activities and services and developing the skills of local people. The wellbeing project is a service for people in primary care with mild to moderate stress, anxiety or depression, with psychosocial problems, who may not necessarily require referral on to secondary care. It benefits those who struggle with everyday life by providing a tailored response to their needs and by linking people to volunteers, voluntary organisations and local support services, as well as providing self-help materials.

The project gives primary care staff the opportunity to offer a wider range of services and to relieve some of the pressure on their time.

Referral is through GPs, health visitors, community nurses, practice nurses or other members of the primary care team.

Anecdotal feedback from primary care suggests a decrease in GP appointments, and evaluation shows a reduction in severity of stress, anxiety and depression by people using the project. Referrals from the primary care team are increasing and the service runs at full capacity almost constantly.

In the first two years of the service, a total of 83 patients have been referred by health visitors and GPs. Sixty-seven review forms were sent to patients using the project and 36 have been returned. Thirty-four of these felt that the project had helped them in some way.

The project is well documented and includes assessment, referral, evaluation and review forms.
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8.2  Frequent attenders

Frequent attenders in primary care, defined as those who consult more than 12 times in a year, represent more than 15% of a GP workload (Heywood et al, 1998). Reducing attendance by one visit a year can lead to a reduction of 1% in a GP workload (Heywood et al, 1998).

**Cowal Stress Management Service**

The aim of the service is to improve mental health and wellbeing. Based in Dunoon, the service provides a wide range of complementary therapies, e.g. aromatherapy, head massage and reflexology, as well as guidance and support on stress, diet, exercise, relaxation, smoking, alcohol etc.

Referral is through a wide range of agencies, including primary care, social services, schools and employers, as well as self-referral. There is currently a long waiting list for the service, although failure to attend appointments is also a significant problem.

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The reasons for frequent attendance are complex but there is some evidence that it is related to unresolved mental health issues (Dowrick et al, 2000). Dowrick et al found that depressive symptoms were the major predictor of frequent attendance and argued that clinical activity should therefore concentrate on the identification and management of psychological problems among frequent attenders in general practice (Dowrick et al, 2000). Heywood also identified the importance of adopting a strategy to tackle low levels of wellbeing in this population (Heywood et al, 1998). Dowrick et al (2000) make three recommendations:

- General practitioners should consider depression to be a likely diagnosis for frequent attendance patients
- Frequent attendance is a clinical phenomenon, like raised blood pressure, which should be routinely recorded in patients’ notes
- Primary care interventions aiming to reduce the extent and burden of frequent attendance should now focus on the effective management of depression and related disorders.

In view of the possible relationship between frequent attendance and common mental disorders, frequent attenders are a further potential target group for social prescribing.
### 8.3 People with long term mental health problems

The majority of people with long term mental health problems are managed within primary care.

In addition to improving the primary/secondary care interface, primary care also has an important role in promoting recovery, broadly described as “a way of living a satisfying, hopeful and contributing life, even with limitations caused by the illness” (Anthony 1993; Scottish Recovery Network, www.scottishrecovery.net).

#### Focus on recovery: Lothian Bridges Group

The project aims to reduce social isolation among people with mental health problems and enable people to move on in their lives. Referral is via community mental health nurses, occupational therapists and GPs, although people can also self-refer. Activities include art and complementary therapies, walks, creative writing, visits and producing crafts.

People attending have been able to move onto mainstream education or employment, reduce or stop medication and set up their own support network. They have become less reliant on mental health services, and visits to GPs have been reduced.

"the key to success in assisting recovery is that the focus is on developing new friends, skills, having an enjoyable time and the opportunity to try new activities. The problem-based focus of many current therapeutic approaches can reinforce negative thinking, rather than focussing on the future and giving people hope – which we believe is what is needed."

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Key themes in the recovery model include broadening clinical outcomes to include the goals of users, e.g. for employment: independence, satisfying relationships and quality of life (Drake et al, 2001). This means re-thinking and expanding definitions of treatment to identify what an individual needs to regain, or hold onto a life that has meaning for them, as well as enabling people to more easily integrate into society.

Lifestyle clinics have been introduced in GP practices in Aberdeen for people with long term mental health problems, run by a CPN, a practice nurse and a phlebotomist. Clinics do a comprehensive physical health screening and the results are fed back to the psychiatrist and the patient.
There is an extensive body of research, including an emerging body of user led research, that identifies what those who use mental health services find helpful in living and coping with mental distress. The Scottish Recovery Network has collated perspectives on recovery from a range of individuals across Scotland (http://www.scottishrecovery.net/content/). A predominant theme in this and other research is the importance of social networks, friendship, acceptance and opportunities to participate in and enjoy the same range of everyday activities as everyone else (Faulkner, 2002; 1997; Mental Health Foundation, 2000).

At a policy level, it is now widely recognised that action to tackle stigma and discrimination and the social exclusion of people with mental health problems is fundamental to achieving improved mental health and quality of life for service users (Scottish Executive, 2004a; Social Exclusion Unit, 2004). Social prescribing is one prong of a broader social inclusion agenda and uses primary care as a gateway to increase opportunities for people with long term mental health problems to access everyday sources of support, leisure, friendship and activity within the community.

9.0 Guidelines on social prescribing

There are currently no general national guidelines on referral to non-medical sources of support in either England or Scotland although the emerging literature on integrated care pathways and the primary care/community interface may be a useful starting point (Scottish Executive, 2005a). A national quality assurance framework for exercise referral was published by the Department of Health in 2001.

It includes depression, anxiety, negative mood and low self-esteem as health problems for which there is strong evidence of the beneficial impact of physical activity (Department of Health, 2001c). The framework provides recommended quality standards but suggests that quality control is the responsibility of individual schemes. Each primary care based referral scheme should establish its own selection criteria, tailored to the local population and the range of facilities available.

The National Institute for Health and Clinical Excellence (NICE) has released guidelines on the management of anxiety and depression, which include within the recommendations for evidence-based treatment options, approaches that often fall under the ‘social prescribing umbrella’, for example, exercise-referral,

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6 The latest guidance on public health interventions from NICE states that ‘there is insufficient evidence to recommend the use of exercise referral schemes to promote physical activity, although this does not, of course, undermine evidence for the mental health benefits of increased physical activity (NICE, 2006a)
self-help, CBT based approaches, bibliotherapy, social support and, more recently, computer-assisted CBT. However, the guidelines do not include referral guidelines (NICE 2004a; 2004b; 2006b).

The extent to which protocols for referral to formal schemes is the most appropriate way forward is, in any case, subject to debate, notably in relation to exercise. For example, the Physical Activity Strategy for Scotland does not recommend exercise referral per se, but recommends that all primary care practitioners should be capable of offering advice and targeted support to all patients (Scottish Executive, 2003c). Some evidence suggests that for the general population, guidance about how to include more physical activity in day to day life, combined with a supportive environment for walking and casual recreation is more effective than being sent to a sports/leisure facility for a prescribed programme (NICE, 2006a).

One of the constraints GPs reported for not giving good information and supporting people to get active has been that they lack a simple tool to assess people’s current level of activity. We are working with the Department of Health in England to develop a short valid measure of activity levels that can be coded and held on patient records and used to direct them to types of support appropriate to their level of activity. We believe that good advice, support and direction from primary care is an essential component in our strategy to increase activity levels in Scotland. We do not believe that this should be narrowed down to GP Exercise referral schemes – this is a view supported with evidence. Our current investment in the NHS goes well beyond this approach and seeks to offer support to everyone in Scotland, not only the limited numbers that can be processed through referral schemes. However, we recognise that such schemes may have a place in this overall approach. We are investing in Glasgow and Highland referral schemes to ensure they become more efficient and effective in narrowing health inequalities and reaching hard to reach groups.

Mary Allison, former Scottish Executive Physical Activity Co-ordinator

9.1 Models and approaches

The level of guidance required will depend on the approach to social prescribing adopted e.g. self-referral and signposting through the provision of information, indirect referral via an advisor or link worker or formal direct referral from a member of the primary care team.

Many primary care settings currently collate information on local self-help groups, in addition to providing a wider range of data on community-based support and services within education, leisure and welfare, for example. This might take the form of a local directory, patient information leaflets, notice
boards, internet access etc., in addition to more proactive provision of space and facilities for community groups within primary care practices.

Other social prescribing or referral schemes have a worker based in primary care to facilitate referrals and joint working.

### Borders: Doing Well by People with Depression Self-help Service

The Self-help service in the Borders consists of three elements: guided self-help, the Toolkit, and a variety of multimedia self-help materials.

**Self-help:** Two self-help coaches (also known as advice workers) based in two Health Centres provide guided self-help to people in the catchment area of these Health Centres. Guided self-help support is offered to people suffering from mild and moderate depression, anxiety and psychosocial problems. The self-help coaches also function as a hub to refer to other services that are part of the Toolkit.

**Toolkit:** This is a sign-posting database containing information about local health, social care, and voluntary services. It provides information to patients, carers, and professionals and facilitates networking between participating local services. **Self-help materials** include booklets and relaxation CDs. These well-received and sought-after materials are disseminated to patients and a wide variety of associated statutory and voluntary organisations.

### Pathway

Initially, only GPs in the participating practices were able to refer patients to the Doing Well Self-help service. However, this was later extended to enable health visitors and nurses to refer patients. Patients are given an appointment at reception on the referral day and are offered up to three sessions with a self-help coach. In the course of these sessions the patients are assessed and the coach judges whether and how to make use of the self-help materials and the Toolkit. If deemed appropriate the self-help coaches accompany a patient to their first appointment with another service. Information about the service is disseminated to patients, carers, and organisations by all services that form part of the Toolkit.

(McCollam et al, 2006)

See also the NHS Borders Kelso lifestyle advice case study in Appendix 5.

Social prescribing can also be integrated within the ‘stepped approach’ to care as piloted in the Doing Well programme (McCollam et al, 2006) which involves the delivery of low intensity, low cost treatments (for example supported self-help), as a first option prior to referral to higher intensity, high-cost care. The following model is taken from the recent NICE guidelines on managing depression.
See also the Glasgow STEPS case study in Appendix 5.

9.2 Liability

Liability issues are often a concern to general practitioners and greater clarity is needed when addressing this in the context of social prescribing. In our questionnaire, concerns about accountability were frequently mentioned as a barrier to GP support for social prescribing in Scotland:

“work needs to be done within primary care regarding legal responsibility for referrals. This issue has been a major stumbling block in the past for similar schemes.”

(response to SDC consultation on social prescribing)

The Medical Protection Society issued a statement in 2000, endorsing the role of GPs in facilitating the use of exercise programmes (Department of Health, 2001c).

**Register of Exercise Professionals**

Registration is available for all fitness professionals who work in gym instruction, group exercise classes, circuits, keep fit, personal training, yoga, advanced instruction techniques, or work with special populations and exercise referral and physical activity programmes. As a member of the REPs, individuals are issued with a membership card and a certificate of registration which shows their level of practice and date of expiry.

Tel: 020 8686 6464  Email: info@exerciseregister.org
Website: http://www.exerciseregister.org/
The Department of Health guidelines distinguish between recommending, for example, that a patient tries to be more active and specifically directing a patient through a referral process (Department of Health 2001c). In the case of exercise, when the patient is specifically referred, responsibility for safety, management, design and delivery passes to the exercise professional – who should be members of the professional register for exercise and fitness. The referrer is responsible for the transfer of relevant information to the person conducting the exercise intervention. In all cases, the patient must give informed consent.

9.3 **Referral criteria and risk assessment**

Referral criteria for social prescribing vary considerably. Explicit criteria, clearly agreed and understood by all partners, are essential. They ensure that patients are referred to appropriate activities and receive a level of support suited to their needs. They are also essential to the evaluation of the project. Some schemes, notably those referring people with complex needs, also carry out risk assessments.

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**Perth City Day Facilities Book Group**

The Book Group is a reading and discussion group for people with mental health problems living in Perth and Kinross. It is aimed at people who are currently unable to attend mainstream book groups due to mental health and is intended as a stepping stone into mainstream services.

A referral form, agreed with and signed by each participant, includes any concerns about risk, physical and mental health issues, as well as the name of a support contact. A standard risk assessment checklist is used to assess risk of harm to self or others.

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**10.0 Evidence of effectiveness**

Social prescribing has been quite widely used for people with mild to moderate mental health problems, with a range of positive outcomes including:

- Enhanced self-esteem
- Reduced low mood
- Opportunities for social contact
- Increased self-efficacy
- Transferable skills
- Greater confidence.
(Huxley, 1997; Oliver et al, 1996; Matarasso, 1997; Fox, 2000; Mutrie, 2000; Darbishire and Glenister, 1998; Grant et al, 2000)

For non-clinical populations, some of the most promising research focuses on addressing protective factors for mental health like for example, social networks, problem solving skills and self-esteem. Both naturalistic studies and controlled trials suggest that psychosocial situations generating new hope are associated with improved outcomes for depression and for those at risk of depression (Harris et al, 1999).

However, the development of an evidence base for social prescribing has been limited by wide variations in how the term is used and understood and considerable inconsistency in indicators used to measure success. The small size of pilot trials, lack of independent evaluation and poor methodology, notably in the design of qualitative research, all make it difficult to draw robust conclusions about the mental health impact of social prescribing, particularly in comparison with usual GP care or in terms of cost effectiveness.

I think one problem lies in how health and social care planners interpret evidence of a project demonstrating results. Their instinct is to "roll out" successful projects, whereas community-led work will surely work best where it is community-led, and therefore will look entirely different from one community to the other.

Members of our Primary Care team, such as community and public health nurses, have been using this type of approach for some time, which will not be found in published literature. For example, we have created a new post here of "family support worker" which is fairly similar to the Hackney project (the Hackney WellFamily Service, see below) except that the main source of referrral is community nurses, and the worker does home visits. And we do not call it social prescribing, but the principles are the same. I know it is difficult to capture that in an evidence review, but maybe the point needs to be made about the wider role of the PC Team, and in particular the public health role of community nurses in such approaches.

(response to SDC consultation on social prescribing)

In many cases, project evaluations are confined to feedback from participants and/or health and other staff involved. Key themes in staff and participant narrative accounts of social prescribing projects include:

- Strengthening individual protective factors e.g. confidence, skills, social networks, self-efficacy
- Strengthening community wellbeing e.g. building capacity, improved partnerships with statutory services
• Increasing social inclusion of deprived groups, notably people with long term mental health problems.
  (Friedli and Watson, 2002)

The use of validated questionnaires to gain participant views is rare. The Doing Well projects routinely used a Client Satisfaction Questionnaire (McCollam et al, 2006). There are some examples of the use of screening tools e.g. SF36, GHQ12, PHQ, and the Becks Depression Inventory, notably in arts and exercise on prescription and computer-assisted therapy schemes (see for example Tyldesley and Rigby, 2003). Although there appears to be a growing body of evidence on the health and social impact of individual projects, there are very few examples of controlled trials or comparisons between referral to non-medical sources of support and usual GP care. Data on cost effectiveness are also limited.

Although the evidence base for social prescribing is emerging, there is not strong evidence to highlight the exact impact of social prescribing and in which context it is most useful. It is potentially helpful for individuals, as an alternative to medication/ psychological interventions or as a method of supporting the psycho-social needs of vulnerable populations.
  (Scottish Executive, 2005a)

10.1  NICE Guidelines

Clinical guidelines on anxiety and depression from NICE demonstrate a growing interest in self-help and self-management approaches, as well as concerns about the use of antidepressants for the treatment of mild depression (NICE 2004a, 2004b). They also state that:

“a focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems”

In particular, the guidelines recommend that further trials of the efficacy of a range of social support interventions for socially isolated and vulnerable groups of people with depression should be undertaken. NHS Quality Improvement Scotland is one of the partner agencies involved in developing the guidelines and can therefore usefully inform approaches to social prescribing in Scotland.7

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7 See, for example, best practice guidance on depression and older people (NHS Quality Improvement, 2004)
10.1.1 NICE *guidelines on depression*

The NICE guidelines on depression (NICE, 2004b) can be summarized as follows:

- Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor
- For patients with mild depression consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT)
- In both mild and moderate depression psychological treatment (problem solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.

*For milder depression:*

- Many patients respond to interventions, such as exercise or guided self-help, although many improve while being monitored without additional help
- More structured therapies, such as problem solving, brief CBT or counselling can be helpful
- Antidepressant drugs and formal psychological therapies, such as longer term CBT or interpersonal psychotherapy (IPT), are not recommended as an initial treatment.

*For chronic depression:*

- Chronic depression is diagnosed when a person meets the diagnostic criteria for depression for at least two years
- Such patients may require combination treatments and attention to social and support factors that may maintain or ameliorate their difficulties
- Patients who have had chronic depression may require rehabilitation to help them regain confidence to return to more independent living
- People who have had severe or chronic depression may have been out of work for some time, so may require special help in returning to work
- Work provides a number of protective factors for depression including structure to a day, social contacts and self-esteem
- For people with chronic depression who would benefit from additional social support, befriending should be considered as an adjunct to pharmacological or psychological treatments
- Befriending should be by trained volunteers providing, typically, at least weekly contact for between two and six months.
10.1.2 *NICE guidelines on anxiety*

These provide specific information on self-help approaches as follows:

- Bibliotherapy, which should be based on CBT principles, should be offered
- Information on user-led support groups should be offered as a means of accessing self-help and support systems
- The benefits of exercise should be discussed.  
  (NICE, 2004a)

10.2 *Evaluation: some tentative conclusions*

In spite of some weaknesses in the evidence base for social prescribing, there is sufficient evidence of potential benefits to merit further investment and a strong case for appropriately designed and funded evaluation. At the same time, social prescribing is not alone in needing more research on effectiveness, cost efficiency, acceptability and accessibility (NIMHE, 2003a).

While the demand for evidence-based practice is likely to remain fundamental, questions about what counts as evidence are growing louder. It is now much more widely accepted that different methods and different criteria for measuring success are required across all areas of health and health service delivery. Central to the debate is the view that measures of success (health outcomes) need to be expanded to:

- Include the goals of mental health service users, for example employment, independence, friendships and quality of life
- Take account of lay/community perspectives in deciding what success looks like
- Draw on user-led research on people’s own expertise in living and coping with mental health problems.  
  (NHS Health Scotland, 2005)

Attitudes to evaluation and what is meant by effectiveness are changing in ways that will influence health and other professionals across all disciplines. At the same time, the difficulty of producing clear, demonstrable mental health outcomes for non-medical forms of care sits uneasily with the requirements of clinical governance (Rogers and Pilgrim, 1997). A key challenge will be finding both the measures and methodologies that can capture a wider range of domains than symptoms, and a wider range of stakeholder perspectives.
The overwhelmingly predominant theme running through people’s ‘most helpful supports’ was the role and value of relationships with other people, in all their different forms.

(Faulkner 2002, p.193)

11.0 Examples of social prescribing – what works?

This section includes a range of social prescribing initiatives drawn from across the UK and summarises some of the emerging research evidence on effectiveness, although much of the literature is confined to small scale evaluation of individual projects. The case studies included should therefore be seen as a basis for developing further work in this area, not as robust evidence of effectiveness.

Models for social prescribing range from supported access to information to a more comprehensive system of supported referral.

11.1 Supported access to information

Supported access to information involves primary care staff providing details about voluntary agencies, self-help groups, leisure, sporting, cultural and educational activities within the community (Blastock et al, 2005). Many primary care teams, local authorities and local voluntary agencies now develop web-based directories and some larger practices keep extensive information about local resources, often in combination with opportunities for patients to access information about health issues, as well as computer assisted self-help and therapy packages (see, for example, Greenwich ‘Splash’ in Appendix 5).

Computer-assisted therapy

Computers and internet-based programmes have the potential to make psychological assessment and treatment more cost-effective. Computer-assisted therapy appears to be as effective as face-to-face treatment for treating anxiety disorders and depression (Newman, 2000), although a major trial in Fife found better long term effects from face-to-face therapy (Richards et al, 2003). Internet support groups may also be effective and have advantages over face-to-face therapy, although research is limited.

A recent review from NICE found good evidence for the effectiveness of some computerised cognitive behaviour therapy for depression and anxiety e.g. ‘Beating the Blues’ (NICE, 2006b; Kaltenthaler, et al 2002).
Many practice nurses are increasingly involved with people with long-term mental health problems (Lewis et al, 2003) and provide information, sometimes in combination with telephone follow up, on self-help and group-based activities (Department of Health, 2002; Simon et al, 2000).

At this level, supported access to information complements a range of initiatives to strengthen patient participation in choices about treatment and management. For example, *Best Treatments*, a website developed by the BMJ Publishing Group, is designed to enable both patients and doctors to look at the effectiveness of treatments for chronic medical conditions, including anxiety (http://www.besttreatments.co.uk/btuk/conditions/9949.jsp).

Supported access is difficult to evaluate because identifying whether patients have acted on information, and to what effect, is complex and time consuming. Most studies report significant benefits from self-help materials based on CBT approaches for depression and anxiety but there is limited information on uptake and about which groups might benefit from particular kinds and formats (Lewis et al, 2003). Bower et al found that self-help treatments show some significant benefits in the treatment and management of anxiety and depression, although data on cost effectiveness is very limited and there is little evidence on the effectiveness of self-help groups (Bower et al, 2001; Segal et al, 2001). A feasibility study for Greenwich Primary Care Trust concluded that supported access to information was suitable for the least vulnerable target groups (Sanders et al, 2002). More vulnerable or disadvantaged patients may be unlikely or unable to access community-based opportunities without additional support.

### Signposting and supported access

#### Sandyford Health Screen and Information Prescription

Following a voluntary health screening and assessment, clients are given an Information Prescription, which they take to the library to access information on a very wide range of health issues, as well as details of local groups, support, resources and helplines etc.

The major outcomes have been the increase in people taking control of their own health and increased usage of the library and free internet services.

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fiona.walker@glacomenc.scot.nhs.uk
Aberdeenshire Signposting project

A Choose Life project, using trained volunteers, this project enables people with mild to moderate mental health problems to access a wider range of services within the community. It aims to increase engagement and access to community resources and to reduce isolation and enhance coping skills for people with mild mental health problems.

Referral is through primary care and partners include Aberdeenshire CVS, NHS Grampian and Aberdeenshire Council.

"primary care teams need more information and support on the benefits of social prescribing and the ways in which it can be delivered”

http://www.chooselife.net/uploadedfiles/AS_Activity1000133.pdf
Contact: Jenny Adie jenny@cvssignposting.org

South East Community Health Care Partnership

In the South East Community Health Care Partnership, an initiative provides access to welfare rights advice for all primary care practice patients, covering money advice, debt consolidation and benefits checks. This has resulted in significant financial gain for those who use the service.

NHS Greater Glasgow (2006)

11.2 Supported referral

There are a number of options for the supported referral model.

The Amalthea Project links patients with one or more of a wide range of activities or sources of support within the community (Grant et al, 2000). This broader approach places less emphasis on the mental health impact of specific activities (e.g. art, music, exercise, or reading) and focuses on the therapeutic benefits of enabling patients to identify and access support that meets their needs. The Amalthea Project used a voluntary organisation to manage referrals and is one of the few projects to have been comprehensively evaluated, using both a randomised controlled trial and economic evaluation.

Referral to the Amalthea Project and subsequent contact with the voluntary sector resulted in clinically important benefits compared with usual general
practitioner care in managing psychosocial problems, but at a higher cost. Compared with routine care, referral to the project:

- Reduced anxiety and other emotional problems
- Patients felt more positive about their health, life in general, and their ability to carry out everyday activities
- The total cost of care was significantly greater in the Amalthea group.

Overall then, patients were less anxious but their care was more costly and contact with primary care was not reduced (Grant et al, 2000). However, the cost differential of £20 over a period of four months was minimal in comparison with the costs of specialist referral (Thornett, 2000).

The **WellFamily Service** in Hackney, developed by the Family Welfare Association and replicated in a range of other locations including Croydon, Newham and Luton, offers a referral facilitation service similar to Amalthea, but combines this with practical and emotional support to help families build on their own resources and find ways around their problems. Family Support Co-ordinators run services within primary care practices, offering advice, information and support, as well as providing a referral route to community resources. Evaluation of the WellFamily Service highlighted a number of themes; focusing on the whole family provides an opportunity to support those who are hard to reach, such as the mother of a delinquent teenager: non-statutory help can also overcome client resistance to authority and gives those at risk a sympathetic hearing in an accessible environment.

Another advantage of a practice-based service is the change it facilitates within primary care; in our case, this has contributed to a more family-centred approach throughout the primary care team. Fundamental to the WellFamily approach is the emphasis on wellness and the 'normalisation' of help-seeking which also underpins health visiting. This has lead us to explore working with health visitors to expand the service. (Goodhart and Graffy, 2000 p160; Goodhart et al, 1999).

In their analysis of the WellFamily project, Goodhart and Graffy argue that short term economic analysis (as used in the Amalthea evaluation) may fail to take into account the long-term benefits to the community, and the consequent reduced burden on all support services if the cycle of deprivation can be broken (Goodhart and Graffy, 2000).

In **Park Practice**, in Penge and Anerley, primary care staff refer patients with psychosocial problems to a community development worker, whose role is to facilitate access to community-based support, providing a link for patients who
would be unable or unlikely to make contact based on information in a leaflet or simply being given a phone number (Sykes, 2000; 2002). The project was evaluated at the end of a six-month pilot phase, when the main target groups were parents with young children and refugees and asylum seekers. Findings were based on retrospective interviews with primary care staff, including some who were not involved with the project, and with patients who had used the service. Of those patients with whom researchers made contact, just over 50% had successfully accessed a voluntary or community group and intended to continue using the service. Key findings included:

- Positive feedback from patients, notably reduced isolation
- Patients accessed services they would otherwise not have been aware of
- Patients supported to establish new self-help groups
- Staff observed increase in self-esteem and confidence in patients
- An increase in primary care’s knowledge and understanding of voluntary and community services.

Key problems highlighted by primary care staff included lack of knowledge of voluntary and community services, what they offer and how they operate and perceived difficulties in establishing an appropriate and feasible referral process, although in practice, those involved found referral via the community development worker simple and quick.

**East Ayrshire CHIP lifestyle referral scheme**
The CHIP project is a supported referral project run by Neighbourhood Services, which links people with a wide range of advice, support, classes and other activities on physical activity, healthy eating, smoking cessation and stress. Referral is via primary care and other health professionals but some primary care practices encourage facilitated self-referral, whereby the patient completes the referral form and this is signed by the GP, without the need for an appointment. Referral criteria include chronic physical health problems, depression and anxiety and risk factors like obesity.

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In Swindon, a primary care-based psychology and counselling service uses a three tier model offering different levels of support. This can be adapted to incorporate the range of options within a social prescribing model, from assisted access to information through to supported referral (Howells, 2001). The service in Swindon, based on the premise that psychology services have a responsibility to the whole patient population, offers support, including community support, and knowledge about psychological approaches and coping skills to equip
patients to cope with problems that cannot be removed. As there is no reliable way to distinguish those patients who will benefit from a brief input from those who will require more intensive help, the service is run on several levels, with no waiting list and no list closure:

- Minimum intervention involves one or two appointments, self-help literature and coping skills teaching. For many, notably because there is no waiting list, this first level is enough
- Level two involves more help, through group sessions, behavioural programmes and occasional appointments
- Level three provides regular but brief long-term group support, more intensive individual work and access to more traditional secondary services if necessary. Supervised and trained volunteers help with the groups and offer individual support.

A 12 month period of evaluation demonstrated:

- Reduced GP consultation
- Reduced referral to secondary care
- Very high patient satisfaction
- Improved GHQ score.
  (Howells, 2001).

11.3 Prescription for learning

Prescription for learning was launched in Nottingham in 2000 and now operates in six city practices. NIACE, the national organisation for adult learning, currently facilitates a consortium of prescription for learning projects, which includes over 60 providers across the UK (www.niace.org.uk). NIACE works closely with the Scottish Adult Learning Partnership.

**The Scottish Adult Learning Partnership (SALP)** is a voluntary organisation established to support and encourage people who do not traditionally participate within the education system. SALP promotes lifelong learning, active citizenship, equality of opportunity and social inclusion. SALP is also closely aligned to all major educational strategies and community learning plans. The Partnership is based on a multi-agency approach between education and training providers and service users.

SALP co-ordinates six annual campaigns, to inspire and encourage adult non-participants to take up learning opportunities.

www.salp.org.uk
In Nottingham, GPs, practice nurses, health visitors, counsellors and mental health nurses refer patients, usually with symptoms such as anxiety, agoraphobia, low self-esteem or chronic pain, to a learning advisor. The advisor works with the patient to identify activities that could help to alleviate symptoms, such as an assertiveness class, yoga, painting or computer training. The patient is then supported through the enrolment process.

The aim of the scheme is to offer patients experiences that will help them cope with their illness and improve their confidence, with an aim of reducing dependence on primary care professionals. Participating surgeries are based in deprived areas of Nottingham, marked by high unemployment levels, poverty and poor health (James, 2001a; Aylward and James, 2002).

Evidence of effectiveness relevant to prescription for learning includes:

- Research on the impact of learning on health
- The relationship between learning and key risk factors for mental health problems, notably unemployment and social exclusion
- Evaluation of specific projects.

Research from the Centre for Research on the Wider Benefits of Learning (WBL), based at the Institute of Education (www.learningbenefits.net), provides evidence of a relationship between participation in learning and improved health outcomes, which are related to increases in three forms of capital:

- Human capital (knowledge and skills)
- Social capital (trust and interdependency)
- Identity capital (positive self image, assertiveness and confidence).

In a study looking at the health impact of participation in learning in a sample of 10,000 adults, Feinstein et al found that learning plays an important role in contributing to the small shifts in attitudes and behaviours that take place during mid adulthood (Feinstein et al 2003).

These included positive changes in:

- Exercise taken
- Life satisfaction
- Race tolerance
- Authoritarian attitudes
- Political interest
- Number of memberships
- Voting behaviour.
Conversely, there is a much higher prevalence of depression among women and men with low literacy skills (Hammond, 2002).

Both NIACE and the WBL centre suggest that education impacts on health through:

- Socio-economic position
- Access to health services and information
- Resilience and problem solving
- Improved self-esteem and self-efficacy. (NIACE, 2003)

Evaluation of prescription for learning in Nottingham, assessing health impact on 196 participants, found the benefits listed below. These are particularly significant as over two-thirds of referrals were for people with no qualifications, who had not accessed any form of learning since leaving school (James, 2001b).

Qualitative research on self-reported health outcomes among people aged 50-71 found that participation in learning had a positive impact on self confidence, self-esteem, satisfaction with life and ability to cope (Dench and Regan, 2000).

A NIACE survey, focusing on previous years' Adult Learners' Week nominees, examines what impact, if any, there has been on personal health as a result of learning. The majority of respondents asserted positive benefits to mental, emotional and physical health such as increased confidence and self-esteem, being better able to cope with illness, feeling less ill and changing health behaviours. Some also reported 'dis-benefits' such as stress, anxiety and relationship difficulties (Aldridge and Lavender, 2000).

**Glasgow Book Prescription Scheme**

This scheme enables GPs and other primary care professionals to prescribe self-help books for common mental health problems, using a list of the most effective self help books, which are stocked in local libraries. Patients are issued with paper prescriptions for books, which they then take to their library.

The project aims to increase the availability and use of self-help literature and to reduce the rates at which medication is prescribed as a first choice for mental health problems. A detailed evaluation of the project is planned.

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Kinross Community Learning Base: Referral for learning

Kinross hoped to establish a scheme whereby primary care staff could refer patients to a guidance worker, based in the surgery, who could refer people to learning opportunities.

The project did not commence due to a combination of pressure of work and limited awareness among medical staff of the potential benefits of learning on mental and physical health and wellbeing.

Training and information on the evidence base for prescription for learning was identified as an important need.

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In an analysis of the findings from evaluation of a range of prescription for learning projects, James (2001a, b, c) identifies the following factors as crucial for success:

- The provision, through a learning advisor, of one-to-one guidance, which is important to motivation and supports access to learning
- A positive relationship between the learning advisor and healthcare staff, which raises awareness of the health benefits of participation in learning
- Immediately available learning opportunities.

11.4 Time Banks

A time bank is a ‘virtual’ bank where people can deposit the time they spend helping each other and withdraw that time when they need help themselves. Everyone’s time is of equal value irrespective of what activity is undertaken. Transactions are facilitated and recorded by a time broker. It is essentially a mutual volunteering scheme using time as a currency.

Time banks have been widely used within broader regeneration and urban renewal programmes. There are also a number of examples of their use in primary care, in recognition that feelings of isolation may be a significant source of poor health status and that many presenting problems are social, rather than medical, in origin. There are two major networks of time banks (www.londontimebank.org.uk and www.timebanks.co.uk) which includes details of a number of Scottish time bank initiatives e.g. Castlemilk and the Gorbals time banks in Glasgow).
**Govanhill Workspace Volunteers in primary care**

Volunteers are recruited through the Castlemilk timebank and a local health project to help out in the Health Centre, for example in the toy library, delivering leaflets etc.

The aim is to increase confidence in a working environment and to introduce people who may not have worked for some time to options for employment.

The project has not yet been evaluated but has formal referral guidelines in place. The newly developed local Primary Care Mental Health Team has an interest in developing social prescribing.

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The New Economics Foundation, with support from the King’s Fund, established a pilot community time bank in partnership with a primary care practice (Rushey Green) in south east London. Some preliminary findings have been published and a further evaluation is currently in preparation. (Harris et al, forthcoming; New Economics Foundation, 2002). The New Economics Foundation has also recently produced a report on time banks and co-production for the Joseph Rowntree Foundation (Boyle et al, 2006).

The Rushey Green Group Practice pilot involved 14 clinicians, including GPs, nurses, a health visitor and a child mental health specialist. The scheme was managed by a time bank co-ordinator, responsible for recruiting new members and matching offers and requests for help, which included befriending, social events, babysitting, lifting, swimming, gardening, form filling, writing, woodwork and running errands. Within 18 months, the scheme had 60 individual members and nine organizations, including the health centre, a garden centre, nursing home, church and the Community Health Council.

An initial qualitative study involving interviews with time bank participants and practice staff suggested a positive impact on confidence and self-esteem, provided opportunities for elderly and disabled people to contribute and strengthened community based self-help and mutual aid. However, a more comprehensive evaluation, focusing on health outcomes, suggests that infrequent participation (‘just a few hours or the odd visit’) is not associated with either health or psychological benefits. The main impact comes from sustained befriending and intensive or frequent volunteering (Harris, personal communication).
These findings raise familiar questions about the criteria for evaluating the success of time banks, in addition to their impact on clinical outcomes. The NEF concluded that the Rushey Green time bank had the following benefits:

- Patient involvement as partners in delivering health
- Levered hidden resources in the community
- Health professionals enabled to work in a more holistic way.

An evaluation of time banks in the UK found that they are successful in attracting participants from socially excluded groups and people who would not normally volunteer (Seyfang and Smith, 2002; Seyfang 2003). Only 16% of traditional volunteers have an income under £10,000, whereas 58% of time bank participants do. 72% of time bank volunteers are not in formal employment compared to 40% of traditional volunteers. 60% of referrals to time banks were from GPs and health workers.

Other outcomes included:

- Improved quality of life through social interaction and having practical needs met
- For depression: support, confidence, friendship and new skills, for example the creation of a garden attached to health centre
- An alternative for people reluctant or unable to use psychological therapies (although also works well alongside talking treatments)
- Helped increase people’s understanding and tolerance of depression and mental illness
- Support for primary care workers by creating a system of social support for more vulnerable patients
- Referral provided access to a much wider range of services.

11.5 Arts on prescription

In a system that focuses on malfunction, spirituality, creativity and imagination can easily become separate, speciality concerns, discussed at appointments with priests or in art therapy.
(Peter Campbell)

Participation in culture adds enjoyment to life, increases self-belief, equips people with important life skills and improves well-being and health.
(Scottish Executive, 2003d)
There is a growing body of literature about the impact of the arts in health (HEA, 1999; Matarasso, 1997; Wilkinson, 1997; Winn-Owen, 1998), considerable debate about the impact of participation in the arts on health and mental health and a number of calls for more robust evaluation of arts/health programmes (Hughes, 2005; Jermyn, 2004; Ruiz, 2004). Art in this context refers to a wide range of creative activities including painting, sculpture, photography, music, poetry, drama, dance and other performance arts. Key themes in the literature include:

- The place of arts and creativity in promoting community health (Matarasso, 1997)
- The use of art works in clinical settings e.g. hospitals (Scher and Senior, 2000)
- The therapeutic value of participation in the arts.

Arts in health is distinct from art therapy, a professional discipline with a long tradition as a psychological therapy (Kalmanowitz and Lloyd 1997).

The original aims of the concept of arts on prescription are included in the Windsor Declaration on the Arts, Health and Wellbeing, derived from an influential conference on arts and health in 1998 (Winn-Owen, 1998). These aim to use arts and creativity to complement other forms of treatment and to:

- Enhance compassion and intuition in doctors and other health practitioners
- Contribute to reducing social exclusion
- Reduce dependence on antidepressants
- Empower patients
- Strengthen the confidence and self-reliance of individuals and communities.

Like other areas of social prescribing, evidence of effectiveness tends to focus on three areas:

- The impact of participation in the arts on self-esteem, self-worth and identity
- The role of creativity in reducing symptoms e.g. anxiety, depression and feelings of hopelessness
- Arts and creativity as resource for promoting social inclusion and strengthening communities.

**Individual mental health benefits**
A number of studies suggest that creative activity has positive mental health benefits. These may relate to the development of self-expression and self-esteem, to opportunities for social contact and participation, (Huxley, 1997)
and/or to providing a sense of purpose, a sense of meaning and improved quality of life (Oliver et al, 1996; Callard and Friedli, 2005; Tyldesley and Rigby, 2003). These findings are significant because low self-esteem is a risk factor for depression, suicidal behaviour, eating disorders and being bullied (Emler, 2002).

Where wellbeing and self-esteem are concerned, there is more indication that positive outcomes are related to involvement with the arts, and not just with getting together socially or carrying out the physical activity involved (HEA, 1999). The results of reviews by both the Health Education Authority (1999) and Matarasso (1997) demonstrated improvements in wellbeing as indicated by:

- Enhanced motivation
- Greater connectedness to others
- More positive outlook
- Reduced sense of fear, isolation or anxiety.

These benefits were brought about by the opportunities that engagement in art afforded for:

- Self-expression
- Enhanced sense of value and attainment
- Pride in achievement.

(HEA, 1999; Matarasso, 1997)

Evaluation of the **Stockport Arts on Prescription** scheme showed a moderate impact on self-esteem and social functioning. However, the increase in involvement in social activities, particularly participative activities, was statistically significant, with some evidence that the use of GPs, social workers and other services was reduced (Huxley, 1997; HEA, 1998; Tyldesley and Rigby, 2003).

One study showed that psychiatric patients who participated in arts projects had fewer readmissions than those who did not (Colgan et al, 1991).

Other studies have shown the positive impact of writing, reading and music. Writing as a therapy has a significant impact on standard measures of disease severity over a four-month period (Smyth, 1999; Spiegel, 1999).

Other benefits are developing self-confidence and helping people into work, the exploration and affirmation of identity – of place, disability, faith, ethnicity – and arts as a mechanism which enables people to articulate their views and needs.
Landry and Matarasso identify the special characteristics of the arts as:

- Engaging people’s creativity
- Addressing meanings and enabling dialogue
- Encouraging questioning and imagining
- Offering opportunities for self-expression – a key characteristic of the active citizen.

(Landry and Matarasso, 1996)

A qualitative study of the views and experiences of young African and Caribbean men in East London found very strong support for the mental health benefits of opportunities for arts and creativity (Friedli et al, 2002). A central theme was the importance of arts and creative expression as protective factors in the face of the racism and discrimination experienced by the young men interviewed, both within mental health services and in the wider community.

Participation in the arts was seen as a resource that empowered young black men to explore their histories and cultures and which acknowledged and validated their identity. Crucially, arts and creativity are non-stigmatising, attractive to a broad range of young African and Caribbean men and may provide an alternative pathway to mental health services, as well as to education and employment. Their emphasis on self-expression, growth, sharing cultural traditions and the development of new skills was widely seen as rooted in young men’s lived experience and engaging with their needs.

Consultation specifically with African and Caribbean young men suggests that their priorities include building partnerships involving arts, creativity, spirituality and alternative therapies and integrating these with education, training and employment opportunities to form the basis of a holistic approach (Friedli et al, 2002).

In the context of ongoing concerns about the failure of mental health services to meet the needs of young African and Caribbean men, arts and creativity provide an important opportunity to explore the therapeutic potential of a very different model of responding to mental distress – both for individuals and the wider African and Caribbean community.

**Community wellbeing**

The Scottish Development Centre’s report on building community wellbeing (SDC, 2003) identified a number of themes relevant to the relationship between art and wellbeing, themes which are also addressed in Scotland’s National Cultural Strategy (Scottish Executive, 2003d):
• The importance of respecting the natural affinities that people have with geographical place and with historical associations
• The significance of relationships and networks
• The legitimate and necessary role of public agencies in strengthening connections and building bridges.

The value of art and creative expression as a resource for the whole community was a strong theme to emerge in the work of Matarasso (1997) and recent qualitative research with excluded communities in Tower Hamlets (Friedli et al 2002). The strength of cultural life within a community may also be a significant quality of life indicator, notably in relation to social capital (Cooper et al, 1999).

In a review of 60 community-based arts projects, Matarasso found that participation in these projects brought a wide range of social benefits, including increased confidence, community empowerment, self-determination, improved local image and identity and greater social cohesion (Matarasso, 1997). In a study of ten arts projects in Wales, Dwelly found that a focus on cultural well-being, people’s ability to express themselves and engage their creative instincts made a major impact in revitalising run down neighbourhoods (Dwelly, 2001).

Arts and creativity have also been seen as a means to:
• Empower communities
• Explore and affirm identity
• Strengthen social cohesion
• Challenge the stigma attached to mental illness.
  (Friedli et al, 2002; Callard and Friedli, 2005)

In spite of some encouraging findings, much existing evaluation is based on short-term or intermediate outcomes. A major review of arts for health initiatives concluded that “there is no single sound or established set of principles and protocols for evaluating outcomes, assessing the processes by which outcomes are achieved and disseminating recommendations for good practice to workers in the field” (HEA 1999 p.1). Many studies are anecdotal, based on small scale surveys, lack a longitudinal dimension and fail to identify arts specific aspects of the programmes (Coulter, 2001).

A recent evaluation of a series of arts for health projects in a deprived inner city area in East Greenwich, London, concluded:

"In co-developing indicators with stakeholders, what became clear was the enormous importance of indicators that capture process. The in-depth interviews turned repeatedly to moving and powerful descriptions of how the project had taken
It frequently seemed to be the quality of the experience itself that was foremost in descriptions of if and why the project was valuable. And it is, of course, enormously difficult to translate complex psychological processes and reactions into the abstractions favoured by social scientific evaluations. Can one, for example, link a participant’s intense enjoyment of and investment in a particular project to a more general, measurable enhancement of that individual’s self-esteem and enjoyment?” (Callard and Friedli, 2005)

11.6 Exercise on prescription

<table>
<thead>
<tr>
<th>Participation in sporting activities is positively related to reported health status. A person participating in 15 minutes of sport per day has a 6% higher probability of reporting “very good” health compared to a non-participant with the same characteristics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farrell and Shields, 2002a; 2002b.</td>
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</tbody>
</table>

In February 2003, the Scottish Executive published its first National Physical Activity Strategy, aimed at improving Scotland’s health record and increasing the physical activity levels in Scots of all ages. It sets a target that 50% of adults and 80% of children will be taking between 30 and 60 minutes of moderate physical activity every day by 2022.

<table>
<thead>
<tr>
<th>Glasgow Live Active Exercise Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow NHS Board and Glasgow City Council jointly introduced an exercise referral scheme in 1997. The aim is to allow sedentary adults and those who might benefit from exercise, for example as part of a cardiac rehabilitation programme, to be referred by GPs, practice nurses and physiotherapists to physical activity counsellors. Of the 5,173 patients referred, 78% attended for baseline interviews. More than half of these patients failed to return for further assessment. 31% of all those referred continued and the patients who participated at length in the exercise programme reported significant health benefits. Many mentioned improved social contact as an unanticipated but welcome effect.</td>
</tr>
<tr>
<td>While only a relatively small number of patients offered free access to a supervised exercise programme will accept, those who participate for a short time will perceive significant improvements in physical and social wellbeing. Those who persevere will show objective improvement and are more likely to continue to exercise beyond the period of the programme. On the basis of these results, support for the scheme continues, although some of the details are being reviewed to improve patient acceptability and uptake.</td>
</tr>
<tr>
<td>(NHS Greater Glasgow, 2003)</td>
</tr>
</tbody>
</table>
There is robust evidence to support the mental health benefits of physical activity in four areas:

- As a treatment or therapy for existing mental health problems
- To improve the quality of life for people with mental health problems
- To prevent the onset of mental health problems
- To improve the mental wellbeing of the general public.

(Fox, 2000)

Exercise is an effective adjunct for some of the negative symptoms of schizophrenia, as well as for depression and anxiety and can also be a helpful coping strategy for symptoms like hallucinations (Faulkner and Biddle, 1999).

Exercise includes running, walking, dance and movement as well as other aerobic and nonaerobic activities. In light of the evidence presented in all reviews it is suggested that exercise significantly reduces symptoms of depression and is more effective than no treatment or patient education. Exercise is as effective as other behavioural interventions but less time and cost intensive, and provides additional health benefits. Evidence also suggests that exercise is beneficial as an adjunct to more traditional forms of therapy (Scottish Executive, 2005a).

### Ayr Gym project

The gym project was part of a National Waiting Times for Psychotherapy Pilot Implementation project in 2002.

Patients with a mixture of anxiety and depression were referred to a local gym for six weeks, with follow up by a nurse delivering guided self-help. The aim was to assess whether a combination of gym and self-help had a positive impact on symptoms and could be used as an alternative to referral to mental health professionals.

Evaluation used a range of rating scales, including BDI and GHQ, to measure depression and general health prior to, immediately afterwards, and at 6 months. All 20 patients referred experienced a reduction in symptoms and went from caseness to non caseness, sustained at 6 month follow up. Qualitative feedback from patients indicated that the social contact of gym attendance was valued more highly than the self-help.

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A number of trials suggest that patients respond positively to GP advice to take more exercise (Killoran et al, 1994).
National Consensus Statements on physical activity and mental health (Grant, 2000) show that exercise prevents clinical depression and is as effective a treatment as psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self-esteem (Fox, 2000; Mutrie, 2000). A meta analysis demonstrates that regular exercise improves cognitive functioning, reduces mental health problems and improves the mental health of older people (Etnier et al, 1997).

Evaluation of Balance for Life found that a GP-prescribed 10 week programme of exercise significantly reduced depression and anxiety and increased quality of life and self-efficacy for exercise. Sixty eight percent of clinically depressed patients achieved non-clinical depression scores within three months (Darbishire and Glenister, 1998).

The Island Health Walk Scheme in the Isle of Wight was established by the West Wight Primary Care Group in 1999. Short volunteer-led walks are offered for those who lack confidence or physical ability to walk alone. While targeted at people with mental health problems and learning disabilities, these walks are particularly beneficial for older people and have been very successful in enabling older people to make new friends and forge community links. Participant feedback has demonstrated enhanced self-confidence, self-esteem, improved physical fitness and increased independence.

Green Gyms are emerging as a UK-wide movement which offers people a way of meeting others, getting physically fit and improving the natural environment. There are currently green gym programmes across Scotland, including Aberdeen, Fife and Inverness (http://www.btcv.org.uk/cgi-bin/office_opps.cgi?region=sc). Scotland’s strategy for conservation and the enhancement of biodiversity includes an objective to: improve opportunities for people to enjoy and care for biodiversity through increased awareness, volunteering, local action and lifestyle, with a specific commitment to increase the number of, and participation in, green gyms (Scottish Executive, 2004e).

Referral may be through primary care or by word of mouth. Local evaluations have demonstrated a range of physical and mental health benefits, including reductions in symptoms on the Hospital Anxiety and Depression Scale and improvements in quality of life (BTCV, 1999). 'Being out in the countryside’ emerged as a significant motivating factor, supporting other findings on the potentially therapeutic value of the natural environment. A survey on public attitudes undertaken in 1995 demonstrated that nine in ten people value the countryside and that there is a very strong desire for greater opportunities to
access rural areas. (Countryside Commission, 1997) The most important benefit from visiting the countryside was the sense of relaxation and wellbeing. Fresh air and peace and quiet were also valued. The Forestry Commission’s recent consultation also demonstrated strong support for the role of Scottish forests in contributing to a healthy and vibrant Scotland (Forestry Commission, 2004).

Although there is robust evidence for the mental health benefits of physical activity, there is very limited evidence on what works to promote the uptake of exercise. In a review of four common methods used to increase the population's physical activity levels (brief interventions in primary care; exercise referral schemes; pedometers; and community-based walking and cycling programmes), NICE concluded that there was insufficient evidence to support the effectiveness of any of them, with the exception of brief interventions (advice and written information) in primary care (NICE, 2006a).

12.0 Measuring success

Questions about the effectiveness of social prescribing and community referrals are part of ongoing debates about ‘who defines success?’ and the measures that are used. Within clinical settings, the preferred focus may be on assessing effectiveness in terms of reduced symptoms or improved mental health scores, using tools like GHQ, Beck's Depression Inventory or Social Functioning 36. Increasingly, however, there is a case for complementing a focus on clinical outcomes with broader measures, for example quality of life and social inclusion. Finally, there is a growing interest in measures that capture mental wellbeing and whether or not symptoms persist. The forthcoming NHS Health Scotland review of scales that measure different elements of mental wellbeing will include the following dimensions:

- Life satisfaction/quality of life
- Optimism
- Self-esteem
- Resilience and coping
- Spirituality/meaning in life
- Social integration
- Emotional intelligence.

This review, to be published in an accessible guideline aimed at practitioners, will provide a valuable resource to support more robust evaluation of social prescribing. At the same time, scales that are valid and reliable measures of individual and/or population mental health and wellbeing cannot capture more complex outcomes which may be embedded in the value, meaning and significance of community-based initiatives and their contribution to new ways of thinking about, understanding and acting in relation to health.
13.0 Social Prescribing: the challenges

Although there is a wide range of different models and definitions of social prescribing, there are a number of common challenges in integrating social prescribing within primary care practice (see, for example, a review by Sykes, 2002):

- Maintaining up-to-date information on sources of voluntary and community support
- Cultural differences between medical and community development models
- The need for a skilled link worker (referrals facilitator)
- Concerns about voluntary sector capacity
- Concerns about increased GP workload, at least initially
- Agreeing referral criteria
- Recording and evaluating outcomes
- Accountability and liability for referred patients.

These issues were also frequently raised by respondents to the SDC questionnaire, with a particular emphasis on the need to raise GP awareness of the evidence base for social prescribing and to address referral, accountability and liability issues.

14.0 Recommendations

Strengthening the provision of and access to non-medical sources of support via social prescribing or community referral has considerable potential to contribute to mental health improvement in Scotland. Social prescribing can be developed to become fully integrated as a patient pathway for primary care practices in Scotland and to strengthen considerably the links between primary health care providers and community, voluntary and local authority services that influence the wider determinants of mental health, for example leisure, welfare, education, culture, employment, and the natural environment.

Creating a positive environment for the further development of social prescribing will require the following:

- **Increasing public awareness** of ‘positive steps’ for mental wellbeing (e.g. Appendix Four) and promoting a wider range of options for coping with stress, anxiety and depression
- **Increasing awareness in primary care** of the potential effectiveness and feasibility of non-medical resources and supports
• Encouraging CHPs to support primary care partnerships with the community and voluntary sector to work towards improved mental health outcomes for their patient populations

• Situating social prescribing in the context of greater choice for patients and a stronger focus on enabling patients to participate in their own care

• Practical support with data, referral criteria, evaluation and accountability.

Community Health Partnerships are designed to promote the development of collaborative cross-sectoral approaches to address health needs and health issues for local populations. Social prescribing models have a central part to play in this. Building on the information presented in this report, a number of steps are indicated to take forward the promotion and development of social prescribing models in Scotland:

• The establishment of a range of pilot projects, either through supporting and developing existing initiatives and/or pump priming new projects
• Holding a series of workshops and consultation events to further explore the possibilities raised by this report and consider their practical application
• Creating opportunity through networking and information exchange for existing initiatives to share ideas and learning and for more dialogues between primary health care and the community and voluntary sector. There is an opportunity here to build on the network developing following the national conference on primary care and mental health held in early 2005 (SDC, 2005)
• Promoting evaluation to identify the mental health and wellbeing outcomes associated with social prescribing for different groups of patients.
Appendix 1  Policy Analysis

The following policy documents were scanned for references:

Arts & Culture

- Scottish Executive (2006) Scotland’s Culture
  http://www.scotland.gov.uk/library5/culture/sncs03.pdf
- Scottish Executive (2000) Creating our future...minding our past: Scotland’s National Cultural Strategy
  http://www.scotland.gov.uk/nationalculturalstrategy/docs/cult-00.asp

Employment, Learning & Training & Volunteering Policy

  http://www.scotland.gov.uk/Publications/2006/06/12094904/14
- Scottish Executive (2004) Volunteering Strategy
- Scottish Executive (1999) Supporting Active Communities in Scotland: Draft Strategy
  http://www.scotland.gov.uk/library2/doc11/acco-00.asp

Environment & Conservation

- Scottish Executive (2003) Towards a strategy for Scotland’s biodiversity Developing Candidate Indicators of the State of Scotland’s Biodiversity
**Health Policy**

- Scottish Executive (2006) *Delivering for Mental Health*
  http://www.scotland.gov.uk/Publications/2006/11/30164829/0
- Scottish Executive (2005) *Delivering for Health*
- Scottish Executive (2005b) *Building a health service fit for the future*
  http://www.scotland.gov.uk/library5/health/his03.pdf
- Scottish Executive (2002) *Our Community’s Health: Guidance on the preparation of joint health improvement plans*
- Scottish Executive (2002) *Making the Connections: developing best practice into common practice: report of the Primary Care Modernisation Group*
- Scottish Executive (2001) *Our National Health: Delivering Change*
- Scottish Executive (1999) *Towards a Healthier Scotland*
  http://www.scotland.gov.uk/library/documents-w7/tahs-00.htm
- Scottish Executive (1997) *A Framework for Mental Health Services in Scotland*
  http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/index.htm

**Sports & Physical Activity**

  http://www.scotland.gov.uk/about/Planning/nppg_11_sportphysica.aspx
Appendix 2  Questionnaire

Social Prescribing for Mental Health

Interviews/key questions

Social Prescribing Projects

Introduction

The Scottish Development Centre for Mental Health has been commissioned by the Scottish Government to undertake a feasibility study on the role and potential of social prescribing in the management of mental health problems in primary care.

What is social prescribing?

Examples of social prescribing that you may be familiar with include exercise on prescription, prescription for learning and arts on prescription.

The definition of social prescribing that we are working with is as follows:

Social prescribing is a mechanism for linking patients in primary care with non-medical sources of support within the community. It provides a framework for developing alternative responses to mental distress and is part of a wider recognition of the influence of social and cultural factors on mental health outcomes across the whole spectrum of disorders.

Although there are many different models of social prescribing and it is used for patients with mild to moderate symptoms, as well as people with severe and enduring mental health problems, its distinguishing feature is the referral to non-medical sources of support. For this reason it does not include referral to a professional counsellor.

Case studies

We are interested in examples of social prescribing projects in primary care across Scotland and would be grateful if you could complete the following brief questionnaire.
Name

Job title

Contact details

Name of project

Project description

Aims of project

Key partners

Referral process
(i.e. how do people access the intervention e.g. exercise, learning opportunities, arts and creativity, horticulture etc).

Referral guidelines or protocol
(do you have a formal criteria for referrals and/or any mechanisms for feedback from the person referred or the referral organisation?)

Which organisations do you refer people to?

How have you monitored and/or evaluated the project?

What have been the major outcomes/achievements of the project?
(These could be, for example, evidence of a reduction in symptoms, improved GHQ scores, reduced use of primary care services or an increase in social contact for people using the project)

Have you faced any barriers or challenges in setting up and delivering the project?

Based on your experiences, what support is needed to develop social prescribing in primary care more widely across Scotland?
# Appendix 3  Examples of Referral Criteria

**East Ayrshire CHIP project**

*Inclusion Criteria For Lifestyle Referral Scheme and Cardiac Referral Scheme*

## Lifestyle Referral Scheme

Patients that are primarily targeted are those:

- Free from established CHD and strokes
- With one or more CHD risk factors which can be helped, by regular activity and lifestyle advice
- With controlled hypertension
- With low grade mental health problems such as anxiety, mild depression and low self-esteem.
- With mild arthritis that are still mobile
- At risk of developing osteoporosis
- With controlled diabetes
- With controlled asthma.

Referral of patients with uncontrolled medical conditions may occur, but only after consultation with the lifestyle development officer.

## Cardiac Referral Scheme.

**Post MI Patients.**

- Cardiac Physiotherapist identifies when the patient is suitable to be referred on to the referral scheme from the Phase III programme
- The Patient has completed a cardiac rehabilitation programme within the last six months following previous CABG/angioplasty/MI.

**Established CHD/Angina/Previous CABG/ Angioplasty.**

- GPs and CHD nurses may identify appropriate patients
- Patients must have had an ETT within the last six months and have no increase in the frequency or severity of the symptoms. (Cardiologists should endorse lifestyle referral on future ETT reports).

**Risk Management**

- Unstable angina
- Unmonitored/ untreated BP consistently greater than or equal to 160/90
- Blood pressure greater than 200/110
- Symptomatic valve disease
- Those unable to perform an ETT or low level exercise programme due to limitations.
Appendix 4  Examples of Positive Steps for Mental Health

‘Positive steps’ for mental health were developed by the Health Education Authority in England as part of the World Mental Health Day Campaign 2000. These were later adapted and published on the National Electronic Library for Health website, as shown below. More recently, complementary versions, including some additional positive steps e.g. nutrition, have been developed by the Mental Health Foundation and the National Institute for Mental Health in England (NIMHE 2005).


Promoting our own mental health

Mental health is about how people think and feel. How we think and feel affects our overall health and wellbeing and quality of life. Many factors influence mental health – housing, jobs, schools, transport, the environment – as well as they way we live our lives. This section gives information about what you can do to look after your own mental health and the mental health of others.

Everyone has mental health needs. From time to time, most of us feel stressed, anxious, worried or afraid. We may also have experiences that are very difficult to cope with, such as losing our job or the end of a relationship. Being bullied, sexual or racial harassment, experiencing discrimination because of a mental health problem, not having a voice because we’re too young, too old or simply different, can all have an impact on our mental health.

Doing something positive can make all the difference – for ourselves and for others.

Accepting ourselves

Our beliefs, background, culture, religion, sexuality and experiences make us who we are. Everyone is entitled to respect, including you.

Accepting others

It’s easy to feel threatened by people who are different. You’ll feel better and learn more if you can accept others. Everyone has something to offer.

Talking about it

Most people feel isolated and overwhelmed by their problems sometimes – it can help to share your feelings. If you feel there is no one to talk to, you could call a helpline.

Being a good listener

Good listening is a skill. Rather than offering advice, it can help to let the person work things out as they talk. Hear them out - avoid making judgements, check from time to time that you’ve understood.
Keeping in touch with friends

Friends are important, especially at difficult times. You don’t have to be strong and struggle on alone. Be there – and let others be there for you. Be a good friend and neighbour - keep in touch.

Getting involved

Meeting new people and getting involved in things can make all the difference – for you and others. Joining a club or offering your services as a volunteer to a charity can be rewarding and help you feel less alone.

Drinking in moderation

Drinking alcohol to deal with problems will only make things worse. It’s best to drink in moderation and avoid binges. If you’re worried about your drinking speak to your doctor.

Taking care with drugs

Illegal drugs can trigger mental health problems. If you have a drugs problem, talk to someone about it.

Learning new skills

Learning a new skill can increase your confidence – whether it's for pleasure, to make new friends or to improve your chances of a job.

Doing something creative

All kinds of creative things can help if you are anxious or low. They can also increase your confidence. Music, writing, painting, drawing, poetry, cooking, gardening – experiment to find something you enjoy.

Relaxing

Try and make time for yourself. Fit things into your day that help you unwind – reading, listening to music, prayer or meditation – whatever you enjoy or find relaxing.

Keeping active

Regular exercise really helps if you’re feeling depressed or anxious. It can give you more energy too. Find something you enjoy – a team sport, swimming, walking, or dancing.

Asking for help

Everyone needs help from time to time - from friends and family, a support group, faith community or from your local doctor or community mental health team. It's OK to ask for help, even though it can feel difficult.

Surviving

When times are difficult, it is sometimes all we can do to survive. Take one day at a time and don’t be too hard on yourself. Take time out if you need it. If you have a long-term mental health problem, try to plan the care you need with your keyworker and others for when you’re less well.
Health Education Authority: World Mental Health Day Campaign 2000

What individuals can do:

Stressed, anxious, worried or afraid?
Most of us feel like this from time to time. We may also have experiences that are very difficult to cope with. Losing someone you love or a relationship breaking up, being bullied, losing your job, sexual or racial harassment, or experiencing discrimination because of a mental health problem. Not having a voice because you’re too young, too old or simply different. Doing something positive can make all the difference - for you and others.

Talking about it
Most people feel isolated and overwhelmed by their problems sometimes - it can help to share your feelings. If you feel there is no one to talk to, you could call a helpline.

Getting involved
Meeting new people and getting involved in things can make all the difference - for you and others.

Keeping active
Regular exercise really helps if you're feeling depressed or anxious. It can give you more energy too. Find something you enjoy - sport, swimming, walking, dancing or cycling.

Drinking in moderation
Drinking alcohol to deal with problems will only make things worse. Its best to drink in moderation and avoid binges, but if you’re worried about your drinking speak to your doctor.

Learning new skills
Learning a new skill can increase your confidence - whether it's for pleasure, to make new friends or to improve your chances of a job.

Doing something creative
All kinds of creative things can help if you are anxious or low. They can also increase your confidence. Music, writing, painting, drawing, poetry, cooking, gardening - experiment to find something you enjoy.

Asking for help
Everyone needs help from time to time. Its ok to ask for help, even though it feels difficult - whether it's from friends and family, or from your local doctor, practice nurse, support group, faith community or helpline
Accepting who you are
Our beliefs, background, culture, religion, sexuality and experiences make us who we are. Everyone is entitled to respect, including you.

Keeping in touch with friends
You don’t have to be strong and struggle on alone. Friends are important, especially at difficult times. Keep in touch.

Surviving
When times are difficult, it is sometimes all we can do to survive. Take one day at a time and don’t be too hard on yourself. Take time out if you need it.

Relaxing
Try and make time for yourself. Fit things into your day that help you unwind - reading, listening to music, prayer or meditation - whatever you enjoy or find relaxing.
Appendix 5

Local Examples of Social Prescribing:
Borders Doing Well By People With Depression Self-Help Service,
Glasgow Steps and Greenwich Splash

Referral via a link worker: NHS Borders Kelso lifestyle advice in general practice

The Service – uptake and capacity
One hundred and seven people accepted a referral to the project during the 12 months of the pilot. One person failed to attend their first appointment, giving an attendance rate at the first appointment of almost 100%. Thereafter, around 90% of those invited kept their appointments, giving a high overall attendance rate. This project has a good uptake by men (41%) and compares well to other services in the Borders. 55% of clients were aged between 45-64 years; with 96% aged between 30 and 79 years.

Lifestyle and health behaviour change
At the initial appointment clients are asked what lifestyle behaviour they would like to change, focusing on smoking, diet, exercise and alcohol. It was most common for clients to choose a range of lifestyle behaviours to address. 66% chose diet and exercise and further 27% alcohol, diet and exercise.

Importance, confidence and wellbeing - psychological change
Clients report that it is very important to them to make a lifestyle behaviour change when they first visit the Lifestyle Adviser (mean score of 9.3 out of 10 at first visit) and it continues to be important to them as they go through the service (mean score of 9.6 at final visit). However, at outset they are still slightly unsure how they will do so. This is reflected in confidence to change (mean score of 6.8 at the first visit). Following the development of an action plan and after signposting to support services, their confidence levels increase (mean score of 8 at final visit) as well their sense of wellbeing (mean score of 5.4 at first visit rising to 6.7 at the final visit).

Community involvement and meeting community needs
This approach, a non-medical model within a medical setting, appears to have a beneficial effect on the people referred, but also on their families, relatives and friends who are also reporting making lifestyle changes to support those referred. There also appears to be positive social implications as people are asking for a support group to help them make and maintain changes, so they can meet together to discuss what they have done and how they are feeling physically and emotionally.
Filling gaps and meeting community needs
There were repeated requests for an exercise class for those who attend the service. This was addressed through ‘Guid Fettle’, and two classes ran; one from October to December 2004 and one from January to March 2005. These both evaluated well. The findings provide some evidence that the lifestyle advice service is not just tackling the ‘topic’ health behaviours and change in them, but also influencing mental health and wellbeing. The majority of people attending this group came through the Lifestyle Adviser service. A gap in exercise provision was also identified through links with the local swimming pool. Through discussion with the manager, it was agreed to start a less intensive class in January 2005 to respond to local needs.

Promotion of joint working and linkage with the community
The pilot results also show how clients are successfully ‘signposted’ to and access community activities and that work in General Practice/Primary Care is being effectively linked to wider community initiatives and services.

Client evaluation
A questionnaire was distributed to 70 individuals who had used the Kelso Lifestyle Adviser Service. Forty-one people (59% of those asked) responded. 89% of respondents stated that they felt the referral to the Lifestyle Adviser was appropriate for them. 83% of respondents stated that they benefited from the service either ‘a lot’ or a ‘great deal’. 6% of respondents also stated that the service and the support activities helped them to make and maintain lifestyle changes. 59% of the respondents said they had tried to make lifestyle changes before but had not maintained changes.

Project management process
Key factors contributing to the successful development of the project in Kelso were that:
- The General Practice showed an interest and a commitment to the project
- All staff from the practice were involved from the outset and kept informed throughout
- Public health, primary care and health promotion services worked together and agreed processes and methods of working together
- The primary care team received brief intervention skills training and the Lifestyle Adviser received in-depth motivational interviewing skills training
- Lifestyle Adviser is part of the practice team and based within the health centre.

Obstacles identified include:
- Service database, which requires some attention to be of value
- Ensuring the signposting pack is kept up-to-date
  - Ensuring accommodation is available for the Lifestyle Adviser
• Keeping development meetings the practice nurses and clinicians to a minimum but ensuring they stay involved
• Perceived inequitable allocation of resources to the lifestyles project as compared to the chronic disease management, hence causing some tension.

The evidence to date suggests that this project is not just about the 'topic’ health behaviours and change, but also about mental health and wellbeing, about accessing community activities and linking work in general practice/primary care to wider community initiatives.
Contact: wendy.lynn@borders.scot.nhs.uk
Evaluation Report: Executive summary

The first year of STEPS Primary Care Mental Health Team, South East Glasgow CHCP

Dr Jim White
Team Leader
**STEPS**

STEPS is the Primary Care Mental Health Team for South East Glasgow CHCP. We serve a population of around 120,000. STEPS has an administrative base in Govanhill Workspace. The team provides clinical and other services in a variety of settings across the locality. We are a Scottish Government Exemplar Project.

The team comprises four CBT workers (two clinical psychologists, two occupational therapists), five person-centred counsellors, three assistant psychologists, two admin workers and a volunteer ‘expert patient’.

The population of SE Glasgow CHCP is spread over Castlemilk, Croftfoot, Govanhill, Battlefield, Gorbals, Toryglen, Shawlands and Pollokshields. The population is served by 27 GP practices, comprising of around 100 GPs. There are three community mental health teams that cover sections of SE Glasgow CHCP. Eleven per cent of the population of SE Glasgow is comprised of people from ethnic minorities, principally Pakistani Muslims. A high percentage of the population live in areas that have been classified as the most economically and socially deprived in Scotland.

**Service Model**

The team’s specific remit is to provide primary care mental health services to adults (16yrs+) with common mental health problems principally centred on anxiety and depression. Our aim from the outset was to devise an innovative primary care service:

- we would provide help to a significantly higher number of people than are reached by traditional services
- we would not allow long waiting lists in the service
- we would not rely on individual therapy as the main delivery model
we would develop, as our name suggests, a stepped-care approach (multi-level, multi-purpose) relevant to the needs of a socially deprived and multi-cultural area

we would empower service users by ensuring they could choose, from a range of options, the approach they best felt would meet their needs (a ‘horses for courses’ approach) and that access to those options would be easy to achieve

we would ensure users could return to the service as easily as possible

we would work in partnership with health, social and other statutory and non-statutory organizations and, whenever possible, share whatever skills we had

we would work in a preventative way

we would work at a population level

we would carefully audit our work to enable us to follow evidence-based practice.

To achieve these goals, we devised a six-level model. This allows users to work simultaneously at several levels or to easily come back into the service to work at different levels as required. Individuals can self-refer to all levels except individual therapy. This evaluation of our first year (1 Nov 04 - 31 Oct, 05) focuses on whether the model has allowed us to achieve our aims.
The evaluation will look at each step in turn. The following page shows the approaches already in place or planned at each step.
Our stepped-care model has allowed us to offer a wide range of help to a huge number of people in the south-east area this year. To put this into context, the average therapist working in a traditional individual therapy service, offering 10-16 sessions per patient, would be expected to treat no more than 60-80 patients each year⁸.

General findings

Our first year has been highly successful. The six level STEPS model has proven itself robust and flexible enough to allow us to develop a wide range of innovative, effective and efficient approaches.

While we have, in this report, been at times, critical of aspects of our service, this is to allow us to improve on the inevitable short-comings and strengthen positive features.

By and large, we are providing a range of services and helping a volume of people well beyond any other primary care service we are aware of in Britain or beyond.

The growing interest in our model from clinicians and managers suggests we are increasingly influencing the development of primary care mental health services across Britain.

Specific services

Individual therapy

- A very large number of referrals were received
- We are getting a very large number of people referred from the most deprived areas
- Waiting times were unacceptably high across the year but, as the year went on, the CBT therapists have virtually eliminated waiting lists and, due to changes made towards the end of the evaluation period, counselling is likely to show improvement over the next year
• We are seeing a high level of people failing to opt-in. There may be an ethical issue in using such a system. This requires further evaluation

• We have found a high level of users failing to attend for their first appointment even after opting-in. A similarly high level of drop-out following first session was found. This appears to affect PCT in particular

• We were unable to gather enough post-therapy measures to determine if the service is clinically effective (although the data we have does suggest this)

• Deprivation and long waiting times are clearly playing a role in DNA rates

• Overall, our poor results are similar to other individual therapy services and call into question the appropriateness of this traditional approach to mental health. We must look more closely at making sure that those who need individual therapy and are motivated to participate in it, get easy access to it and to offer others help from other parts of the service.

Advice Clinic

• This is a popular choice for users and ensures a rapid access to services (typically within one week of phoning STEPS)

• The clinic works well and appears both effective and efficient

• It works well as a triage service into STEPS and other services.

Advice Line

• This service works well but is not getting enough calls to justify the amount of time devoted to it

• We have some innovative plans to develop ‘phone therapy’ but they are beyond our budget.

First Steps

• This class, run by a volunteer ‘expert patient,’ has worked well and meets a need in primary care

• As with similar community approaches, numbers are variable week by week
• Evaluation of the service is positive

• If we can employ the expert patient 5 sessions per week, we will be able to expand First Steps in innovative ways and greatly increase service user involvement with STEPS particularly along the lines of the recovery movement in Britain.

**Stress Control**

• The course is running well and attracting increasing numbers as it gets better known in the community

• Satisfaction ratings and outcome data are positive. Results suggest it is at least as effective as primary care individual therapy approaches and is hugely more efficient

• One of the most satisfying aspects of the course is the ease with which people can access it

• We are getting large numbers of people from the most deprived areas attending

• The addition of a daytime class has proved very successful.

**Healthy Reading / Book prescribing**

• Healthy Reading, now in all south Glasgow libraries (and many libraries in Renfrewshire) has been a major success – well beyond the expectations of City Council Culture and Leisure services

• Book prescribing, after a healthy start, is dropping off. We feel it is not worthwhile expending much time and energy on boosting use as Healthy Reading is working so well

• Healthy reading will shortly be available in all Glasgow libraries (funded by the Primary Care Division)

• There has been a lot of interest in this approach from other NHS services in Scotland, e.g. Highlands now plans to set up a similar service based on the STEPS model.
Website

- Although this is a temporary site, it seems to be a good service with a high level of traffic especially given the problems advertising the site.
- The number of self-help booklets downloaded is impressive (and saves on printing costs for the PCMHT).
- The K10 questionnaire that can be completed onscreen (and which retains the scores of those who complete it) suggests we are attracting people with significant levels of distress to our site.
- We are pleased with progress on the new site and hope to launch it by the end of 2006.
- It is a good example of our ‘horses for courses’ approach.

Services to the over 65s

- We should be in contact with more people in this age group (the same is true for those between 16-21).
- We need to think in a more innovative way in order to make contact.

GP evaluation

- We are pleased with GPs’ perceptions of our service and these data complement the other feedback we are getting when we meet up with GPs.
- We have been able to go some way in solving the two main problems noted by them – waiting times and problems getting through to the service by phone.

CMHT / Direct Access referrals rates and evaluation

- We are pleased with the positive evaluations given by our colleagues in the CMHTs. We have had very few difficulties working alongside our colleagues and this must reflect the fact that we have good networks in mental health in the south east.
• We appear to be significantly easing pressure on Direct Access Psychology as it appears that GPs are increasingly referring to STEPS rather than psychology.

Training

• Three evaluated training events are reported. Generally they suggest that STEPS has an important role to play in training and we would hope to open a training arm of the service as this is an important part of any primary care service.

Information from those who did not use the service

• We attempted to find out more from those who failed to opt-in or who did not attend. Unfortunately, the poor response rate does not allow us to gather much information about this.

Other STEPS activities

• We have presented our model at a range of national and international events

• We have presented the model at many local events and have had clinicians and mangers visit from around the country to find out more about us

• We have rolled-out projects across the city

• We have set-up (but not yet instituted) e-refs to the team

• We have carried out a range of projects with the Asian community including sponsoring Prayer Timetables; offering a mental health Tip of the Day on Radio Ramadhan; setting up ‘STEPS’ stalls at various BEM community events and taking part in phone-ins on Radio Awas

• We have written 13 ‘Step out of Stress’ booklets on a wide range of themes. These are available in print and on download

• We have taken part in a range of community events and health fairs. We ran a ‘Just had a baby?’ event at Langside Halls and a ‘Looking for a Fresh Start?’ event in the Gorbals (centred on mental health, employment, debt, community involvement). These were unsuccessful due to the small number of people who attended
• We have been funded to carry out a stigma awareness/early intervention project in our secondary schools for senior pupils

• We have been funded to put together a DVD on common mental health problems

• We have been involved in a range of perinatal projects

• We have put together two service directories – one specific to the south east and one, in partnership, covering the south side of Glasgow

• We are involved in a ‘Trigger Project’ to enable GPs to better recognise mental health problems and to arrange immediate help

• We are placing ‘Panic’ and ‘Coping with Trauma’ booklets in our local A and E department as an early intervention approach.

**Our aim, at the start of the year, was to devise an innovative primary care service:**

We would provide help to a significantly higher number of people than are reached by traditional services

*We have achieved this*

We would not allow long waiting lists in the service

*We have achieved this for CBT and are confident that we will achieve this for PCT*

We would not rely on individual therapy as the main delivery model

*We have achieved this*

We would develop, as our name suggests, a stepped-care approach (multi-level, multi-purpose’) relevant to the needs of a socially deprived and multi-cultural area

*We have achieved this*

We would empower service users by ensuring they could choose from a range of options, the approach they best felt would meet their needs (a ‘horses for courses’ approach) and that access to those options would be easy to achieve

*We have achieved this*
We would ensure users could return to the service as easily as possible
We have achieved this

We would work in partnership with health, social and other statutory and non-statutory organizations and, whenever possible, share whatever skills we had
We have achieved this

We would work in a preventative way
We have achieved this

We would work at a population level
We have achieved this

We would carefully audit our work to enable us to follow evidence-based practice
We have achieved this

Conclusions

The Glasgow PCMHT development has put the city in the forefront of primary care mental health in Britain. We have been able to develop an innovative service that has attracted significant attention from other mental health workers across the country.

This evaluation has enabled us to improve on weaknesses and develop the strengths in the service. We are now in a strong position to build upon the many successes of the past year and anticipate continued development. In particular, we are making significant changes to the way we offer individual therapy.
Splash – Greenwich social prescribing initiative

The Greenwich Splash website aims to link residents of this London borough with organisations and activities that support health and well-being. The flowchart below aims to support primary care staff in deciding on social prescribing referrals.

http://www.greenwichsplash.org/mainframeset/index.html
Social Prescribing Flowchart for Primary Care Staff

Primary care staff to identify patient who may benefit from being put in touch with a service provider in the community

Does patient consent to referral

Yes

Refer patient to:
Website/directory of community services
Primary care link worker

No

No formal primary care involvement but primary care staff may decide to offer the patient informal advice/consultation

Do you want to monitor if patient accesses the community based service

Yes

Please issue patient a social prescribing referral form to take to the service provider

No

Provide the patient with access to website/information about sources of community services

Does patient need assistance in accessing the website

Yes

Offer patient support and guidance in finding appropriate services

No

Encourage patient to make contact with organisation they have been referred to

Does patient need support in accessing service?

Arrange for the service provider organisation to contact the patient via social prescribing referral form
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