



UCL



A Review of Community Referral Schemes

Linda J. Thomson, Paul M. Camic
& Helen J. Chatterjee

Authors

Dr L J Thomson¹, Prof. P M Camic² and Prof. H J Chatterjee¹

¹University College London; Canterbury Christ Church University²

Corresponding author: Helen Chatterjee h.chatterjee@ucl.ac.uk

© 2015 University College London

All images © UCL unless otherwise stated

Please cite this publication as:

Thomson, L.J., Camic, P.M. & Chatterjee, H.J. (2015). *Social Prescribing: A review of community referral schemes*. London: University College London.

Acknowledgements

The authors of this document are extremely grateful to the staff of museums and galleries, health and social care providers, and statutory, voluntary and community organisations who participated in surveys and interviews about social prescribing. We would especially like to thank our Editorial Advisory Board including Andrew Mowlah, Senior Manager, Policy & Research at Arts Council England; Dr Heather Davison, Development Director at the Royal Society for Public Health; Dr Theodore Stickley, External Advisor and Associate Professor of Mental Health at the University of Nottingham; and Robert Trimble, Chief Executive and Team Leader at the Bromley by Bow Centre; for their input into the publication of this document. We also acknowledge the Arts and Humanities Research Council for funding this research entitled 'Museums on Prescription: Exploring the role and value of cultural heritage in social prescribing' (Grant Ref: AH/L012987/1; PI H. Chatterjee).



The University of
Nottingham



bromley by bow centre



Arts & Humanities
Research Council

Disclaimer

While the authors of this document have made every reasonable effort to ensure that the material within it is factually correct; the authors, the Editorial Advisory Board, University College London or Canterbury Christ Church University do not accept responsibility for any errors or omissions it might contain.



Contents

	Foreword by Sir Peter Bazalgette and Shirley Cramer CBE	4
1	Executive summary	5
	Overview	6
2	2.1 Aims and objectives	6
	2.2 What is social prescribing?	7
	2.3 Background to social prescribing	7
	2.4 Climate for social prescribing	8
3	Models of social prescribing	10
	3.1 Main types of scheme	10
	3.2 Case studies	17
	3.3 Timeline of social prescribing schemes	20
4	Evidence base	22
	4.1 Evaluated UK schemes	22
	4.2 Key findings	22
	4.3 Summary of evaluation methods	29
5	Pathways to implementation	31
	5.1 Ways in which social prescribing schemes have been set up	31
	5.2 Scaling up pilot studies	32
	5.3 Choice of referral options and pathways to implementation	32
6	Recommendations	34
	6.1 Best practice guidance for sector workers	34
	6.2 Frameworks for setting up social prescribing schemes	34
	6.3 Methods for evaluating social providing schemes	35
7	References	37
8	Appendices I – XIII (online version only)	i-xxiv

Tables and Figures

Table 1	Social prescribing timeline	20
Table 2	Summary of researched and evaluated UK schemes	23
Table 3	Quantitative evaluation of social prescribing schemes	30
Figure 1	Social prescribing by GP	31
Figure 2	Social prescribing by primary care staff	31
Figure 3	Social prescribing through link worker	32
Figure 4	Social prescribing as part of IAPT	32

Foreword - Sir Peter Bazalgette

I welcome this review. Social prescribing is an idea whose time has come. In addition to changes in health and social care, the UK is facing the prospect of an ageing population, with the chronic health problems that brings. The arts sector can have an important role to play in offering community-based support for healthy life-long living. Arts and culture also underpin mental health.

In fact, as this review demonstrates, the arts have long been an effective part of social prescribing programmes in the United Kingdom and elsewhere. This is particularly pertinent given the transformations wrought by the Health and Social Care Act of 2012. Current health reforms offer many opportunities, such as cultural commissioning and personal health budgets. But there are also challenges for the arts sector. This review of social prescribing gives an insight into the process of community referral, and provides examples of best practice, guidance on evaluation and suggested pathways for social prescriptions.

Many of the examples of best practice draw upon the diverse work of the arts sector – the Arts Council has supported several arts-on-prescription projects. The research outlined in this report shows that arts-on-prescription has a positive effect on mental health by improving wellbeing, self-esteem, providing purpose and meaning, developing creativity and enhancing quality of life. Not a bad list. So the Arts Council believes that culture enhances our lives, and is intrinsic to our health and happiness, both personally and as a society. I hope this review will encourage everyone to think about what more the arts can do for our health – and how we should explore these critical ideas.

Foreword - Shirley Cramer CBE

The financial constraints on the health and social care system have placed a significant strain on many of our services. However, it has also been the catalyst for a rethinking of how we get to grips with some of the most deep-rooted and perennial lifestyle health challenges we are facing, particular for the most vulnerable in our society. It is an accepted fact that engaging in arts, social activities and interacting within our communities makes us feel more engaged, boosts confidence and makes us more resilient, which in turn does wonders for our broader health and wellbeing. This report offers a solid evidence base for what many people already suspected; that Social Prescribing is a powerful and under-utilised tool but one which can have a massively positive impact on our wellbeing, self-esteem and overall quality of life.

The public health challenges we are facing today have never been greater. Stubborn levels of physical inactivity, increasing social isolation, and rising levels of poor mental health, particularly in older people, need to be tackled using innovative and effective treatments. This is more necessary than ever before with a population which is both ageing and living with complex and long term conditions.

Social prescribing is an effective means of combating many of the underlying causes of poor health and wellbeing and this should be championed by all those who care about improving the lives of those in our society suffering from poor health.

Only by taking a holistic approach to the public's health can we begin to keep people living healthy, fulfilling and socially active lives for the long-term. Social Prescribing has the ability to bring communities together and breakdown the social isolation that afflicts so many in our society. We hope that this review will act as a clarion call for the wider and more frequent adoption of social prescribing in all our communities.



Sir Peter Bazalgette
Chair, Arts Council
England



Shirley Cramer, CEO
Royal Society for
Public Health



1

1 Executive Summary

Definitions of social prescribing have originated from a variety of sources with the most clear-cut being proposed by the CentreForum Mental Health Commission (2014: 6) as: **‘A mechanism for linking patients with non-medical sources of support within the community’**. Well known models include: ‘Arts on Prescription’; ‘Books on Prescription’; ‘Education on Prescription’ and ‘Exercise on Prescription’. Lesser known models include ‘Green Gyms’ and other ‘Healthy Living Initiatives’; ‘Information Prescriptions’; ‘Supported Referral’; ‘Social Enterprise Schemes’ and ‘Time Banks’.

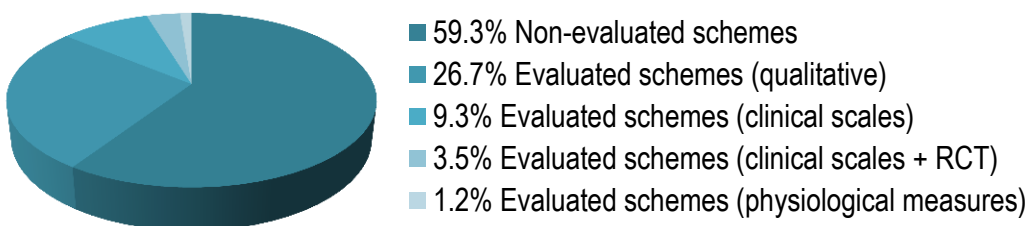
Social prescribing in the United Kingdom (UK) has been brought about by decentralisation of healthcare decision making from national to local government, an emphasis on the notion that prevention is better than cure, and the organisation of multi-agency and holistic approaches to healthcare. Recent government initiatives and key policy reports have provided a climate for development of social prescribing within local communities; these include: the inception of Clinical Commissioning Groups and Improving Access to Psychological Therapy (IAPT); findings from the Marmot Review; the concept of the Big Society; the Foresight Report on Mental Capital; and the National Institute for Health and Clinical Excellence (NICE) guidelines. Just over 40% of the UK social prescribing schemes reviewed here have been subject to evaluation. Around two-thirds of the evaluated schemes reviewed employed qualitative analysis of questionnaires, interviews, surveys or focus groups whereas the other third used statistical analysis of measures from reliable and validated clinical scales; three of these schemes employed randomised controlled trials (RCT) and another scheme compared physiological measures. Robust evaluation of social prescribing schemes is recommended, as nearly 60% of the programmes included in this review have not been subject to any formal means of assessment.

‘To complement medical treatment with interventions which enabled patients to become more confident and able to manage their own condition’
NESTA (2013:6)

‘A means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services’
...‘Local support groups, the voluntary and community sector will be key to successful social prescribing’
Lewisham Clinical Commissioning Group (2014: 10)

‘To expand the options available in a primary care consultation’
Brandling & House (2009: 454)

‘To ensure a holistic approach’
CentreForum Mental Health Commission (2014: 7)



Outcomes of social prescribing have produced benefits for participants including:

- ▶ **Increases in self-esteem and confidence**
- ▶ **Sense of control and empowerment**
- ▶ **Improvements in psychological or mental wellbeing**
- ▶ **Positive mood linked to a reduction in symptoms of anxiety and depression**

These outcomes in turn have the potential to reduce inappropriate prescribing of antidepressants in line with NICE (2004) guidelines. Furthermore, encouraging patients to become proactive in decisions about their own health, plus increasing social contact and support in local communities, has led to reductions in levels of reliance on primary and secondary care. The benefits have been particularly pronounced for marginalised groups such as mental health service-users and older adults at risk of social isolation. The most successful schemes have favoured the use of a link worker or referral agent acting as a ‘one stop shop’ for referrers from general practice, health and social care services and, potentially an array of other professionals working within the community.

2



2 Overview

2.1 Aims and objectives

The review aims to set the scene for the conditions under which social prescribing has arisen and consider the efficacy of different referral options. Its objectives are to provide definitions, models and notable examples of social prescribing schemes and to assess the means by which and the extent to which these schemes have been evaluated. The review makes recommendations for practice, policy and future research.

2.2 What is social prescribing?

Social prescribing was described by the CentreForum Mental Health Commission (2014: 6) as 'a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, new skills, volunteering, mutual aid, befriending and self-help, as well as support with benefits, employment, housing, debt, legal advice or parenting problems'. CentreForum found that social prescribing was usually delivered through primary care and although a range of referral models and options existed, appropriate community structures (e.g. third sector agencies) needed to be in place to support referral.

A report commissioned by the Lewisham Clinical Commissioning Group (CCG) (Malcolm-Smith & Richards, 2014: 10) defined social prescribing as 'A means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. Often these services are provided by voluntary, community and faith sector (VCFS) organisations with in depth knowledge of local communities and how best to meet their needs of specific groups'.

The Care Services Improvement Partnership North West (2009: 25) found that social prescribing schemes represented an 'innovative approach to engaging with health

inequalities' that 'used partnership working to address the social causes of mental ill health'. The Care Services Improvement Partnership stressed that recovery was a central principle in mental health care and advocated that referring and signposting should be a continuous process to maintain throughput for schemes and onward referral for continuing participation

The Scottish Development Centre for Mental Health (2007) recognised that informal referral addressed the needs of people reluctant to self-refer to mental health services, offering lower cost alternatives to medication or cognitive behavioural therapy (CBT) especially where demand outweighed supply. The Centre considered social prescribing was useful for addressing psychosocial issues leading to mild anxiety or depression where referral to psychiatric services was inappropriate. The notion of social prescribing was influenced by the quality of life and wellbeing agenda supported by the Scottish Government's policy on arts and culture. The agenda aimed to increase participation in deprived and marginalised groups, reduce social exclusion, help people take responsibility for their own health and promote opportunities for physical activity.

Brandling and House (2009: 454) asserted that social prescribing options available to general practitioners (GPs) would address psychosocial or socioeconomic issues and 'expand the options available in a primary care consultation' that would 'make available new life opportunities that can add meaning, form new relationships, or give the patient a chance to take responsibility or be creative'. The authors suggested that 'the big picture difficulty with leaving underlying psychosocial problems largely hidden in the consulting room is the medicalization of society's ills... this sort of medicalization may help immediate problems... but it is not enough if our society is to have a sustainable future'.

Social prescribing 'should be available in every primary care practice in order to connect patients to local wellbeing services and other support available in the wider community that can address the psychosocial factors that influence wellbeing'
CentreForum (2014: 47)

'While the medical model diagnoses and treats disease rather than people, it is the social context in which people live their lives that often determines their health, and wellbeing'
NESTA (2013: 6)

'A valuable complement to other recent and ongoing developments within the NHS to promote access to psychological treatments and interventions'
Scottish Development Centre for Mental Health (2007: 5)



Friedli, Jackson, Abernethy and Stansfield (2009: 2) described social prescribing as a non-medical intervention that was helpful for ‘vulnerable and at risk groups... people with mild to moderate depression and anxiety; people with long-term and enduring mental health problems; and frequent attenders in primary care.’ Friedli *et al.* noted that most social prescribing models were primary care-based where patients were referred to specific programmes or signposted to information or support from community, voluntary or local authority services.

2.3 Background to social prescribing

The London Borough of Bromley Primary Care Trust (PCT), which ceased to operate in 2013 due to restructuring of healthcare planning and commissioning in England and Wales, hosted a workshop in 2002, ‘Social Prescribing: Making it happen in Bromley’, and identified six prescribing practices (Brandling & House, 2007):

- ▶ Information with advertising and directory access but no face-to-face contact
- ▶ Information and telephone line with advertising and patient self-initiated telephone discussion with health worker
- ▶ Primary care referral to social prescribing service appointment
- ▶ Primary care referral or self-referral to clinic in general practice acting as ‘one stop shop’
- ▶ Primary care referral or self-referral to clinic in general practice also offering advice, referral or signposting onwards
- ▶ Non-primary care referral from practice-based staff sent to referral centre offering one-to-one facilitation

The workshop kept records of feedback on social prescribing and stressed that although there should be equitable access, services should be prioritised where demand was high or resources were limited (e.g. accident and emergency, areas of deprivation, to avert

crises, and vulnerable groups). To allay third sector concerns about the capacity to cope with referrals, it was suggested that health organisations should arrange funding provision through service level agreements and well-defined processes so that health professionals would develop confidence in the schemes. The workshop found that only half of referrals in Bromley came from GP practices though did not investigate the contributing reasons (Grant, Goodenough, Harvey & Hine, 2000). GPs identified additional costs but failed to take account of long term community benefits and reduction in social services (Goodhart & Graffy, 2000).

The Care Services Improvement Partnership North West (2009: 16) recommended self-help management of anxiety and depression based on ‘CBT principles, user-led support groups and exercise’, in line with the NICE (2004a) stepped care approach:

- ▶ Step 1: Watchful waiting (sub-clinical patients and those not choosing to have the intervention)
- ▶ Step 2: Guided self-help, exercise, education, signposting, computerised CBT (mild to moderate depression)
- ▶ Step 3: Medication, case management and collaborative care, psychological therapy (moderate depression)
- ▶ Step 4: Medication, case management and collaborative care, psychological therapy (severe depression)
- ▶ Step 5: Specialist services (chronic, atypical refractory or recurrent depression)

The Care Services Improvement Partnership North West (2009: 25) proposed that ‘social prescribing has a potential role to play within each of the steps but the main benefits are in building capacity at step two’. They pointed out that the availability of non-clinical interventions within stepped provision recognized that mental health issues were not purely bio-medical but influenced by a range of social factors.

‘GPs do suggest social avenues, such as visiting a Citizens Advice Bureau for financial problems, or a dance class for exercise and loneliness, but without a supportive framework this tends to be a token action’

Brandling & House (2009: 454)

‘Improved access both to psychological treatments and to interventions addressing the wider determinants of mental health’

Friedli *et al.* (2009: 2)

‘The potential to become fully integrated as a patient pathway for primary care practices and to strengthen the links between healthcare providers and community, voluntary and local authority services that influence public mental health’

Friedli *et al.* (2009: 2)



2.4 Climate for social prescribing

Clinical Commissioning Groups (CCGs) were set up following the Health and Social Care Act (2012) and replaced PCTs in April 2013. CCGs are clinically-led statutory National Health Service (NHS) bodies, responsible for 60% of the budget involved with planning and commissioning health care services. CCGs are independent and accountable to the Secretary of State for Health. They work closely with Local Authorities, now responsible for public health through Health and Wellbeing Boards, by developing a joint needs assessment and strategy for improvement. Their remit is to obtain the best possible health outcomes for the local population by determining priorities and commissioning healthcare such as urgent and emergency care, community care, elective hospital services, and mental health services). Commissioning Support Units provide services for CCGs (e.g. data management and finance) which CCGs can choose to buy or retain in-house depending on efficiency and appropriateness. CCGs are, therefore, instrumental in commissioning programmes of social prescribing from local voluntary and third sector agencies.

The Marmot Review (Marmot, 2010) articulated the principles of a fair society, linking them to the challenge of addressing health inequalities in England that had resulted in a social gradient in health. Marmot considered that economic growth was not the only measure of a country's success; a fair distribution of sustainability, health and wellbeing was just as important. Although Marmot did not refer overtly to social prescribing, scaled-up versions of a community referral model could address social determinants of health inequalities.

Community aspects of social prescribing align with the 'Big Society' initiative launched by the UK Coalition Government (2010) that emphasized partnerships and voluntary or third sector delivery. The 'Big Society' aimed

to create a climate to empower local communities. Its priorities were to transfer power from central to local government; encourage people to take an active role in their communities; support charities, co-operatives, mutual societies and social enterprises; and publish government data for greater transparency. By increasing community participation, the Big Society was expected to build social capital and improve wellbeing by reducing social isolation, and increasing social connectivity and resilience. Similarly, the mental health strategy (Her Majesty's Government and Department of Health, 2011) aimed to improve population mental health by achieving parity with physical health and promoting wellbeing through equal access to high-quality services.

The Foresight Mental Capital and Wellbeing Project (2008) found that positive mental health and wellbeing were associated with social and economic benefits (e.g. education, productivity, social connectivity and reduced crime rates) and identified two themes:

- ▶ The vulnerability of our mental resources and mental wellbeing to future challenges
- ▶ The potential of these same resources to adapt and meet those challenges, and indeed to thrive

Mental wellbeing was defined as 'a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community' Foresight (2008: 10). Mental wellbeing was linked to 'mental capital', involving cognitive and emotional resources including cognitive ability, flexibility and learning efficiency, and 'emotional intelligence' comprising social skills and resilience to stressors. Key factors such as purposeful activity, health, social support and self-esteem were seen to build individual and community resilience by exploiting mental wellbeing and mental capital.

'Close the treatment gap that leaves almost one in ten adults suffering from depression and anxiety... 1-2% of the adult population experiencing severe mental illnesses, such as schizophrenia... and who do not receive the parity of care which you would expect if you had a physical illness'

CentreForum (2014: 7)

'Community empowerment occurs when people work together to shape the decisions that influence their lives and health and begin to create a more equitable society'

Public Health England (2015: 4)

'Despite the evidence base, the NHS remains doggedly stuck in a model of care that separates the physical from the psychological and the social.'

CentreForum (2014: 7)



The CentreForum Mental Health Commission (2014: 7) identified five policy shifts:

- ▶ Make mental wellbeing or the 'pursuit of happiness' a clear and measurable goal
- ▶ Roll out a National Wellbeing Programme led by Public Health England to foster mutual support, self-care and recovery 'locally tailored' by Health and Wellbeing Boards to build community capacity
- ▶ Prioritise investment in the mental health of young people to transform their life chances and reduce costs to society of low educational attainment and antisocial behaviour
- ▶ Make work places 'mental health friendly'
- ▶ 'Close the treatment gap' so that adults suffering from mental illness receive the parity of care expected for a physical illness and ensure a holistic approach

CentreForum commented, however, on the lack of progress in mental health: 'three years on, the strategy still sets the right direction. But translating it into practice has been painfully slow'.

In keeping with NICE (2004) guidelines to reduce the level of antidepressant drugs prescribed for mild to moderate depression, the Improving Access to Psychological Therapies (IAPT) programme was set up with £400 million committed to it over four years (2011-15). IAPTs were initiated in response to statistics indicating a high incidence of mental illness (Andrews, Poulton & Skoog, 2005; McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009) and showed better recovery rates compared with medication alone, (e.g. De Rubeis *et al.*, 2005). Consequently, the Department of Health's (2012) goal was to ensure access to psychological therapies by March 2015 to those who would benefit, and the nationwide roll-out of IAPTs, ensuring equitable access, expanded access to those with severe mental illness, and extended access to patients with long-term conditions or medically unexplained symptoms'.

The Mental Health Policy Group (2012) found that nearly half of adults under 65 diagnosed by the NHS with ill health had mental ill health and anxiety and depression accounted for most diagnoses. This was an important finding as anxiety and depression precipitate neurological degeneration associated with Alzheimer's disease and other dementias (Leonard, 2007). Improving services and quality of care was a key priority of the Prime Minister's Dementia Challenge because of the economic, personal and social impact on an estimated 850,000 people with dementia in the UK, their carers and families (DH, 2012). NICE guidelines advocated that people with mild to moderate dementia 'should be given the opportunity to participate in a structured group cognitive stimulation programme' (NICE-SCIE, 2007: 1.6.1). Spector, Orrell and Hall (2012) found evidence for the efficacy of cognitive stimulation therapy for people with dementia using multi-sensory methods associated with increased cognitive processing.

Due to potential costs of untreated mental ill health particularly when occurring with physical ill health, the Mental Health Policy Group (2012: 1) proposed 'when people with physical symptoms receive psychological therapy, the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of the psychological therapy'. Radhakrishnan, Hammond, Jones, Watson, McMillan-Shields and Lafortune (2013) calculated costs for IAPT sessions across all PCTs and although marginally higher than estimated (low intensity £98.59, high intensity £176.97) were cost-effective. Hammond *et al.* (2012) compared high intensity, face-to-face CBT with low intensity, telephone CBT for 39,000 adults with mixed anxiety and depression attending IAPTs. The authors found benefits for both groups implying less costly low intensity interventions were equally effective.

'At least one in four will experience a mental health problem at some point in their lives... One in six has a mental health problem at any one time'

McManus *et al.* (2009)

'Almost half of all adults will experience at least one episode of depression during their life'

Andrews *et al.* (2005)

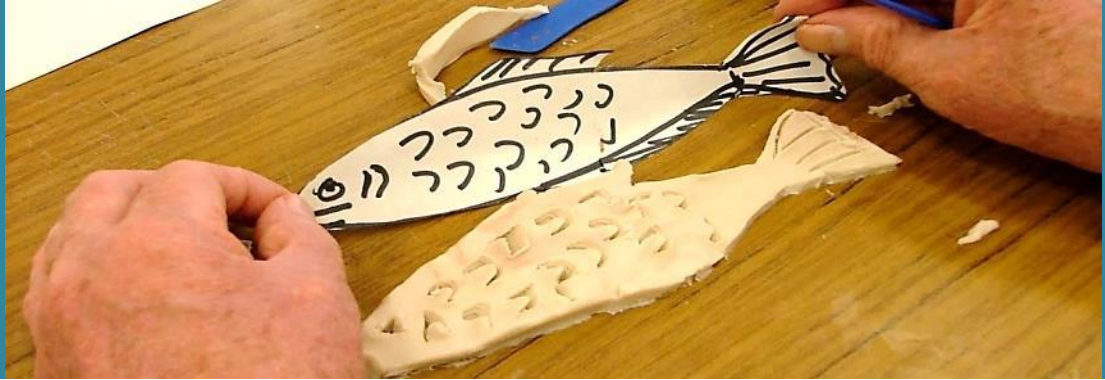
'Altogether the extra physical healthcare caused by mental illness now costs the NHS at least £10 billion. Much of this money would be better spent on psychological therapies for those people who have mental health problems on top of their physical symptoms'

Mental Health Policy Group (2012: 1)

'The adult brain retains significant neuronal plasticity and therefore has the capacity for regeneration and compensation'

Spector *et al.* (2012: 244).

3



3 Models of social prescribing

3.1 Main types of scheme

Arts on Prescription

Arts on Prescription was established in the mid-1990s and offered workshops to support patients suffering from anxiety and other mental health issues. Workshops comprised creative activities (e.g. dance, drama, film, music, painting, photography, poetry and sculpture). Creative activity appeared to have a positive effect on mental health, was related to self-expression and self-esteem, and initiated opportunities for social contact and participation (Huxley, 1997). Arts on Prescription provided purpose, meaning and improved quality of life (Callard & Friedli, 2005; Tyldesley & Rigby, 2003). In a national study, Hacking, Secker, Spandler, Kent and Shenton (2008) evaluated the impact of arts activities for patients with common mental health conditions. Findings showed that arts programmes made participants feel more empowered and confident and reduced feelings of social exclusion and isolation.

Arts on Prescription can be differentiated from art therapy/psychotherapy which in the UK are professional disciplines where art therapist/psychotherapist training is validated by the Health and Care Professions Council. Arts on Prescription has similar aims to art therapy in enabling a client to change and grow being also developed from longstanding arts and health practices. Like much art therapy, evaluation was based on small-scale surveys with short term outcomes which lacked a longitudinal dimension. Initially, Arts on Prescription assessment tended to be reliant upon anecdotal evidence or failed to identify arts-specific aspects of the programme (Coulter, 2001).

Books on Prescription

Books on Prescription or Bibliotherapy is the use of self-help books and literature to enable people to manage and understand their psychological issues. Books written by

health professionals employ CBT principles for common mental health conditions (e.g. anxiety, depression, phobias and eating disorders). Bibliotherapy usually takes the form of referral by a GP or mental health worker for a book borrowed 'on prescription' from a public library. Prescribed books are available from local libraries and can also be borrowed without a prescription so that people can obtain guidance without seeing a GP. Other opportunities for bibliotherapy within a social prescribing model include GP referral or self-referral to reading groups or literature with a personal development theme (The Reading Agency, 2003). Hicks (2006) reported that over half of library authorities in England operated forms of bibliotherapy, and Books on Prescription operated nationally in Wales but there was little communication between schemes or sharing of practice.

The Reading Agency and Loughborough University Information Statistics Unit (2010) conducted research for the Museums, Libraries and Archives Council that revealed considerable health and wellbeing library activity but lack of a coherent strategic delivery framework. Research commissioned to test reading as a form of relaxation found that reading for six minutes was sufficient to reduce stress levels by 60%, slowing the heartbeat and relaxing muscle tension (Mindlab International, 2009).

In February 2012, the Public Library Health Offer Group received funding from the Library Development Initiative to pilot its 'Reading Well: Books on Prescription' scheme. Due to its popularity, the scheme was launched nationally as part of the Universal Health Offer for Libraries across 84% of English library authorities in May 2013. It was supported by the DH; Society of Chief Librarians; the Reading Agency; and Arts Council England (Department for Culture, Media and Sport, 2013). 'Reading Well: Books on Prescription' pooled all bibliotherapy schemes into a single and

'Rather than a trained art therapist working with individuals or small groups in an acute setting, Arts on Prescription programmes are facilitated by artists or musicians and engage groups of people living in the community'
Bungay & Cliff (2010: 227)

'Provides mental health workers with an alternative and additional approach to a problem... many people develop emotional or psychological problems at some time during their lives and some need treatment but scheme provides alternate approach'
Sutton Council Project website: Books on Prescription (2015)



consistent offer across England to provide benefits for people with mild to moderate mental health conditions. National schemes were already running in Wales and parts of Scotland, and the Universal Health Offer was based on a Cardiff scheme developed by clinical psychologist, Prof. Neil Frude (2005).

The aim of the Reading Agency and Society of Chief Librarians was to make optimal use of resources by creating a shared model for Books on Prescription, incorporating quality assurance, best practice and creation of a national evidence base. The core collection of 30 titles was developed by researching best practice and consulting health partners comprising the British Association for Behavioural & Cognitive Psychotherapies, the British Psychological Society, the DH IAPT programme, Mind, the Royal College of General Practitioners, the Royal College of Nursing, and the Royal College of Psychiatrists. The Reading Agency worked with the Public Library Health Offer Group to develop central resources and materials for libraries which operated as co-ordinators working directly with local partners, GPs and community health nurses. Although the scheme was based on self-help reading, it was hoped participants would be signposted to other aspects of the library health offer such as Reading Well Mood-boosting Books (novels and poetry) and reading groups.

In March 2014, Library Services in England estimated that, based on loan figures of recommended titles, over 100,000 people with mental health issues had engaged with Reading Well Books on Prescription since its launch. Additionally, loans increased by 145% in the first three months of the scheme. Following the success of Books on Prescription, Arts Council England agreed to fund further work on how libraries could support people with dementia. In January 2015, the Reading Agency launched 'Reading Well Books on Prescription for Dementia' as part of the national library

strategy to support development of dementia-friendly communities, build understanding and awareness of the condition, and provide support for people with dementia, their carers and anyone wanting to find out more or worried about symptoms in the absence of a formal diagnosis.

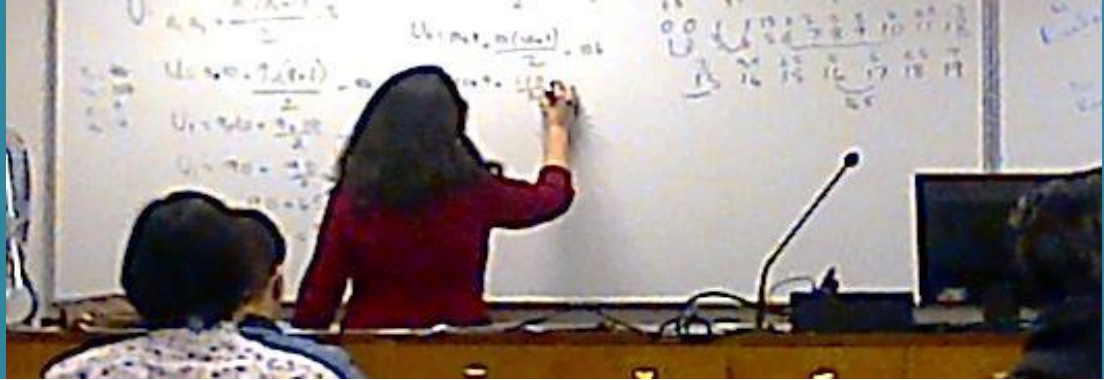
Health experts and people with lived experience of dementia recommended 25 titles divided into four categories: Information and advice; living well with dementia; support for relatives and carers; and personal stories. The books offer practical advice for carers and suggestions for shared therapeutic activities. People can self-refer using the booklist to access free-to-borrow titles from their local library. At a national average cost of £1 per person, the scheme was shown to be cost-effective in delivering community-based dementia care and support.

Whilst no specific studies of the effects of reading on dementia care have been carried out, Verghese *et al.* (2003) conducted a five-year longitudinal study looking at the effects of leisure activities and dementia risk for 469 participants over the age of 75 living in the community, without dementia at baseline. Though not an RCT, the authors showed that participation in some activities (e.g. board games, dancing, playing musical instruments, and reading) was associated with reduced risk. Reading reduced the likelihood of dementia by 35%, although for dancing this was 73%. Participation in other physical exercise (e.g. cycling, swimming, playing golf) did not appear to affect mental capacity, though may have benefited cardiovascular capacity, associated with vascular dementia, not specifically examined in the Verghese *et al.* study.

Education on Prescription

Education on Prescription consists of referral to formal learning opportunities, including literacy and basic skills. It can involve the use of learning advisers placed within educational establishments, day services, mental health

Reading is:
68% better than listening to music,
100% better than drinking a cup of tea,
300% better than going for a walk and
700% better than playing video games
for reducing stress levels
Mindlab International (2009)



'A considerable information and knowledge gap'
Mental Health Foundation
(2005: 6)

teams or voluntary sector organisations to identify appropriate educational activities for individuals and support access. Opportunities for learning can impact positively on health by improving an individual's socioeconomic position, access to health services and information, resilience, problem-solving, self-esteem and self-efficacy (National Institute for Adult Continuing Education, 2003).

A longitudinal American study (Vemuri *et al.* 2014) examined the relationship between lifetime intellectual enrichment and cognitive decline in older adults. The authors found that higher education or occupation scores were associated with higher levels of cognition, particularly in later life. They concluded that lifetime intellectual enrichment might delay the onset of cognitive impairment and be used as a successful preventive intervention for dementia. Their calculations indicated that carriers of the apolipoprotein E (APOE) gene on chromosome 19, the major genetic source of common forms of late-onset Alzheimer's, who had experienced high lifetime intellectual enrichment, onset of cognitive impairment was later (by about 8.7 years) than those with a low lifetime intellectual enrichment.

A longitudinal UK study of the health impact of participation in learning for 10,000 British adults aged 33-42 found that education played an important role in contributing to small shifts in attitudes and behaviours during mid-adulthood. Participation in education resulted in increases in exercise; life satisfaction; race tolerance; political interest and voting behaviour; number of memberships of community groups; and reduction in authoritarian attitude (Feinstein, Hammond, Woods, Preston & Bynner, 2003).

Morrison and Clift (2006) evaluated the effect of supported further education for 148 mature students (mean age 39.5 years) with a long term mental health diagnosis. The students typically lacked concentration, had poor organisational abilities, poor long and/or

short-term memory, negative mood, inconsistent attendance and required frequent breaks. The supported education which began off-campus in NHS day services, led to an introductory course on campus and then to a mainstream course with continued support. Students were referred through NHS staff and a coordinating occupational therapist acted as a link between referrers and personal tutors.

Morrison and Clift's evaluation was based on the Antonovsky's Salutogenic (1993) model of health. Students receiving supported further education completed the Short-form Sense of Coherence Scale (SOC13) on programme entry and exit. Although no significant difference was found between entry and exit scores, 70% of participants entering the programme with very low scores made significant gains. A questionnaire used with a second cohort of students indicated that advantages of education referral included peer support, which influenced the programme's learning effects that in turn reduced negative symptoms and increased positive affect. In practical terms, most students completed their courses and moved on to other courses or employment.

Exercise on Prescription

Exercise on Prescription or Exercise Referral involves referring patients to supported exercise programmes (e.g. cycling, guided healthy walks, gym or leisure centre activity, keep fit and dance classes, swimming, aqua-therapy and team sports). In addition to physical health improvements, the benefits include learning new skills and achieving goals, improving the way that people look and feel about themselves, meeting new people and making friends, adding structure to the day and improving patterns of sleep. Since their inception in 1990, UK exercise referral schemes have increased to around 600 (Pavey *et al.*, 2011).

The Mental Health Foundation (2005) report 'Up and Running?' highlighted the need to



promote exercise therapy for depression as a realistic and readily available tool for GPs and an option which patients could self-select. In a review of research into effects of exercise on mental health and wellbeing, Callaghan (2004) reported reductions in anxiety, depression and negative mood with increases in self-esteem and cognitive functioning, and concluded that exercise was a neglected intervention in mental health care. Previous studies indicated a positive association of physical activity with health-related quality of life and wellbeing among people with moderate to severe mental health diagnoses (Biddle & Mutri, 2001).

The biological basis for exercise referral is that regular exercise releases naturally-occurring morphine-like neuropeptides (endorphins) produced by the central nervous system and pituitary gland that inhibit the transmission of pain signals and produce a feeling of euphoria similar to that produced by other opioids (e.g. Vaughan, Wallis, Polit, Steele, Shum & Morris, 2014; Hillman, Erickson & Kramer, 2008).

The Joint Consultative Forum (JCF: 2011) produced proposals for operational and professional exercise referral standards for health professionals and fitness instructors, incorporating performance benchmarks, evaluation standards, accreditation and appraisal. The JCF recommended referral by a health care professional to a service or an independent exercise instructor to provide a programme of long term benefit to the patient as part of the normal management of chronic disease or disability and/or one or more cardiovascular risk factors. Their report also covered GP training regarding exercise referral in the light of participant risk factors and recommended that referrers should be from the Royal Colleges of: General Practice, Physicians, Psychiatrists, Physiotherapists, Paediatricians or Child Health Professionals. The National Quality and Assurance Framework (DH, 2001) set out a clinical,

operational and legal framework for exercise referral stressing the difference to GPs between recommending and prescribing exercise. The Mental Health Foundation (2005; 2009) carried out two surveys of perceptions of exercise referral with a UK sample of 200 NHS GPs (c. 77% England; 10% Scotland; 10% Wales; 3% Northern Ireland). In the first survey they found that 42% of GPs thought they had access to an exercise referral scheme; none said they used it 'very frequently' for patients with mild or moderate depression and 15% said they used it 'fairly frequently' (2005: 6). Of those who indicated 'not very frequently' or 'not at all', 43% said they were not convinced it was an effective treatment, leading the Mental Health Foundation to conclude that GPs lacked sufficient information and knowledge about exercise referral schemes.

In the second survey, when asked about the three most common treatment responses for patients with mild to moderate depression, most GPs (94%) indicated that they would prescribe anti-depressant medication, in line with the first survey (92%). However, around a fifth (21%) said they would refer to a supervised programme of exercise and 4% (over four times more than the first survey) said they would use it as their first treatment response. Significantly, over 40% of GPs did not have access to an exercise referral scheme and of these, 95% said that they would refer patients with mild to moderate depression if given access. Of the GPs who did have access to exercise referral, over 80% used it as a treatment option.

NICE (2014) updated previous public health guidelines (NICE, 2006) on exercise referral for adults aged 19 years and over. NICE identified gaps in research such as lack of RCT evidence and cost effectiveness for multiple health conditions and mental health; whether effects were maintained long term; how practitioners identified participants suitable for physical activity; levels of

'An exercise referral scheme directs someone to a service offering an assessment of need, the development of a tailored physical activity programme, monitoring of progress and follow-up. They involve participation by a number of professionals and may require the individual to go to an exercise facility such as a leisure centre'
NICE (2006: 5)

'Physical activity can play an important role in preventing and managing health conditions such as coronary heart disease, type two diabetes, stroke, mental health problems, musculoskeletal conditions and some cancers. It also has a positive effect on wellbeing and mood, providing a sense of achievement or relaxation and release from daily stress'
NICE (2014: 5)



'Social support is a key prerequisite for successful exercise initiation and maintenance for most people'

Carless & Douglas (2008: 12)

'Exercise referral schemes have a small effect on increasing physical activity in sedentary people, but it is not certain that this small benefit is an efficient use of resources'

Williams et al. (2007: 985)

'Being indoors is like being trapped in my mind – getting outside allows me to escape from that and be reminded that there is a solid, real earth out there for me to enjoy'

Mind (2003: 6)

'Now I am part of the team and I feel like I have something to get up for in the morning. I enjoy the fresh air and gardening and I get a real sense of achievement and satisfaction when we finish a garden'

Mind (2003: 8)

participation in under-represented groups and short and long term benefits including the 'feel good factor' (2014: 43). They concluded that exercise referral had limited benefit compared with other interventions (e.g. providing information about local opportunities to be active).

Pavey *et al.* (2011) carried out a systematic review of exercise referral studies (6 UK; 2 non-UK) that met RCT inclusion criteria comparing exercise with usual care or other interventions for over 5000 participants pooled across studies. Pavey *et al.* found weak evidence to support exercise referral comprising a short term increase in physical activity and reduction in levels of depression of sedentary individuals after participation in a 10-12 week leisure centre programme compared with usual care. They found inconsistent research in support of exercise referral for other outcomes (e.g. health related quality of life) though concluded that despite limited evidence, exercise referral was a potentially valuable primary care intervention for promoting physical activity.

The British Heart Foundation (2010) published a toolkit for exercise referral implementation developed in consultation with professionals and national stakeholders. The report evaluated over 150 schemes in England, Scotland and Northern Ireland (2006-08) using a 50-item questionnaire designed and piloted in collaboration with the West and East Physical Activity Networks. The British Heart Foundation found a range of inclusion criteria (e.g. arthritis, asthma, coronary heart disease risk factors, diabetes, hypertension, inactivity, osteoporosis, and raised blood cholesterol) and that 97% of schemes involved data collection on health, fitness and physical activity. Schemes varied in the number of activities offered (e.g. 3-7 in England and Scotland; 1-2 in Northern Ireland) and averaged 12 weeks in duration with a typical exit strategy of concessionary rates at leisure centres. Initially over 90% of

referrers were from general practice but subsequently two thirds of schemes accepted referral by allied health professionals (e.g. physiotherapists).

Carless and Douglas (2008) carried out research into experiences of men with severe mental illness taking part in sports exercise and found that social support was a key motivating factor. Williams, Hendry, France, Lewis, and Wilkinson (2007: 984) reviewed 18 exercise studies, six of which were RCTs, and concluded that exercise referral resulted in a 'statistically significant increase in the numbers of sedentary people becoming moderately active' but that the risk reduction was small because every 17 people referred, one became moderately active.

Green Gyms

Green Gyms, also called Ecotherapy or Green Activity, support participants in becoming physically and mentally healthier through contact with nature (e.g. gardening, walking in parks, developing green spaces). Exercise in a natural environment is associated with self-esteem and positive mood (Countryside Recreation Network 2005; Pretty, Griffin, Sellens & Pretty, 2003). A report from Mind (2013) proposed that ecotherapy was an accessible, cost-effective complement to existing treatment options for mild to moderate mental health conditions.

Webber, Hinds and Camic (2015: 20) used a mixed methods approach to assess the wellbeing of 171 UK allotment gardeners. The main themes to emerge were 'a space of one's own, meaningful activity, increased feelings of connectedness, and improved physical and mental health'. The authors found increases in measures of eudaimonic wellbeing that emphasizes an intrinsically worthwhile way of living (Waterman *et al.*, 2010). A review of studies published since 2003 on gardening as a mental health intervention, found benefits across emotional, social, vocational, physical and spiritual domains (Clatworthy, Hinds & Camic, 2013).



In a national review of 52 UK green gym projects (Yerrell, 2008), 194 out of 703 participants completed both the introductory and continuation questionnaires using the Short Form Health Survey (SF-12) and demonstrated improved physical and mental health.

In the projects reviewed, 80% of participants were aged 25-64 and 60% were male. Green gyms had the greatest impact on participants with the poorest health on joining; those with the lowest physical health scores were nine times more likely to improve, and those with the lowest mental health scores were three times more likely to improve. Yerrell (2008: 3) found that the highest rated factors for joining were 'being outdoors' and 'improving the environment' and the lowest rated factors were 'losing weight' and 'being with family or partner'.

Pretty, Peacock, Hine, Sellens, South and Griffin (2007) reviewed the effects of ten green exercise studies (e.g. conservation activities, cycling, horse-riding and walking) for 263 participants across four UK regions. Even though participants were mostly active and healthy, green exercise led to significant improvements in self-esteem and reduction in measures of negative mood regardless of the duration, intensity or type of exercise, indicating the potential of green schemes as public health interventions for mental health.

The British Trust for Conservation Volunteers (BTCV: 2002), now called The Conservation Volunteers (TCV), found significant mental health improvement in the first three months of green gym participation, using the SF-12. TVC (2013) demonstrated physical and mental health benefits to quality of life and wellbeing. Being in the countryside emerged as a significant motivating factor, which supported other findings on the therapeutic value of natural environments, including acquiring new skills, increased awareness of conservation, participating in something worthwhile and social aspects of group working.

Healthy Living Initiatives

Healthy Living Initiatives use social prescribing models to support health improvement and address health inequalities by targeting disadvantaged sectors of the population. Healthy living initiatives involve activities for promoting health in its broadest sense (e.g. health checks, healthy eating, exercise and smoking cessation) prescribed by community nurses or other health visitors. Initiatives focus on the aim of giving hope and encouraging people to try different activities, develop new skills, make friends and have an enjoyable time.

Information Prescriptions

Information Prescriptions, often referred to as Signposting, consist of a series of links or 'signposts' designed to guide patients to sources of health and welfare information (e.g. financial advice, care services, housing support, treatment options, self-help and support groups). The prescriptions give information through websites addresses and telephone numbers and, and provide current NHS and patient organisation updates.

Museums on Prescription

Museums on Prescription schemes consist of referral to cultural and heritage activities (e.g. guided talks, tours, object handling and collections-inspired arts activities) which take place in a museum or gallery location, or as outreach. Museums including art galleries are well-placed to offer public health interventions in the form of activities that are 'community-based, low-cost and nonclinical' (Roberts, Camic & Springham, 2011: 146). Camic & Chatterjee, (2013: 66) found that 'possibly unknown to the health-care sector, numerous museums currently offer innovative programmes that seek to address challenging health-care problems, offer support to caregivers and provide education, often within an aesthetically pleasing environment'.

Several museums have piloted prescription schemes, with the first of its kind at Tate

Models of social prescribing 'tackle a range of factors that directly impact on health, including: diet and exercise; social isolation and support networks; mental and physical health and wellbeing; and employment and finances'
NESTA, 2013: 20)



Britain (Art-based Information Prescription: Shaer *et al.*, 2008); others include the Beaney House of Art & Knowledge, Canterbury (Paper Apothecary, 2013); the Cinema Museum, Lambeth, London (Cinema Museum Prescriptions, 2014); the Holburne Museum, Bath (Recollection, 2014); and Oxford University Museums (Memory Lane Prescription for Reminiscence, 2015).

The Museums on Prescription (MoP) research project was launched in 2014 to firstly, undertake a review of existing social prescribing schemes (the present review) and secondly, to use best practices derived from the review to investigate the impact of museum activities on socially isolated older adults referred through health and social care providers and third sector agencies. MoP was grounded in previous research which explored the effects of object handling and other museum activities on the psychological wellbeing and subjective happiness of hospital patients, care home residents and community members using clinical measures and qualitative methods (Camic, Baker & Tischler, 2015; Morse, Thomson, Brown & Chatterjee, 2015; Solway, Camic, Thomson & Chatterjee, 2015; Thomson & Chatterjee, 2014a; Chatterjee & Noble, 2013; Thomson, Ander, Lanceley, Menon & Chatterjee, 2012a; 2012b). Thomson and Chatterjee, (2015; 2014b) also developed the UCL Museum Wellbeing Measures, a toolkit for museum and other third sector professionals to evaluate effects of cultural and creative activities on participant wellbeing, specifically in museum and gallery contexts.

Social Enterprise Schemes

Social Enterprise Schemes or Social Firms (e.g. community businesses, cooperatives and credit unions) provide employment to people with mental health issues. Supported employment provides an early intervention to keep people in work and maintain social contact. Schemes subscribe to three core values (Social Enterprise Coalition, 2005):

- ▶ Enterprise: Businesses combine market orientation with a social mission
- ▶ Employment: Workplaces provide all employees with support, opportunity and meaningful work
- ▶ Empowerment: Employers are committed to social and economic integration of disadvantaged people including paying market wages to all employees

Supported Referral

Supported Referral focuses on enabling mental health patients to identify and access support to meet their needs, and places less emphasis on specific activities. Options for referral depend on the level of support required though most models involve a facilitator whose role includes liaising with providers and enabling patients to access the service prescribed by overcoming practical barriers or providing moral support.

Time Banks

Time banks are mutual volunteering schemes; people deposit time spent helping others and withdraw time when they need help. All time is valued equally and transactions are recorded by a time broker. The use of time banks within urban renewal recognised that isolation might be a source of poor health, and problems could be social rather than medical in origin. Over 290 UK time banks provided referral to services in parallel with IAPTs, and the DH worked with Timebanking UK to explore practical aspects of rolling out time banks in GP surgeries (National Endowment for Science, Technology and the Arts: NESTA, 2013). Seyfang and Smith (2002) found that time banks attracted socially excluded groups such as disabled or retired people and compared with traditional volunteers around twice as many time bank volunteers were not in formal employment. Frequent volunteering impacted positively on self-esteem and quality of life through social interaction. Volunteering (under 'Give') was one of the 'Five Ways to Wellbeing' (New Economics Foundation, 2009).

'Local government, the NHS and third sector have vital roles in building confident and connected communities, where all groups, but especially those at highest health risk, can tap into social support and social networks, have a voice in shaping services and are able to play an active part in community life'
Public Health England (2015: 6)



Image © Bromley by Bow Centre

3.2 Case Studies

A selection well known of social prescription programmes are explored below; these have been highlighted to demonstrate a diversity of popular referral models.

Bromley by Bow Centre ‘Social Prescribing’ London

The Bromley by Bow Centre was one of the first healthy living centres to be built in the UK. It was founded in 1984 as a charity with the aim of transforming the local community. The Centre is situated in the East End of London within the Borough of Tower Hamlets which is the seventh most deprived local authority area in England. The Centre focuses on services for vulnerable and disadvantaged people including those with learning and physical disabilities, mental health conditions and low levels of skill as well as those who are elderly, socially isolated, living in poverty or who do not have English as a first language. The Centre’s buildings and courtyards are built around a three-acre community park and designed to promote access, interaction and empowerment. The Centre is keen to encourage interaction and this includes a lack of signage so that visitors need to ask other people for directions. Facilities include a GP surgery, café, children’s centre and nursery, community facilities and a Connection Zone that serves as the hub for a time bank with 400 members. The Centre works closely with a range of local partners including social housing providers, GP practices, children’s centres, schools and faith groups, to co-develop holistic approaches and integrated service models. Many of the services are delivered in local venues as part of the provision. The Centre is accessed by around 8000 people each month who use its facilities and services and who contribute to their development and running. Each year the Centre helps to realise dozens of resident-led community projects that support healthy living initiatives in local neighbourhoods. It has been at the forefront of social enterprise development in London and has created a model which focuses on unlocking talents and skills within deprived communities. In the last decade its social enterprise incubation programme supported the establishment of a network of over 50 businesses that provide goods and services to the community, employ over 300 local people.

Since 1997, the Centre has worked jointly with the Bromley by Bow Health Partnership to create a new and unique delivery model which employs a holistic approach derived from combining primary care with around non-clinical social projects delivered at the same venue. In response to Marmot’s (2010) contention that 70% of health outcomes are attributable to socio-economic factors, the Centre created a programme to bring together primary care provision, public health programmes, social care and non-clinical services to address the wider determinants of health. The Centre is set up with 27% medical intervention and 63% social intervention which form a blended offer. Healthcare practitioners lease consultancy spaces from the Centre. The integration of the health centre led to the creation of an ‘intelligent waiting room’ to engage with patients and connect them to wider services on offer including a social prescription scheme where health professionals (e.g. GPs, psychologists, nurses, counsellors, and phlebotomists) refer patients to the Centre’s non-clinical services (e.g. arts on prescription, crafts including stained glass, stonemasonry and gardening). The Centre employs paid and voluntary staff to facilitate its social prescribing offer including Social Prescribing Navigators at the interface between healthcare practice and non-medical services offered by charities and voluntary sectors. Local artists were amongst the first people to get involved with the Centre, consequently arts on prescription is central to social referral activities and is key to service-user creativity self-esteem. The Centre’s aim is to enable people to remain independent, active and safe, and achieve the things that matter to them most such as accessing work, learning new skills or building self-confidence.

‘I urge you to take your colleagues down to the Bromley by Bow Centre and let them see what has emerged from nothing.

It is one of the most impressive displays of social entrepreneurship anywhere in Europe’

Lord Brian Mawhinney



'Claremont Project Social Prescribing' London

The Claremont Project is a resource centre in the London Borough of Islington that carried out two, one-year social prescribing schemes (2012-14) and is now in its third year. The schemes are funded by 'Islington Giving', a local charity. The Claremont Project aims to facilitate social prescribing to connect older adult residents at risk of isolation with social, physical and therapeutic activities in a community setting. The centre offers a range of activities including keep fit, tai chi, dance, gentle exercise, creative writing and crafts for older adults who participate as members with subsidised fees (£1.50-£2 per class). The objective of social prescribing was to reach a sub-set of isolated people aged 55 years and over, especially those 70 years and over, older men, people who were mobile but not currently engaged in any community services, and people from black and ethnic minorities. Referral criteria also included those experiencing mild to moderate mental health issues (e.g. anxiety and depression) and physical ailments (e.g. balance or co-ordination difficulties). It was envisaged that referral would be by GPs and practice nurses who would issue patients with a 'Claremont Prescription', though many prescriptions are issued by other health professionals (e.g. physiotherapists, occupational therapists or keyworkers) with a minority of self-referrals.

After referral, participants attend an assessment interview at Claremont with the Social Prescription Manager using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant *et al.*, 2007) to assess level of health and wellbeing and suitability to function in a group. A personalised programme and timetable aimed at improving health and psychological well-being is devised from available interventions for an initial three weeks. Participants are asked to sign a consent form to allow their GP or other referrer to be informed of their progress. After six weeks, another interview and WEMWBS assessment is carried out. The initial six weeks of classes are free and if participants wish to continue attending they are invited to sign up as members with subsidised fees or signposted to other services. Further assessment is conducted at three-month follow-up either through interviews with participants still attending classes or by post.

Evidence collected from the WEMWBS assessment over the previous two years indicated that participants showed an increase in psychological well-being, a reduction in isolation and an improvement in physical health. An evaluation of the first scheme by the resident Counselling Psychologist suggested that both real and perceived barriers to access the services on offer were broken down through participation in classes. Participants reported feeling less lonely and isolated, socialised more with others and many, as members, would call in for a hot drink and a chat in the lounge area.

Oxford Museums 'Prescription for Reminiscence', South East England

The Prescription for Reminiscence Project links into museum services across the Oxford Aspire Museums Partnership, a consortium of Oxford University Museums and Oxfordshire County Council Museums Service (and one of 16 Renaissance Major Partner Museum Services funded by ACE to support excellence and resilience within regional museums). Lead partners are the Museum of Oxford and Oxford Aspire; delivery partners are Oxford University Museums Outreach Service, the Ashmolean Museum, Pitt Rivers Museums, Oxford Museum of Natural History, Museum of the History of Science, Oxford Botanic Gardens and 'Hands on Oxfordshire Heritage' (Oxfordshire County Council Museum Service); referral partners are Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Guideposts Trust, Young Dementia UK and Oxfordshire County Council Dementia Advisors.

'Loneliness ends when I walk through the doors at Claremont'
Claremont Member

'This opportunity to share and remember different times in the past is often confidence boosting and fun helping to reduce stress and immediate anxieties'

Senior Occupational Therapist, Oxford Health NHS Foundation Trust



Older adults are referred by local healthcare professionals to the Reminiscence Officer and self-referral is also possible. Referrers are given a referral leaflet about the project that includes information for participants. Potential participants are contacted by the Reminiscence Officer and offered an introduction and access to the Museum of Oxford's 'Memory Lane Group' monthly meetings and other suitable museum services. The social prescribing scheme is linked to the Memory Lane reminiscence group that began in 2010 as an informal monthly meeting at the Museum of Oxford (or nearby museum and heritage locations) to reminisce about a chosen theme and enjoy company in a comfortable environment. Evaluation of projects highlighted that taking part provides participants with great enjoyment and a sense of belonging and making a contribution (e.g. The Morris Motors Centenary Reminiscence Project, 2013, commemorated the start of Morris Car production in Oxford. Participants took part in seven reminiscence events at Morris Motors' related sites. Memories and stories were collected to contribute to a BBC Radio documentary aired on BBC Radio Oxford, Dec 2013).

'The reminiscence sessions are hugely beneficial to older people in that they encourage them to explore and share their memories in a friendly and supportive environment'

**Arts Coordinator,
Oxford University
Hospitals NHS Trust**

'Arts on Prescription' Arts and Minds, Cambridgeshire and Peterborough

Arts and Minds is an arts and mental health charity, established in 2007 and based in Cambridgeshire. The charity is linked to Cambridgeshire and Peterborough Foundation NHS Trust and the former Cambridgeshire PCT. Arts and Minds delivers programmes for people with mental health issues and/or learning difficulties. It offers a 12-week programme of two-hour art workshops for people experiencing mild to moderate depression and anxiety as an alternative to CBT. GPs, health promotion workers, occupational therapists, social workers, psychologists and counsellors can refer clients directly to Arts on Prescription using a referral form. Led by a professional artist and supported by a counsellor, each session offers the chance to work in various media (e.g. drawing, collage, clay and wirework) with the objective of decreasing anxiety and/or depression, while increasing wellbeing. The programme also includes facilitated group visits to museums and galleries. Arts on Prescription sessions provide a safe and therapeutic environment where participants feel mutually respected and can explore their creativity with like-minded individuals. On completing the programme, participants are signposted to other opportunities and invited to Arts and Minds events.

'I was really glad to get a place in a group. At the time, I was barely leaving the house. The only thing that made me feel slightly happy was doing crafty things. I couldn't find any pleasure in anything else'
Participant (2014)

The most recent programme, Phase 3 (2014-15) was delivered in locations across Cambridgeshire (Cambridge, Cambourne, Huntingdon, March, Wisbech) to 66 adults with mild to moderate anxiety and/or depression. The evaluation of this programme (Potter, 2015) used a mixed methods design with valid and reliable psychological measures. The study examined whether participants experienced change in self-reported levels of anxiety, depression, social inclusion and wellbeing across the programme. Scales included GAD-7, PHQ-9, WEMWBS and Social Inclusion (SI). Participants were asked to complete the scales before and after the 12-week programme. Semi-structured interviews were conducted with a sample of participants before and after 12 weeks to explore their experiences. Positive outcomes were reported for 91% of participants, a greater number than in Phases 1 or 2, either through increase in mental wellbeing (76%) or social inclusion (69%), and/or decrease in anxiety (71%) or depression (73%). Participants rated their Arts on Prescription experiences highly, reporting they enjoyed the programme and would recommend it to a friend (95.5%); developed artistic skills (78%); increased in confidence (64.4%); increased in motivation (71%); and felt more positive about themselves (69%).

'We're going to try and meet up here as a group, just to kind of socialise to begin with and then see where that takes us. It would be a real shame to lose touch with everybody because we've almost become like a family now'
Participant (2015)

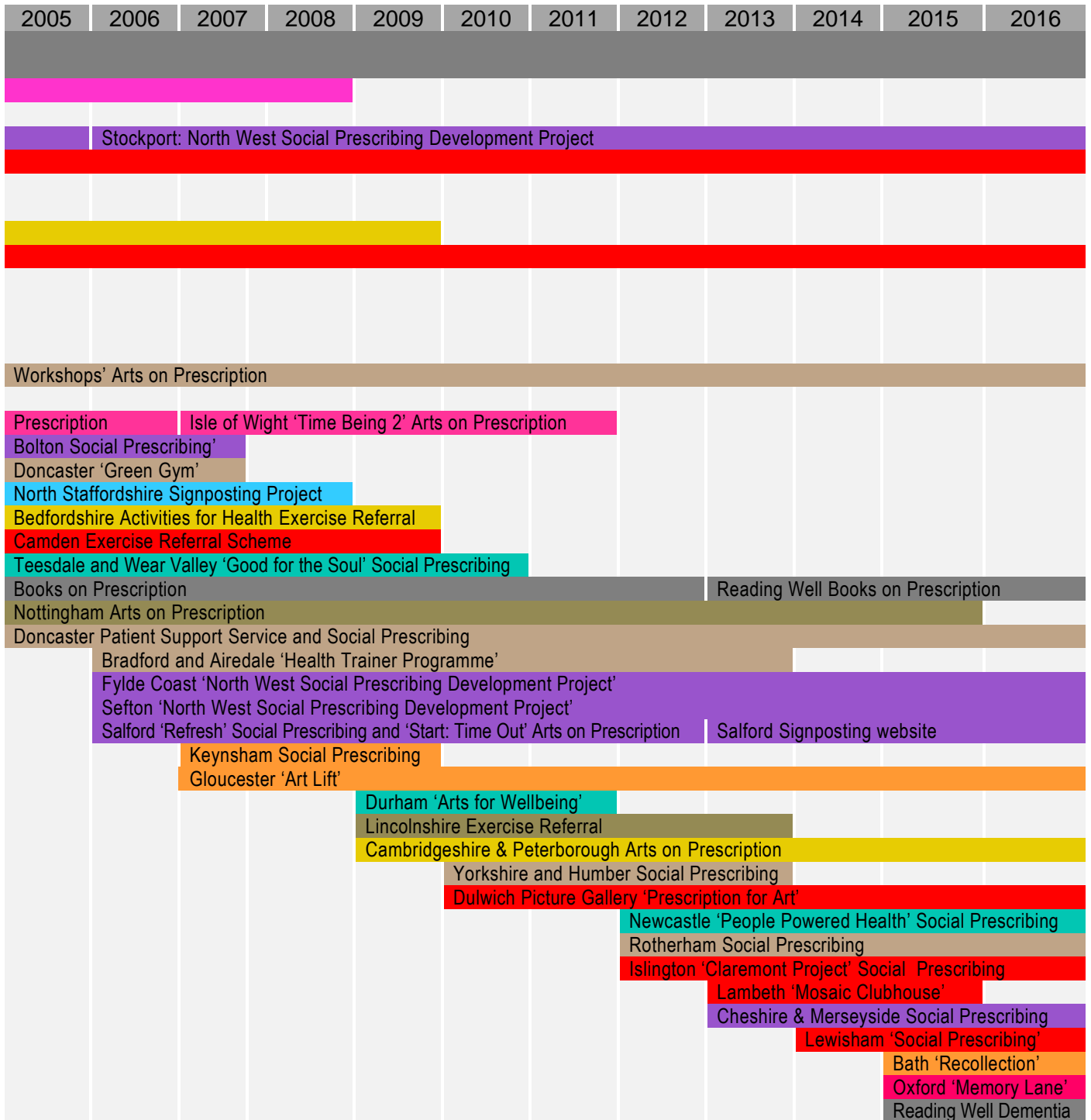


3.3 Timeline of social prescribing

Although national schemes have been running since their inception in the 1990s, others have been set up and carried out over several years, then ended due mainly to funding cuts or policy changes (Table 1).

Table 1. Social prescribing timeline

1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	
Volunteering												
Exercise on Prescription												
	Eastern and Coastal Kent Exercise Referral Scheme											
	Avon 'The Amalthea Project' Supported Referral											
	Stockport Metropolitan Borough Council Arts on Prescription											
	Hackney 'Well Family Service' Supported Referral											
				Manchester Referral Facilitation Service								
						Sonning Common Green Gym						
						Cambridge 'Start-Up' and 'Invigorate' Exercise Referral						
						Lewisham 'Rushey Green Time Bank'						
						Penge & Anerley Park Practice Supported Referral						
								Portslade 'Green Gym'				
								Nottingham Prescription for Learning				
								Swindon Supported Referral				
								North and South Tyneside 'Taking Part				
									East London Arts on Prescription			
									Isle of Wight 'Time Being' Arts on			
Key to colour coding												
National	London	South East	South West	Eastern	East Midlands	West Midlands	Yorkshire and the Humber	North East	North West			



4



4 Evidence base

4.1 Evaluated UK schemes

This review has drawn a distinction between evaluation and research which are related but different activities. Evaluation generally assesses the effectiveness of a particular programme or intervention, whereas research seeks to develop new knowledge and contribute to a theoretical understanding. Thirty-five of the UK social prescribing schemes reviewed have been researched and evaluated by 42 groups of authors at the time of the programme or subsequently by carrying out meta-analyses (see summary, Table 2). Evidence has been obtained using quantitative methods (e.g. reliable and valid scales of measurement), qualitative methods (e.g. questionnaires, surveys, interviews and focus group) or mixed methods approaches (combining quantitative and qualitative methodologies).

4.2 Key findings

Ten key findings have emerged from the summarised evidence:

- ▶ Increases in self-esteem and confidence, sense of control and empowerment
- ▶ Improvements in psychological or mental wellbeing, and positive mood
- ▶ Reduction in symptoms of anxiety and/or depression, and negative mood
- ▶ Improvements in physical health and a healthier lifestyle
- ▶ Reduction in number of visits to a GP, referring health professional, and primary or secondary care services
- ▶ GPs provided with a range of options to complement medical care using a more holistic approach
- ▶ Increases in sociability, communication skills and making social connections
- ▶ Reduction in social isolation and loneliness, support for hard-to-reach people
- ▶ Improvements in motivation and meaning in life, provided hope and optimism about the future
- ▶ Acquisition of learning, new interests and skills including artistic skills

In addition to those that have included evaluation, all of the social prescribing schemes included in this review have been summarised and tabulated according to UK electoral regions (Section 8: Appendices I - XII). Twelve further examples of social prescribing and community referral schemes from non-UK literature have been selected as illustrations of different strategies and methodologies used to assess the effectiveness of social prescribing schemes (Appendix XIII). Compared with the UK, so-called local non-UK schemes have considered much larger geographic areas with participants from much more scattered and isolated populations. In terms of evaluation, non-UK evaluation appeared to have placed a greater emphasis on the inter-relationship between mental and physical health with several interventions being appropriate for people with both types of ill health and taking the view that benefits to physical health and appearance can only bring about benefits to mental health. The majority of RCTs with waiting list controls in the UK have been for exercise referral whereas non-UK social prescribing schemes have carried out RCTs for a wider range of cultural activities.



Table 2. Summary of researched and evaluated UK schemes

UK region	Scheme	Authors	Summary of findings
London	Camden 'Exercise Referral Scheme'	Stathi, Milton & Riddoch (2006)	<ul style="list-style-type: none"> Participant positive feedback with self-reported improvement in mental health, positive mood, confidence and self-esteem.
		The Mental Health Foundation (2009)	<ul style="list-style-type: none"> Pre- and post-intervention analysis of health (SF-12) and exercise level (IPAQ). Improved confidence, recognition of being unwell and feeling in good physical health.
	Dulwich Picture Gallery 'Prescription for Art'	Harper & Hamblin (2010) Oxford Institute of Ageing	<ul style="list-style-type: none"> Review of 'Good Times' (from which 'Prescription for Art' emerged) recognised that older people with mental or physical disability should be able to tackle similar creative challenges as other adult groups.
	East London 'Arts on Prescription'	Griffiths (2002)	<ul style="list-style-type: none"> Qualitative study of views and experiences of young African and Caribbean men; showed importance of arts and creative expression as protective factors in the face of racism and discrimination.
	Hackney 'Well Family Service' supported referral	Goodhart & Graffy (2000)	<ul style="list-style-type: none"> Focus on family provided an opportunity to support hard-to-reach people in a sympathetic and accessible environment, contributing to a family-centred approach.
	Islington 'Claremont Project Social Prescribing'	Claremont Social Prescription Manager & Counselling Psychologist	<ul style="list-style-type: none"> Pre-post assessment of exercise and creative activities for older adults using WEMWBS at two, 3-week intervals. Real and perceived barriers broken down through classes, participants felt less lonely and isolated, and socialised more.
	Penge and Anerley Park Practice supported referral pilot	Sykes (2002)	<ul style="list-style-type: none"> Signposting to services; complemented primary care and bridged gap between primary care and voluntary sector. Participant outcomes included increased self-esteem, reduced isolation and resolution of practical issues.
	Lewisham 'Rushey Green Time Bank'	Boyle, Clark & Burns (2006)	<ul style="list-style-type: none"> Aimed to build core economy of family and community by valuing and rewarding work. Involvement in time banks associated with reduced level of medication /hospitalisation.



South East	Canterbury, Beane House of Art & Knowledge 'Paper Apothecary' museums on prescription	'Happiness Investigators' and 'Chemists' (2013)	<ul style="list-style-type: none"> • 'Happiness Investigators explored collections to answer 'What makes you happy at the Beane?' 300 participants responded to: 'How did you feel after the cultural treatment? 37% felt happy, 15% very happy, 14% had fun, 12% were inspired and 10% felt peaceful. • In-depth questionnaire with 40 participants showed that responses aligned with NEF's 'Five Ways to Wellbeing'.
	Eastern and Coastal Kent 'Exercise Referral Scheme'	Milton (2008)	<ul style="list-style-type: none"> • Over 6,500 patients referred in 3 years; showed physical benefits though some participants thought they were prescribed inappropriate programmes, were unable to perform the exercises or felt demotivated at not achieving their fitness aims.
	Isle of Wight 'Time Being' arts on prescription scheme	Eades & Ager (2008) Secker, Spandler, Hacking, Kent & Shenton (2007)	<ul style="list-style-type: none"> • Interviews, questionnaires and focus groups found positive benefits for people with mental health issues through empowerment and increasing social inclusion. • Review of 53 pre-post intervention questionnaires from participants with mild to moderate mental health issues showed Improvements in self-esteem, renewed motivation, social contact, decreased anxiety and interest in further arts activity.
South West	Avon 'The Amalthea Project' supported referral	Grant, Goodenough, Harvey & Hine (2000)	<ul style="list-style-type: none"> • RCT primary outcomes: psychological wellbeing (HADS) and social support (Duke-UNC Functional Social Support Questionnaire); secondary outcomes: quality of life (Dartmouth COOP/WONCA Functional Health Assessment, Delighted-Terrible Faces); economic evaluation of contact costs with primary care. • Found reductions in anxiety and negative emotion, patients were more positive about general health and quality of life.
	Gloucester 'Art Lift' arts on prescription	Crone, O'Connell, James, Tyson & Clark-Stone (2011)	<ul style="list-style-type: none"> • Nearly 50% participants completed 10 weekly sessions giving better rate than for exercise referral. Pre-post quantitative analysis showed significant improvement in wellbeing of those who completed. • Artists identified benefits and thought that the project gave them more credence with health professionals.



South West	Keynsham 'Social Prescribing' pilot	Brandling & House (2007)	<ul style="list-style-type: none"> • Semi-structured interviews with 8 practice staff, 11 patients, and 2 community members explored acceptability of scheme. • Patient insight limited; patients saw GP as person most likely to address needs despite being embedded in medical model.
	South Gloucestershire 'Exercise on Prescription'	Flannery, Loughren, Baker & Crone (2014)	<ul style="list-style-type: none"> • Self-reported pre-post measures found increase in 30 minute weekly exercise sessions with decrease in systolic blood pressure and waist measurement. • Interviews with 14 patients and 10 practice nurses identified weight loss, and increased self-perceptions and social interaction.
	Swindon 'Supported Referral'	Howells (2001)	<ul style="list-style-type: none"> • Included assisted access, information referral supported referral, self-help literature and coping skills. • GHQ over 12 months showed reduction in GP consultation and referral to secondary care, and increase in patient satisfaction.
Eastern	Bedfordshire 'Activities for Health' exercise referral	The Mental Health Foundation (2009)	<ul style="list-style-type: none"> • Referral from GPs for patients with anxiety and depression as part of the National Primary Care Mental Health Collaborative. • HADS evaluation and fitness tests identified physical health needs among mental health patients.
	Cambridge 'Start-Up' and 'Invigorate' exercise referral	The Mental Health Foundation (2009)	<ul style="list-style-type: none"> • Referral for arthritis, back pain, obesity, diabetes and mental health. 60% patients completed 12-week exercise programme. • Reasons given for non-completion included lack of time, not enjoying and/or limited choice of activities.
	Cambridgeshire and Peterborough 'Arts on Prescription'	Potter (2013, 2015) McDaid & Park (2013)	<ul style="list-style-type: none"> • Waiting list RCT, 12 weekly sessions, pre-post measures: anxiety (GAD-7); depression (PHQ-9); mental wellbeing (WEMWBS); social isolation (SI), and analysis of semi-structured interviews. • Positive outcomes for 78% of patients: increase in mental wellbeing (83%); decrease in social isolation (44%), anxiety (61%) or depression (67%). • Independent cost analysis of IAPT or IAPT plus arts intervention showed scope to be cost effective in reducing risk of persistent moderate or severe depression for 30% of participants.



East Midlands	Lincolnshire 'Exercise Referral Programme'	Henderson and Mullineaux (2013, unpublished)	<ul style="list-style-type: none"> Evaluated completion rates (62%) for 6600 participants showed significant relationship between participants who completed programme and reduction in BMI; those aged 70-79 were three times more likely to complete.
	Nottingham 'Arts on Prescription'	Stickley & Hui (2012a)	<ul style="list-style-type: none"> In-depth interviews with 16 mental health patients using narrative enquiry showed that scheme provided a creative and therapeutic environment with social, psychological and occupational benefits, participants were able to determine a new future.
		Stickley & Hui (2012b)	<ul style="list-style-type: none"> Semi-structured interviews with 10 out of 148 health professional referrers over 4 years. Scheme gave GPs greater range of options for patients' complex social problems but concerns about whether resources would be maintained in future.
		Stickley & Eades (2013)	<ul style="list-style-type: none"> Follow-up one-to-one interviews with 10 mental health service-users previously interviewed still involved with scheme. Two-year involvement led to increased self-confidence, motivation and aspiration and improved communication skills.
Nottingham 'Prescription for Learning'	Aylward & James (2002)	<ul style="list-style-type: none"> Assessed impact on 196 patients with anxiety, low self-esteem and chronic pain, found enhanced confidence and self-esteem, lifted mood, improved sleep, increased activity and healthier behaviour, widened social networks and gave sense of control. 	
West Midlands	North Staffordshire 'Signposting Project'	Blastock, Brannelly, Davis & Howes (2005)	<ul style="list-style-type: none"> Made recommendations of local services for patients experiencing mental distress. Analysis of 12 service-users from wellbeing postal or phone questionnaires; and phone interviews with practice staff indicated offer was valued but it increased staff workload.
Yorkshire and the Humber	Bradford 'CHAT' social prescribing scheme pilot	Woodall & South (2005)	<ul style="list-style-type: none"> 18 semi-structured interviews over 10 weeks examined scheme from perspectives of 10 patients with non-clinical needs and 8 health professionals. 82% patients visited health care professional less in 6 months after scheme than in 6 months before it; staff saw intervention as access to expert knowledge and as part of holistic practice.



Yorkshire and the Humber	Doncaster 'Patient Support Service' and 'Social Prescribing' pilot	Faulkner (2004)	<ul style="list-style-type: none"> • Case study design used semi-structured interviews with 11 patients and 9 staff. GP selected patients with additional problems to those treated medically and provided prescription for referral; voluntary sector employed advisors to link patients to community support groups.
	Rotherham 'Social Prescribing' pilot	Dayson, Bashir & Pearson (2013) CRESR Sheffield Hallam University	<ul style="list-style-type: none"> • Examined social outcomes and hospital episodes with 'outcomes star' style tool developed for scheme with 8 measures, on referral and after six months. Of those referred 87% were adults over 60. • Found that patients had around half the number of outpatient appointments, Accident & Emergency attendances and hospital admissions in 6 months after scheme than in 6 months before.
	Yorkshire and Humber 'Social Prescribing' pilot	AgeUK (2011)	<ul style="list-style-type: none"> • Assessment of older adult social, emotional and practical support needs led to 62 referrals to AgeUK services and 34 referrals to other organisations. • Small number of older people completed WEMWBS before (mean 24.5 out of 70) and after scheme (mean 36 out of 70) indicating that wellbeing improved though no statistical analysis carried out.
North East	Durham 'Arts for Wellbeing'	White & Salamon (2010)	<ul style="list-style-type: none"> • Primary prevention service not therapy, aim to increase service-user confidence, resilience and self-esteem. • Interim evaluation of 18-month pilot: analysis of WEMWS (14-item and later 7-item) participant comments, focus group narratives and interviews with facilitators and carers.
	Newcastle 'People Powered Health' social prescribing programme	ERS Research & Consultancy and Beacon North Ltd (2013)	<ul style="list-style-type: none"> • Evaluation of project governance and allocation of budgetary resources. • Did not report service-user outcomes as unable to access patient-level data including SWEMWBS scores and confidence ratings used by link workers.



North West

Manchester
'Referral
Facilitation
Service'

Clarke, Sarre,
Gledinning &
Datta (2001)

- Evaluation of referral facilitation service in primary care employing coordinators to provide generic advice, support and counselling for individuals and families.
- Over 1200 referrals in 2.5 years showed reasons for uptake: emotional and minor mental health and material problems such as welfare and housing. Service anonymous therefore less stigmatising than social services.

Salford
'Refresh' social
prescribing

Brandling &
House (2007)

- Aimed to tackle health concerns through community activities as complement to medical care.
- Evaluation of initial scheme found 66% of patients had fewer GP visits with 34% reduced by 3 or more, and 46% reduced medical prescription.

Sefton 'North
West Social
Prescribing
Development
Project'

Lovell &
Bockler
(2007)

- Adults with mild to moderate mental health issues offered creative activities instead or as well as medication. Evaluation at start, 3 x 2 month intervals, and 2 x 3 month follow-ups for anxiety and depression (HADS) and life skills (CO-OP).
- Analysis not reported as insufficient data; diary entries of facilitator commenting on individual progress showed confidence and self-esteem.

Stockport
'North West
Social
Prescribing
Development
Project'

Huxley (1997)

Department
for Culture,
Media & Sport
(1999)

- GHQ-28 before and after the initial 15 week scheme with 33 participants found reduction in mental health issues.
- Continued use of GHQ-28 showed moderate impact on self-esteem and social functioning with statistically significant involvement in participatory activities and evidence of reduced use of GPs, social workers and other services.
- Case study of referral to arts activities by health and social services. Participants used less in-patient and other hospital services, and showed reduced risk of relapse.

North West	Stockport 'North West Social Prescribing Development Project'	Secker, Spandler, Hacking, Kent & Shenton (2007)	<ul style="list-style-type: none"> • Review of patients (24 for social functioning, 17 for depression and 10 for postnatal depression) and responses to two open-ended questions. • Significant improvement in depression but not social functioning; responses were positive and identified mental health, self-esteem and social contact improvements, decreased anxiety, renewed motivation and interest in further arts activities.
Wales	'National Exercise Referral Scheme'	Murphy <i>et al.</i> (2010)	<ul style="list-style-type: none"> • RCT to compare self-reported physical activity, depression and anxiety at 12 months compared with usual GP care. • All participants had higher levels of physical activity than controls; difference significant for coronary heart disease risk referral, with positive effects on anxiety and depression. Cost effectiveness evaluation demonstrated cost per quality adjusted life years (QALY) of £12,111.
Scotland	Dundee 'Healthy Living Initiative'	Dundee Healthy Living Initiative (2014)	<ul style="list-style-type: none"> • Used principle of social model of health where people identified own health needs and solutions. 1400 people questioned about what affected their health, health of communities and what could be done to improve health and wellbeing (1998-99). • Key issues were: social isolation; poor mental wellbeing; high incidence of smoking; lack of exercise; eating healthily on low income; lack of local health advice; and life circumstances.
Northern Ireland	'Ecotherapy'	Seifert, McCarton, McCann & McLaughlin (2011)	<ul style="list-style-type: none"> • Tested effectiveness of eco-therapy for alcohol related issues. • Thematic analysis of semi-structured interviews with staff from 11 projects found outcomes of developing new skills, communication, confidence building, leadership and working with others.

4.3 Summary of evaluation methods

Out of 86 published UK social prescribing schemes, 35 (40.7%) have been evaluated and 12 of these employed quantitative methods using one or more validated and reliable indicator scales (Table 4) to assess a variety of individual and/or population, and mental and/or physical health outcomes with three of these using RCTs and one scheme comparing physiological measures. The other 23 schemes employed qualitative analysis of questionnaires, interviews, surveys and focus groups.



Table 3. Quantitative evaluation of social prescribing schemes

Outcome	Indicator scale	Authors	Frequency of use
Anxiety	General Anxiety Disorder 7-items (GAD-7)	Spitzer, Kroenke, Williams & Lowe (2006)	2
Cost	Cost per Quality Adjusted Life Years (QALY)	Phillips (2009)	1
Depression	Patient Health Questionnaire 9-items (PHQ-9)	Spitzer, Williams & Kroenke (2001)	2
Exercise level	International Physical Activity Questionnaire (IPAQ)	Craig, Marshall, Sjöström, Bauman, Booth, Ainsworth, <i>et al.</i> (2003)	1
Functional status (health and wellbeing)	Short Form Health Survey 12-items (SF-12)	Ware, Kosinski & Keller (1996)	1
	Dartmouth CO-OP charts (CO-OP)	Nelson, Wasson, Kirk, Keller, Clark, Dietrich, <i>et al.</i> (1987)	1
	International version CO-OP / WONCA (World Organization of National Colleges, Academies, and Academic Associations of General Practices / Family Physicians) Charts	Nelson, Wasson, Kirk, Keller, Clark, Dietrich, <i>et al.</i> (1987)	1
Mental health	General Health Questionnaire 28-items (GHQ-28)	Sterling (2011)	1
Mental wellbeing	Warwick-Edinburgh Mental Wellbeing Scale 14-items (WEMWBS)	Tennant, Hiller, Fishwick, Platt, Joseph, Weich, <i>et al.</i> (2007)	4
	Short Warwick-Edinburgh Mental Wellbeing Scale 7-items (SWEMWBS)	Stewart-Brown, Platt, Tennant, Maheswaran, Parkinson, Weich, <i>et al.</i> (2011)	1
Psychological wellbeing	Hospital Anxiety and Depression Scale (HADS)	Zigmond & Snaith (1983)	4
Quality of life	Delighted-Terrible Faces Scale (DTFS)	Andrews & Withey (1976)	1
Social isolation	Social Isolation 19-items (SI)	Hughes, Waite, Hawkey & Cacioppo (2004)	2
Social support	Duke-UNC Functional Social Support Questionnaire	Broadhead, Gehlbach, Van de Gruy & Kaplan (1988)	1



5

5 Pathways to implementation

5.1 Ways in which social prescribing schemes have been set up

The first social prescribing schemes, which were generally exercise or self-help book based, involved GP referral (Figure 1), a process in keeping with the medical model of healthcare and in place since the inception of the NHS in the 1940s, with the objective of constraining costs (Clark, 2011). Referral was limited as many GPs were unaware of the options available among voluntary and community sectors in their area, furthermore, they did not have the time to keep abreast of these. Referral was widened to other health professionals within primary care such as practice nurses or physiotherapists to reduce the burden on GPs and because they might have more time to find a suitable session for a particular patient (Figure 2).

Social prescribing schemes available within specific regions have increased in variety to incorporate other ongoing practices (e.g. arts in health; and existing adult education) and became more organised providing online and printed directories available to primary care practices. Referrer boundaries were widened further to include other health professionals such as pharmacists and health and social care workers, particularly those with access to people in their homes.

Figure 1. Social prescribing by GP

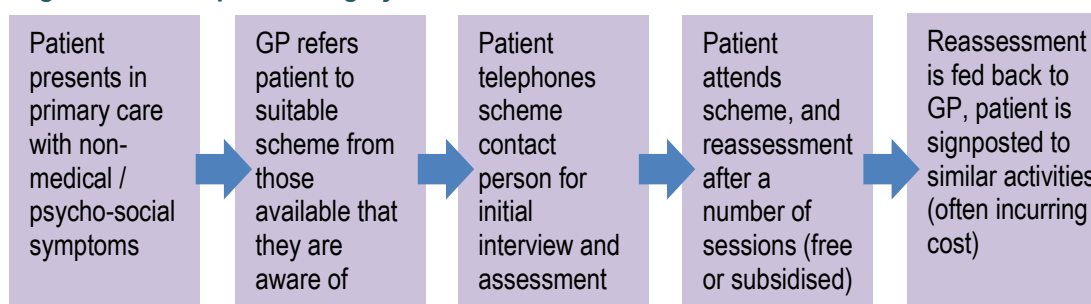
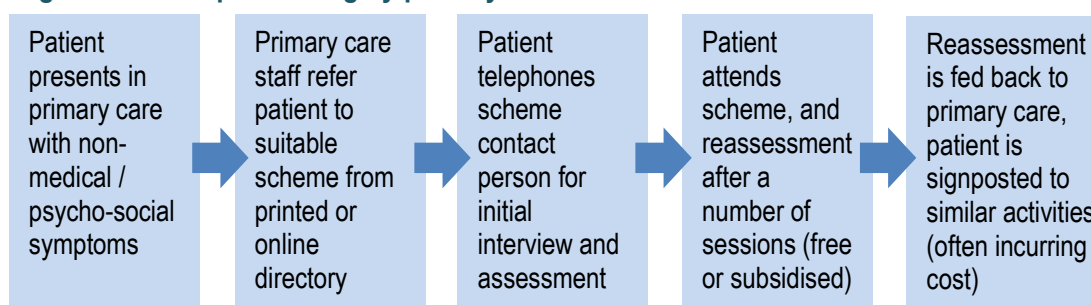


Figure 2. Social prescribing by primary care staff



In the last ten years, the responsibility of social referral has tended to move from the GP to a link worker (also known as a referral agent, social facilitator or navigator) either based within primary care, or sited in the community and employed by a charity or voluntary agency. For primary care referrers, the link worker acts as a 'one stop shop' in that a patient with psycho-social issues, possibly in addition to physical or mental health issues, is referred to a consultation with a referral agent who can recommend a suitable scheme (Figure 3). Some agencies running social prescribing schemes have their own consultants to whom the referral agent refers the patient for an interview; this is particularly prevalent in exercise referral and schemes that require fitness checks, such as green gyms, where patients receive health

Social prescription tips for practice guidance:

- *Embed link workers in GP practices*
- *Invite GPs to local community centres to spend time with link workers and talk to service-users who have benefited*
- *Provide evidence to GPs about effectiveness of social prescribing*
- *Emphasise advantages for GPs in reducing patient consultation by putting patients in control of their own healthier lifestyles*
- *Make links and encourage partnerships between services to improve communication*

NESTA (2013: 13)



'To understand the factors that contribute to effective initiatives, provide insight into the nature of change and highlight potential improvements'
Salamon (2008)

screening to ensure they are fit to participate. Although at the inception of social prescribing, exercise referral was generally reserved for patients with physical health issues (e.g. obesity and Type 2 Diabetes), and self-help reading for those with mental health issues (e.g. mild to moderate anxiety and depression), recent research has shown that prescribed physical interventions (e.g. exercise and walks) are of benefit for mental health conditions and dementia, providing a positive experience to combat negative symptoms and side effects of medication, opportunities for social support and a means of boosting confidence and self-esteem. It is surprising that book referral does not generally occur for physical health conditions where patients might benefit from an increased understanding of their medical condition and treatment options available. Furthermore, some referral schemes (e.g. self-help books and online CBT books, art and exercise) have been incorporated into Step 1 of IAPT stepped recovery, after IAPT referral by GPs for patients with mental health conditions as an alternative to drug treatments, and have been used in conjunction with therapies such as psychological counselling, or while waiting to receive it (up to 6 months). Additionally, schemes have been incorporated into Step 2 as an adjunct to therapy (Figure 4).

Figure 3. Social prescribing through link worker

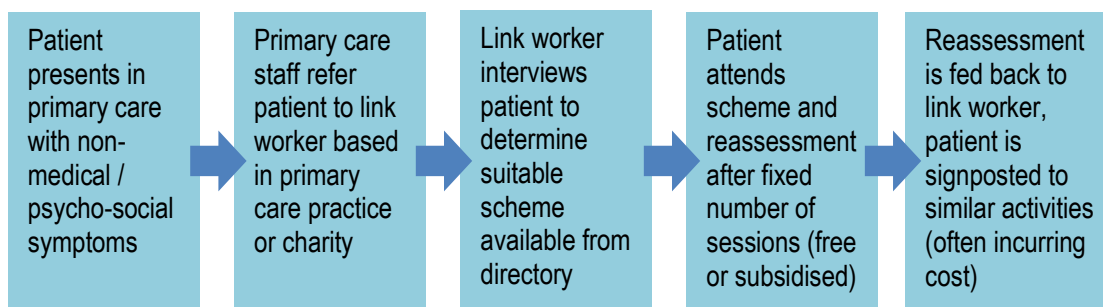
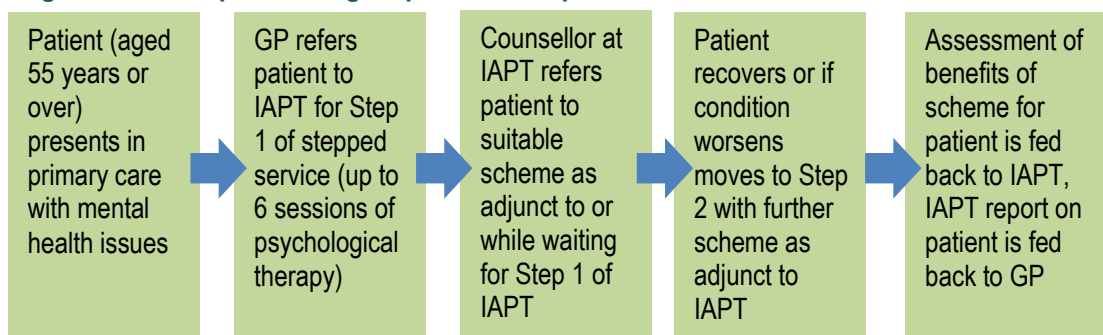


Figure 4. Social prescribing as part of IAPT provision



5.2 Scaling up pilot studies

Several of the reviewed social prescribing programmes carried out evaluation of pilot studies which operated for a limited amount of time, often with positive outcomes but then have ceased to continue due to lack of further funding, or have diminished to a web- or leaflet-based signposting service. One of the barriers for community-based services and social prescribing in particular is that the future of pilot schemes is not secure because they are funded by grants rather than commissioned. The temporary nature of schemes also means that commissioners, clinicians and service-users are not able to shape the services provided.

'Patient Support Service 'acted as a linchpin between the professional role of medicine and the voluntary world of psychosocial support'
Faulkner (2004: 46)



In addition to grant-funding, NESTA (2013: 24) advocated two other funding pathways:

- ▶ Directly commissioned from service providers, possibly in conjunction with local authorities
- ▶ Directly funded by patients given personal budgets to buy services to help them manage their long-term conditions

Public Health England (2015), in its guide to community-centred approaches for health and wellbeing, endorsed the notion that since most services for NHS patients are commissioned by CCGs, it is essential for social prescribing schemes to be regarded as part of the NHS commissioning process in order for their future to be secured. Dayson *et al.* (2013) found that the benefits of social prescribing to CCGs, GP practices and the wider NHS included offering a gateway to refer patients with long term conditions to community-based services to complement traditional medical interventions, reducing the demand on more costly hospitalization and other specialist services; broadening and diversifying provision for patients with complex needs; and offering an alternative and holistic approach.

5.3 Choice of referral options and pathways to implementation

Due to lack of knowledge of resources, their availability and the lack of time spent with individual patients, research has shown that it can be difficult for primary care teams to facilitate access to available resources appropriately (e.g. Graham, 1995; Scoggins, 1998; Sykes, 2002; Wilson & Read, 2001). NESTA (2013) considered that social prescribing could take a formal pathway with direct referral from a clinician or the clinician could refer patients to a link worker for support. Brandling and House (2009) favoured the use of a link worker or referral agent acting as a bridge between primary care professionals and the array of social opportunities, boosted by personal support (e.g. a volunteer befriender) for a patient taking up any of the options (Grayer, Cape, Orpwood, Liebowitz & Buszewicz, 2008).

In providing GPs with a one-stop shop, prescribing schemes that employ a link worker with knowledge of local organisations, can improve patient access to community and voluntary sector resources (Goodhart *et al.*, 1999; Grant *et al.*, 2000; Sykes, 2002). In an RCT of a facilitated scheme in Bristol, Grant *et al.* (2000) found patients referred through a referral agent improved mental health outcomes. Similarly, Sykes carried out a qualitative evaluation of social prescribing in Penge and Anerley which used a referral agent, where patients reported reduced social isolation and increased confidence and self-esteem.

'Yet it is only by bringing them together that we can hope to make the best use of the resources available and improve the wellbeing of the nation'
CentreForum (2014: 7)

6



‘Show the effectiveness of different approaches’ and ‘offer a more robust source of evidence’

NHS Confederation (2014: 3)

‘GPs and practice staff may not be ideally placed to refer to community resources due to the additional time needed to consult with patients and to keep abreast of the diversity services and providers’

Thomson, Camic & Chatterjee (2015)

6 Recommendations

6.1 Best practice guidance for sector workers

Many patients in primary care present with issues which are psychosocial and do not appear to be medical or physical in origin (Gulbrandensen, Hjortdahl & Fugelli, 1997). While some are helped by referral to mental health practitioners, others might benefit from social interventions offered through local community and voluntary sectors, either instead of or as an adjunct to IAPT or other psychological services. This review indicates, however, that GPs and practice staff may not be ideally placed to make referrals to community resources due to the additional time needed to consult with patients and taken to keep abreast of the diversity of services and providers.

Mental health professionals, such as clinical psychologists, family therapists, link workers and nurses who work with a range of adults and young people, are ideally positioned to consider social prescribing as an a supplement to traditional interventions. Careful assessment of a person’s care needs and potential risk factors need to be an essential prelude to referral, although in some cases, socially-oriented engagement in a non-stigmatising environment as offered by social prescribing may be particularly welcomed.

Health care practices and other agencies set up with a link worker in post are often a preferable option for primary care staff, and offer a ‘one stop shop’ where link workers can spend time with patients to identify suitable schemes using local knowledge and access to directories. In addition to the involvement of link workers, other health and social care workers, especially those who go into people’s homes, might be well placed to advocate schemes to older adults or mental health service-users who would otherwise be socially isolated.

Professionals who are not from health or social care backgrounds and have access to people’s homes, such as the fire service safety advisors, faith and charity organisations, and meals on wheels schemes may also be ideally positioned to make social referrals directly to or via a link worker. A caveat here though is that if social prescribing is devolved to other, non-health or social care professionals, with access to potentially vulnerable adults, or the self-referral pathway is encouraged, then there needs to be a line of communication set up where the referrer actively involves health care services should a health condition worsen or require specialist care.

6.2 Frameworks for setting up social prescribing schemes

In the UK, social prescribing is typified by a shift towards services sensitive to individual needs that offer increased control over personal health choices. The Health and Social Care Act (DH, 2012), which introduced major reforms to UK health and social care delivery, advocated preventive, multi-agency approaches prompted by pressures on health care services from an aging population with increases in age- and lifestyle-related diseases, and evidence for a social gradient (Marmot, 2010).

The NHS ‘Five Year Forward View’ took a strong focus upon preventative treatments in public health, stating ‘That’s why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing’ (NHS, 2014: 10). Whilst most local authorities have responsibility for a range of broad-based public health programmes, the NHS has a distinct role in secondary prevention. This review demonstrates that social prescribing is able to encompass new approaches to secondary prevention by which people become engaged with responsibility for their own health and wellbeing, and pursue a healthier lifestyle.



To reduce future health costs a stronger focus on collaborative commissioning of services and interventions is needed which will involve the strategic promotion of mental wellbeing, mental capital, creativity and resilience as outcomes. It is important to make connections with a far wider range of stakeholders than previous traditional health models have encompassed, and where partners might include community services, such as business, culture, education and leisure sectors, in addition to local third sector and voluntary agencies.

It is also vital to look for other sources of provision within the community to provide non-medical interventions which have the possibility of being linked to IAPT Steps 1 and 2 and a range of other mainstream health intervention programmes. Through identifying local provision, community resources can be expanded and developed to address many social, health and wellbeing issues. Museums and galleries, for example, as community resources are well-placed to promote health and wellbeing activities in non-traditional audiences (Camic & Chatterjee, 2013) as are other cultural, arts, environmental, exercise and socially-oriented programmes.

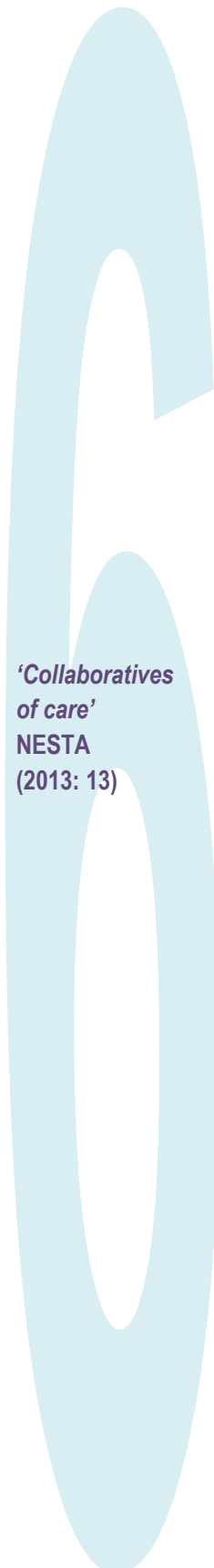
6.3 Methods for evaluating social prescribing schemes

Whenever possible, it is advantageous to set up social prescribing schemes with methods of evaluation in place to compare measures at baseline with progress or stability over time. Additionally, it is vital to capture the lived experience of participants during and after the end of the programme. As budgetary and staff constraints can limit the thoroughness of any evaluation, these factors need to be taken into consideration at the early stages of programme development. The extent of any evaluation depends on the importance of evidencing outcomes, expectations of the funders and available resources.

The NHS Confederation (2014: 3) advocated that service providers should monitor outcomes from interventions, and consider using externally sourced evaluations and different approaches to offer 'a more robust source of evidence'. They also proposed using social return on investment (SROI) to measure social impact. As this review demonstrates, it is not possible to take a 'one size fits all' approach to evaluation consequently it is essential to discuss the expectations of any evaluation with those who have commissioned the social prescribing programmes. Deciding upon suitable outcome measures will vary depending on the reasons for referral, type of social prescription and the needs of participants.

For research purposes, the most robust approach is considered to be a randomised controlled trial (RCT) where intervention and control groups are compared, usually over time in a longitudinal study. RCTs tend to be expensive and time-consuming, so may not always be feasible. There are other well-respected methodological approaches that should be considered as alternatives to RCTs and these include pre-post studies where participants provide their own baseline measure taken before an intervention that is compared with the same measure taken after the intervention.

Outcomes currently measured and assessed include subjective wellbeing, quality of life, behaviour changes, physiological changes, and health service uptake and medication usage. Whereas quantitative research measures pre-post differences using validated and reliable scales (see Section 4), qualitative research delves deeper into the nature of change, and begins to suggest mechanisms by which any effects are mediated. Rather than use a single method to assess outcomes, it is preferable to gather converging evidence using mixed methods



'Collaboratives of care'
NESTA
(2013: 13)



(a mix of quantitative and qualitative approaches) for data evaluation.

An exemplary health and wellbeing programme that used mixed methods was Well London Phase 1 (2007-11) which combined a cluster RCT with a qualitative approach (Phillips, Bottomley, Schmidt, Tobi, Lais, Yu, *et al.*, 2014). Funded by the Big Lottery Fund, Well London was hosted by the Greater London Authority, led by the London Health Commission and delivered by the Well London Alliance. The programme compared populations from 20 geographic target sites with 20 matched control sites from London's poorest areas (census-defined 'lower super output areas'). Fourteen projects, focused on physical activity, healthy eating, mental wellbeing, local environments, and arts and culture, aimed to build community capacity and cohesion.

Approximately 100 randomly selected adults were surveyed before and after the Well London intervention across all sites giving a sample of around 4000. This quantitative approach was complemented by qualitative interviews with a sample of participants comprising both intervention and control group residents. Primary outcomes were effects on healthy eating (five portions of fruit/vegetables a day), physical activity (five 30-minute moderate-level physical activities a week) and mental wellbeing (GHQ-12 and WEMWBS). Secondary outcomes were a range of other healthy eating, physical activity, mental wellbeing and social cohesion measures. Although no statistically significant difference was found for primary outcomes, two secondary outcomes were significant; the intervention group ate more healthily and thought that people pulled together more to improve the local area, compared with controls.

It is important to take into account lessons learnt through evaluation of programme outcomes. Well London Phase 2 (2012-15) evolved from learning acquired in Phase 1;

target sites are now places within natural neighbourhoods rather than those defined by census information, and communities have opportunities to shape local project delivery. Phase 2 has also started to explore how the intervention can be scaled-up to reach larger audiences. Scaling up service provision to a system-wide healthcare intervention is another important aspect of social prescribing, particularly for initiatives which are successful at a modest level and are able to acquire sufficient investment.

This review represents a snapshot in time of research into social prescribing schemes carried out over 12 months. It is hoped that the work will be added to as more community referral projects emerge and are seen to be successful in promoting individual health and wellbeing, and community cohesion and resilience.

'While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change'
NHS (2014: 10)



7 References

- AgeUK (2011). *Social Prescribing: A model for partnership working between primary care and the voluntary sector*. Yorkshire and the Humber: Age Concern Support Services.
- Andrews, G., Poulton, R. & Skoog, I. (2005). Lifetime risk of depression: Restricted to a minority or waiting for most? *British Journal of Psychiatry*, 187, 495–496. doi:10.1192/bjp.187.6.495
- Andrews, F.M. & Withey, S.B. (1976). *Social Indicators of Wellbeing: American's perceptions of life quality*. New York: Plenum Press.
- Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. *Social Science and Medicine*, 36(6), 725–33.
- Aylward, N. & James, K. (2002). *Prescriptions for Learning Project: 2nd evaluation report*. Nottingham: Nottingham HAZ.
- Batson, G. (2010). Feasibility of an intensive trial of modern dance for adults with Parkinson disease. *Complementary Health Practice Review*, 15(2), 65–83.
- Biddle, S.J.H., & Mutrie, N. (2001). *Psychology of Physical Activity: Determinants, well-being and interventions*. London: Routledge.
- Blastock, D. Brannelly, T. Davis, A. & Howes, D. (2005). *Signposting Evaluation Report*. West Midlands: Suresearch, NIMHE West Midlands & University of Birmingham.
- Boyle, D., Clark, S. and Burns, S. (2006) *Hidden Work: Co-production by People Outside Paid Employment*. York: Joseph Rowntree Foundation.
- Brandling, J. & House, W. (2007). *Investigation into the Feasibility of a Social Prescribing Service in Primary Care: A pilot project*. Bath: University of Bath and Bath and North East Somerset NHS Primary Care Trust.
- Brandling, J. & House, W. (2009). Social Prescribing in General Practice: Adding meaning to medicine. *The British Journal of General Practice*, 59(563), 454–456. doi:10.3399/bjgp09X421085
- The British Heart Foundation National Centre for Physical Activity and Health (2010). *A Toolkit for the Design, Implementation and Evaluation of Exercise Referral Schemes*. Loughborough: Loughborough University; British Heart Foundation.
- British Trust for Conservation Volunteers (BTCV) (2002). *Green Gym Research Summary*. Oxford: Oxford School for Healthcare, Research and Development, Oxford Brookes University.
- Broadhead, W.E., Gehlbach, S.H., Van de Gruy, F. & Kaplan, H. (1988). The Duke-UNC Functional Social Support Questionnaire: Measurement of social support in family medicine patients. *Medical Care*, 26(7), 709–723.
- Bungay, H. & Clift, S. (2010) Arts on Prescription: A review of practice in the UK. *Perspectives in Public Health*, 6(103), 277–281. doi:10.1177/1757913910384050
- Callaghan, P. (2004). Exercise: A neglected intervention in mental health care? *Journal of Psychiatric and Mental Health Nursing*, 11, 476–483.
- Callard, F. & Friedli, L. (2005). Imagine East Greenwich: Evaluating the impact of the arts on health and wellbeing. *Journal of Public Mental Health* 4(4), 29–41.
- Camic, P.M., Baker, E. & Tischler, V. (2015). Theorising how art gallery interventions impact people with dementia and their caregivers. *The Gerontologist*. Advance access: <http://gerontologist.oxfordjournals.org/cgi/reprint/gnv063?ijkey=e9cuXXuz8FD2xJB&keytype=ref>
- Camic, P.M. & Chatterjee, H.J. (2013). Museums and art galleries as partners for public health interventions. *Perspectives in Public Health*, 133(66), 66–71. doi:10.1177/1757913912468523
- Care Services Improvement Partnership (CSIP) (2009). *Social Prescribing for Mental Health: A guide to commissioning and delivery*. Manchester: CSIP North West Development Centre.
- Care Services Improvement Partnership (2006). *Briefing Document on Social Prescribing*. Manchester: CSIP North West Development Centre.
- Carless, D. & Douglas, K. (2008). Social support for and through exercise and sport in a sample of men with serious mental illness. *Issues in Mental Health Nursing*, 29(11), 1179–1199.
- CentreForum Mental Health Commission (2014). *The Pursuit of Happiness: A new ambition for our mental health*. London: CentreForum.
- Chatterjee, H.J. & Noble, G. (2013). *Museums, Health and Wellbeing*. Farnham, UK; Burlington, USA: Ashgate Publishing.
- Clark, D.M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, 23, 375–384.
- Clarke, K, Sarre, S, Gledinning, C and Datta, J. (2001). *Providing Family Support in Primary Care: Evaluation of the WellFamily service*. Manchester: University of Manchester. 17.



- Clatworthy, J., Hinds, J., Camic, P.M. (2013). Gardening as a mental health intervention: A review. *Mental Health Review Journal*, 18(4), 214–225. doi:10.1108/MHRJ-02-2013-0007
- The Conservation Volunteers. (2013). *Green Gym*. Doncaster: TCV.
- Cohen, G.D., Perlstein, S., Chapline, J. & Kelly, J. (2006). *The Creativity and Aging Study: The impact of professionally conducted cultural programs on older adults: Final report*. Washington, DC: The George Washington University.
- Cohen, G.D., Perlstein, S., Chapline, J., Kelly, J., Firth, K.M. & Simmons, S. (2006). The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. *The Gerontologist*, 46(6), 726–734.
- Coulter, F. (2001). *Realising the potential of cultural services: The case for the arts*. London: Local Government Association.
- Countryside Recreation Network (2005). *A Countryside for Health and Wellbeing: The physical and mental health benefits of green exercise*. Sheffield: Countryside Recreation Network, Sheffield Hallam University.
- Craig, C.L., Marshall, A.L., Sjöström, M., Bauman, A.E., Booth, M.L., Ainsworth, B.E., Pratt, M., Ekelund, U., Yngve, A., Sallis, J.F. & Oja, P. (2003). International physical activity questionnaire: 12-country reliability and validity. *Medical Science Sports Exercise*, 35(8), 1381–1395.
- Crone, D., O'Connell E., James, D.V.B., Tyson, P. & Clark-Stone, F. (2011). *Art Lift, Gloucestershire: Evaluation Report: Executive Summary*. Gloucester: University of Gloucestershire.
- Dayson, C., Bashir, N. & Pearson, S. (2013). *From Dependence to Independence: Emerging lessons from the Rotherham Social Prescribing Pilot*. Sheffield: Sheffield Hallam University
- Department for Culture, Media and Sport (1999). *Arts and Sport. Policy action team 10: A report to the Social Inclusion Unit*. London: Department of Culture, Media and Sport.
- Department for Culture, Media and Sport (2013). *Report under the Public Libraries and Museums Act 1964 for 2012/2013: A report presented to parliament pursuant to section 17 of the Public Libraries and Museums Act 1964*. London: Department of Culture, Media and Sport.
- Department of Health (2006). *Our health, our care, our say: a new direction for community services*. London: Department of Health.
- Department of Health: Mental Health Division (2009). *New Horizons: A shared vision for mental health*. London: Department of Health.
- Department of Health (2012). *IAPT Three Year Report: The first million patients*. London: Department of Health.
- Department of Health (2012). *Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015*. London: Department of Health.
- De Rubeis, R., Hollon, S., Amsterdam, J., et al. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry* 62(4) 409–416.
- Diehl, J.J. & Choi, H. (2008). Exercise: The data on its role in health, mental health, disease prevention, and productivity. *Primary Care*, 35(4), 803–16. doi:10.1016/j.pop.2008.07.014.
- Dundee Health Living Initiative and the Equally Well Test Site (2011). *Paper to NHS Tayside Board*. Dundee: Dundee Healthy Living Initiative.
- Eades, G. & Ager, J. (2008). Time Being: Difficulties in integrating arts in health. *Journal of the Royal Society for the Promotion of Health*, 128, 73–78.
- ERS Research and Consultancy & Beacon North Ltd (2013). *Newcastle Social Prescribing Project: Final report*. Newcastle upon Tyne: Involve North East.
- Faulkner, M. (2004). Supporting the psychosocial needs of patients in general practice: The role of a voluntary referral service. *Patient Education and Counselling*, 52, 41–46.
- Feinstein, L., Hammond, C., Woods, L., Preston, J. & Bynner, J. (2003). *The Contribution of Adult Learning to Health and Social Capital*. London: Centre for Research on the Wider Benefits of Learning.
- Flannery, O., Loughren, E., Baker, C., & Crone, D. (2014). *Exercise on Prescription Evaluation Report for South Gloucestershire*. Cheltenham: University of Gloucestershire.
- Foresight Mental Capital and Wellbeing Project (2008). *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century, final project report*. London: The Government Office for Science.
- Griffiths, S. (2002). The mental health benefits of arts and creativity for African and Caribbean young men. *Mental Health Review Journal*, 10(2): 27–31.
- Friedli, L., Jackson, C., Abernethy, H. & Stansfield, J. (2009). *Social Prescribing for Mental Health - A guide to commissioning and*



- delivery. Lancashire: Care Services Improvement Partnership.
- Friedli, L. & Watson, S. (2004). *Social Prescribing for Mental Health*. Durham: Northern Centre for Mental Health.
- Goodhart, C. & Graffy, J. (2000). Long term benefits need to be taken into account when evaluating family support projects. *British Medical Journal*, 320, 1600–1600.
- Goodhart, C., Layzell, S., Cook, A. & Graffy, J. (1999). Family support in general practice. *Journal of the Royal Society of Medicine*, 92, 525–528.
- Gournay, K. (2006). *Review of free to access computerised behavioural therapy websites*. Bury: British Association for Behavioural and Cognitive Psychotherapies.
- Grant, C., Goodenough, T., Harvey, I. & Hine, C. (2000). A randomised trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *British Medical Journal*, 320(7232), 419–432.
- Graham, N. (1995). GPs and voluntary organisations. *British Journal of General Practice*, 45, 272–273.
- Grayer, J., Cape, J., Orpwood, L., Liebowitz, J. & Buszewicz, M. (2008). Facilitating access to voluntary and community services for patients with psychosocial problems: A before-after evaluation. *BioMed Central Family Practice*, 9(27), 1–8. doi:10.1186/1471-2296-9-27
- Greasley, P. & Small, N. (2005). Providing welfare advice in general practice: Referrals, issues and outcomes. *Health and Social Care in the Community*, 13(3), 249–258.
- Gulbrandensen, P., Hjortdahl, P. & Fugelli, P. (1997). General Practitioners knowledge of the patient's psychosocial problems: Multipractice questionnaire survey. *British Medical Journal*, 314, 1014–1018.
- Gusi, N., Reyes, M.C., Gonzalez-Guerrero, J.L., Herrera, E. & Garcia, J.M. (2008). Cost-utility of a walking programme for moderately depressed, obese, or overweight elderly women in primary care: A randomised controlled trial. *BioMed Central Public Health*, 8, 231–241. doi:10.1186/1471-2458-8-23
- Hacking, S., Secker, J., Spandler, H., Kent, L. & Shenton, J. (2008). Evaluating the impact of participatory art projects for people with mental health needs. *Health & Social Care in the Community*, 16(6), 638–648. doi:10.1111/j.1365-2524.2008.00789.x
- Harding, R., Sherr, L., Singh, S., Sherr, A. & Moorhead, R. (2002). Evaluation of welfare rights advice in primary care: The general practice perspective. *Health and Social Care in the Community*, 10(6), 417–422.
- Hammond, G.C., Croudace, T.J., Radhakrishnan, M., Lafortune, L., Watson, A., McMillan-Shields, F. & Jines, P.B. (2012). Comparative Effectiveness of Cognitive Therapies Delivered Face-to-Face or over the Telephone: An observational study using propensity methods. *PLoS One*, 7(9). doi:10.1371/journal.pone.0042916.
- Harper, S. & Hamblin, K. (2010). *Oxford Institute of Ageing Report Good Times: Art for Older People at Dulwich Picture Gallery*. Oxford: Oxford Institute of Ageing, University of Oxford.
- Health Education Authority (1998). *Community action for mental health*. London: Health Education Authority.
- Henderson, H. & Mullineaux, D. (2013 Unpublished). *Lincolnshire exercise referral evaluation*. Lincoln: University of Lincoln.
- Her Majesty's Government and Department of Health (2011). *No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. London: Central Office of information. Hicks, D. (2006). *An Audit of Bibliotherapy / Books on Prescription Activity in England*. London: Arts Council England.
- Hillman, C.H., Erickson, K.I. & Kramer, A.F. (2008). Science and Society: Be smart, exercise your heart: exercise effects on brain and cognition. *Nature Reviews Neuroscience*, 9, 58–65. doi:10.1038/nrn2298
- Howells, L. (2001). The Swindon primary mental health care service. *Journal of Primary Care Mental Health* 5(2), 33–34.
- Hughes, M.E., Waite, L.J. Hawkley, L.C. & Cacioppo, J.T. (2004). A short scale for measuring loneliness in large surveys: Results from two population-based studies. *Research in Aging*, 26(6), 655–672.
- Huxley, P.H. (1997). *Arts on Prescription: An evaluation*. Stockport: Stockport Healthcare NHS Trust.
- James, K. (2001). *Prescribing Learning: A guide to good practice in learning and health*. Nottingham: National Institute for Adult Continuing Education.
- James, K. (2002). *Prescriptions for Learning: Evaluation Report 2*. Leicester: National Institute for Adult Continuing Education.
- Joint Consultative Forum of Medical Royal Colleges, Chartered Society of Physiotherapy and the Fitness Sector of the United Kingdom (2011). *Professional and Operational Standards for Exercise Referral*.
- Kroenke, K., Spitzer, R.L. & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression



- severity measure. *Archives of Internal Medicine*, 16(9), 606–613.
doi:10.1046/j.1525-1497.2001.016009606.x
- Leonard, B.E. (2007). Inflammation, depression and dementia: Are they connected? *Neurochemical Research*, 32, 1749–1756.
doi:10.1007/s11064-007-9385-y
- Lewisham Clinical Commissioning Group (2014). *Lewisham Clinical Commissioning Group: Public Sector Equality Duty Annual Report April 2013 - January 2014*. London: Equality and Diversity Lead for the NHS South London Commissioning Support.
- Lovell, E. & Bockler, J. (2007). *Creative Alternatives: Project Report Nov 2006–Aug 2007*. Sefton: Sefton MBC's Leisure Services Department (Arts Development), Sefton Health Improvement Support Service, and Sefton PCT.
- Ma, W.F., Lane, H.Y. & Laffrey, S.C. (2008). A model testing factors that influence physical activity for Taiwanese adults with anxiety. *Research in Nursing and Health*, 31(5), 476–489.
- Marmot, M. (2010). *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*. London: The Marmot Review.
- McCollam, A., Maxwell, M., Huby, G., Woodhouse, A., McLean, J., Themessl-Huber, M. & Morrison, J. (2006). *National Evaluation of the Doing Well By People with Depression Programme*. Edinburgh: Scottish Executive.
- McCormick, B, Frey, G, Lee, C, Chun, S, Sibthorp, J, Gajic, T, Stamatovic-Gajic, B & Maksimovich, M. (2008). Predicting transitory mood from physical activity level among people with severe mental illness in two cultures. *International Journal of Social Psychiatry*, 54(6), 527–538.
- McDaid, D. & Park, A. (2013). *Investing in Arts on Prescription: An economic perspective*. London: London School of Economics.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P. & Jenkins, R. (2009). *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care.
- The Mental Health Foundation (2005). *Up and running? Exercise therapy and the treatment of mild or moderate depression in primary care*. London: Mental Health Foundation.
- The Mental Health Foundation (2009). *Moving on Up*. London: Mental Health Foundation.
- Milton, K. (2008). *Evaluation of the Eastern and Coastal Kent Exercise Referral Scheme: Final Evaluation Report*. Loughborough: Loughborough University.
- Mind (2013). *Making Sense of Ecotherapy*. London: Mind.
- Mindlab International, Sussex University (2009). *Galaxy Commissioned Stress Research*. Brighton: Sussex University.
- Morrison, I. & Clift, S.M. (2006). Mental health promotion through supported further education: The value of Antonovsky's salutogenic model of health. *Health Education*, 106(5), 365–380.
doi:10.1108/09654280610685956
- Morse, N., Thomson, L.J., Brown, Z. & Chatterjee, H.J. (2015). Effects of creative museum outreach sessions on measures of confidence, sociability and well-being for mental health and addiction recovery service-users, *Arts & Health: An International Journal for Research, Policy and Practice*, 7(3), 231–246.
doi:10.1080/17533015.2015.1061570
- Murphy, S., Raisane, L., Moore, G., Edwards, R.T., Linck, P., Hounscome, N., Williams, N., Din, N.U. & Moore, L. (2010). *The Evaluation of the National Exercise Referral Scheme in Wales*. Cardiff: Welsh Assembly Government.
- National Health Service Confederation (2014). Comparing apples with oranges? How to make better use of evidence from the voluntary and community sector to improve health outcomes: *NHS Confederation Briefing*, 273, 1–11.
- National Health Service England (2014). *Five Year Forward View*. London: NHS England.
- National Institute for Health and Clinical Excellence (NICE) (2002). *Computerized Cognitive Behaviour Therapy for Depression and Anxiety. Technology Appraisal 51*. London: National Institute for Health and Clinical Excellence.
- National Institute for Adult Continuing Education (2003). *Mental Health and Social Exclusion – Social exclusion consultation document: A commentary and response from the National Institute for Adult Continuing Education*. Nottingham: National Institute for Adult Continuing Education.
- National Institute for Health and Care Excellence (2014). Exercise referral schemes to promote physical activity. *NICE Public Health Guidance*, 54. London: National Institute for Health and Care Excellence.
- National Institute for Health and Care Excellence (2006). Four commonly used methods to increase physical activity: Brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. *NICE*



- Public Health Guidance, 2. London: National Institute for Health and Care Excellence.
- National Institute for Health and Clinical Excellence (2006). *Computerized Cognitive Behaviour Therapy for Depression and Anxiety. Technology Appraisal 97*. London: National Institute for Health and Clinical Excellence.
- National Institute for Health and Clinical Excellence – Social Care Institute for Excellence (2007). *Dementia: Supporting people with dementia and their carers in health and social care. NICE Clinical Guideline 42*. London: National Institute for Health and Clinical Excellence.
- New Economics Foundation (2009). *National Accounts of Wellbeing: Bringing real wealth onto the balance sheet*. London: New Economics Foundation.
- National Endowment for Science, Technology and the Arts (NESTA) (2013). *More than Medicine: New service for people powered health*. London: NESTA Innovation Unit.
- Nelson, E., Wasson, J., Kirk, J., Keller, A., Clark, D., Dietrich, A., Stewart, A. & Zubkoff, M. (1987). Assessment of function in routine clinical practice: Description of the CO-OP Chart method and preliminary findings. *Journal of Chronic Disfunction, 40(1)*, 555–635.
- Pavey, T.G., Anokye, N., Taylor, A.H., Trueman, P., Moxham, T., Fox, K.R., Hillsdon, M., Green, C., Campbell, J.L., Foster, C., Mutrie, N., Searle, J., & Taylor, R.S. (2011). The clinical effectiveness and cost-effectiveness of exercise referral schemes: A systematic review and economic evaluation. *Health Technology Assessment, 15(44)*.
- Pavey, T.G., Taylor, A.H., Fox, K.R., Hillsdon, M., Anokye, N., Campbell, J.L., P., Foster, C., Green, C., Moxham, T., Mutrie, N., Searle, J., Trueman, P. & Taylor, R.S. (2011). Effect of exercise referral schemes on physical activity and improving health outcomes: Systematic review and meta-analysis *British Medical Journal, 343*, 1–14. doi:10.1136/bmj.d6462
- Phillips, C. (2009). *What is a QALY?* London: Hayward Medical Communications.
- Phillips, G., Bottomley, C., Schmidt, E., Tobi, P. Lais, S., Yu, G., et al. (2014). Well London Phase 1: Results among adults of a cluster-randomised trial of a community engagement approach to improving health behaviours and mental well-being in deprived inner-city neighbourhoods. *Journal of Epidemiology Community Health, 68*, 606–614. doi:10.1136/jech-2013-202505.
- Phinney, A., Moody, E., Pickersgill, M., Solorzono, J.G. & Naylor, M. (2012). *The Arts Health and Seniors Project: Executive Summary*. Vancouver: Vancouver Coastal Health SMART Fund, Vancouver Board of Parks and Recreation, Society for Arts and Health, Canada Council for the Arts, Vancouver Foundation, United Way of the Lower Mainland, British Columbia Arts Council, North Shore Community Foundation, and North Vancouver Recreation Commission.
- Potter, S. (2013). *Arts on Prescription 2010–12 Evaluation Report: Executive Summary*. Cambridge: Arts and Minds.
- Potter, S. (2015). *Arts on Prescription 2014–15 Evaluation Report*. Cambridge: Arts and Minds.
- Powell, J. & Clarke, A. (2006). Internet information seeking in mental health: Population survey. *British Journal of Psychiatry 189*, 273–277.
- Pretty, J., Griffin, M., Sellens, M. & Pretty, C. (2003). Green Exercise: Complementary roles of nature, exercise, diet in physical and emotional wellbeing and implications for public health policy. *CES Occasional Paper, 1*. Chelmsford: University of Essex.
- Pretty, J., Peacock, J., Hine, R., Sellens, M., South, M. & Griffin, M. (2007). Green exercise in the UK countryside: Effects on health and psychological well-being, and implications for policy and planning. *Journal of Environmental Planning and management, 50, 2*, 211–231.
- Public Health England (2015). *Guide to Community-centred Approaches for Health and Wellbeing: Briefing*. London: Public Health England.
- Radhakrishnan, M., Hammond, G., Jones, P., Watson, A., McMillan-Shields, F. & Lafortune, L. (2013). Cost of improving access to psychological therapies (IAPT) programme: An analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England region. *Behaviour, Research and Therapy, 51*, 37–45. doi:10.1016/j.brat.2012.10.001
- The Reading Agency (2003). *Reading and health mapping research project*. St. Albans: Reading Agency.
- Roberts, S. Camic, P.M. & Springham, N. (2011). New roles for art galleries: Art-viewing as a community intervention for family carers of people with mental health problems. *Arts & Health: An International Journal for Research, Policy and Practice, 3(2)*, 146–159. doi:10.1080/17533015.2011.561360
- Reynolds, V. (1999). The Green Gym: Evaluation of a pilot project in Sonning Common. *Oxford Centre for Healthcare Research and*



- Development Report, 8, Oxford: Oxford Brookes University.
- Salamon, E. (2008). *Good for the Soul: Evaluation report*. County Durham: Teesdale Borough Council.
- Scoggins, E. (1998). *Forging links: A report on stage 1 of the voluntary sector primary care liaison project on making links with General Practice*. London: Bromley Centre for Voluntary Service.
- Scottish Development Centre for Mental Health (2007). *Developing Social Prescribing and Community Referrals for Mental Health in Scotland*. Glasgow: Healthier Scotland Scottish Government.
- Secker, J., Spandler, H., Hacking, S., Kent, L. and Shenton, J. (2007). *Mental Health, Social Inclusion and Arts: Developing the evidence base. Final report*. London: Department for Culture, Media and Sport; Department of Health.
- Seifert, A., McCarton, C., McCann, M. & McLaughlin, A. (2011). *Investigating Community Gardening as a Form of Rehabilitation for People with Alcohol Misuse Problems in Northern Ireland: Findings from a pilot study*. Belfast: Queen's University Belfast Institute of Child Care Research.
- Seyfang, G. & Smith, K. (2002). *The time of our lives: Using time banking for neighbourhood renewal and community capacity building*. London: New Economics Foundation.
- Shaer, D., Beaven, K., Springham, N., Pillinger, S., Cork, A., Brew, J., et al. (2008). The role of art therapy in a pilot for art-based Information Prescriptions at Tate Britain. *International Journal of Art Therapy*, 13(1), 25–33.
- Sherratt, M., Jones, K. & Middleton, P. (2000). A citizen's advice service in primary care: Improving patient access to benefits. *Primary Health Care Research & Development*, 1, 139–146.
- Smith, T. (2003). *Common Knowledge: An evaluation of sorts*. Durham: Centre for Medical Humanities.
- Social Enterprise Coalition (2005). *There's More to Business: A manifesto for social enterprise*. London: Social Enterprise Coalition.
- Solway, R. Camic, P.M., Thomson, L.J. & Chatterjee, H.J. (2015). Museum object handling groups in older adult mental health inpatient care. *International Journal of Mental Health Promotion*. doi:10.1080/14623730.2015.1035520
- Sorensen, J.B., Kragstrup, J., Skovgaard, T. & Puggaard, L. (2008). Exercise on prescription: A randomized study on the effect of counselling vs counselling and supervised exercise. *Scandinavian Journal of Medical Science and Sports*, 18, 288–97.
- Sowter, T. & Stone, C. (2000), *Exploring Opportunities, Social prescribing in Bromley*. London: Bromley Primary Care Trust
- Spector, A., Orrell, M. & Hall, L. (2012). Systematic Review of Neuropsychological Outcomes in Dementia from Cognitive-Based Interventions. *Dementia and Geriatric Cognitive Disorders*, 34, 244–255.
- Spitzer, R.L., Kroenke, K., Williams, J.B. & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097. doi:10.1001/archinte.166.10.1092
- Stathi, A., Milton, K. & Riddoch, C. (2006). *Evaluation of the London Borough of Camden Exercise Referral Scheme*. Harrow: Middlesex University London Sport Institute.
- Sterling, M. (2011). General Health Questionnaire 28. *Journal of Physiotherapy*, 57(4), 2011–2059. doi:10.1016/S1836-9553(11)70060-1
- Stickley, T. & Eades, M. (2013). Arts on prescription: A qualitative outcomes study. *Public Health*, 127(8), 727–734. doi:10.1016/j.puhe.2013.05.001
- Stickley, T. & Hui, A. (2012a). Social prescribing through arts on prescription in a UK city: Participants' perspectives (Part one). *Public Health*, 126, 574–579.
- Stickley, T. & Hui, A. (2012b). Social prescribing through arts on prescription in a UK city: Participants' perspectives (Part two). *Public Health*, 126, 580–586.
- Stewart-Brown, S.L., Platt, S., Tennant, A., Maheswaran, H., Parkinson, J., Weich, S., et al. (2011). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): A valid and reliable tool for measuring mental well-being in diverse populations and projects. *Journal of Epidemiology and Community Health*, 65(2), A38-A39.
- Sykes, S. (2002). A social prescribing scheme in Penge and Anerley. *Journal of Primary Care Mental Health*, 6, 11–12.
- Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J. & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes* 5(1), 63–76. doi:10.1186/1477-7525-5-63
- Thomson, L.J. & Chatterjee, H.J. (2015). Measuring the impact of museum activities on wellbeing: Developing the Museum Wellbeing Measures Toolkit. *Museum Management and*



- Curatorship, 30(1), 44–62.
doi:org/10.1080/09647775.2015.1008390
- Thomson, L.J. & Chatterjee, H.J. (2014a). Wellbeing with Objects: Evaluating a museum object handling intervention for older adults in healthcare settings. *Journal of Applied Gerontology*, 34(4), 539–42.
- Thomson, L.J. & Chatterjee, H.J. (2014b). Assessing wellbeing outcomes for arts and heritage activities: Development of a Museum Wellbeing Measures Toolkit. *International Journal of Applied Arts and Health*, 5(1), 29–50. doi:org/10.1386/jaah.5.1.29_1
- Thomson, L.J., Ander, E.E., Menon, U., Lanceley, A. & Chatterjee, H.J. (2012a). Quantitative evidence for wellbeing benefits from a heritage-in-health intervention with hospital patients. *International Journal of Art Therapy*, 17(2), 63–79.
doi:org/10.1080/17454832.2012.687750
- Thomson, L.J., Ander, E.E., Lanceley, A., Menon, U. & Chatterjee, H.J. (2012b). Enhancing cancer patient wellbeing with a nonpharmacological, heritage-focused intervention. *Journal of Pain and Symptom Management*, 44(5), 731–740.
doi:org/10.1016/j.jpainsymman.2011.10.026
- Thornett, A. (2000). The economic consequences of treating psychosocial disorders. *British Medical Journal* 320, 7232.
- Timebanking UK (2011). *People Can*. Stroud: Timebanking UK.
- Trimble, R. & Hopewell, D. (2015). *Stop Building Health Centres*. London: Bromley-by-Bow Centre.
- Trimble, R. & Hopewell, D. (2015). *Unleashing Healthy Communities*. London: Bromley-by-Bow Centre.
- Tyldesley, R. & Rigby, T. (2003). *The Arts on Prescription Postnatal Depression Support Service: An evaluation of a twelve week pilot*. Stockport: Stockport Primary Care Trust.
- Vaughan, S., Polit, D., Steel, M., Shum, D. & Morris, N. (2014). The effects of multimodal exercise on cognitive and physical functioning and brain-derived neurotrophic factor in older women: A randomised controlled trial. *Age and Ageing*, 43(5), 623–629.
doi:10.1093/ageing/afu010
- Vemuri, P., Lesnick, T.G., Przybelski, S.A., Machulda, M., Knopman, D.S., Mielke, M.M., Roberts, R.O., Yonas, E.G., Rocca, W.A., Petersen, R.C. & Clifford, J.R. (2014). Association of lifetime intellectual enrichment with cognitive decline in the older population. *Journal of the American Medical Association Neurology* 71(8), 1017–1023.
doi:10.1001/jamaneurol.2014.963
- Vergheze, J., Lipton, R.B., Katz, M. J., Hall, C.B., Derby, C.A., Kuslansky, G., Ambrose, A.F., Sliwinski, M. & Buschke, H. (2003). Leisure activities and the risk of dementia in the elderly. *New England Journal of Medicine*, 348, 2508–2516.
doi:10.1056/NEJMoa022252
- Vogelpeel, N., Lewis-Holmes, B., Thomson, L.J. & Chatterjee, H.J. (2013). Touching Heritage: Community health and wellbeing promotion through sustainable and inclusive volunteer programming in the museums sector. *The International Journal of the Inclusive Museum*, 6(1), 109–119.
- Wand, T. & Murray, L. (2008). Let's get physical. *International Journal of Mental Health Nursing*. 17(5), 363–369.
- Ware, J.E., Kosinski, M. & Keller, S.D. (1996). A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34(3), 220–233.
- Webber, J., Hinds, J. & Camic, P.M. (2015). The well-being of allotment gardeners: A mixed methodological study. *Ecopsychology*, 7(1), 20–28. doi:10.1089/eco.2014.0058
- White, M. & Salamon, E. (2010). *An interim evaluation of the 'Arts For Well-being' social prescribing scheme in County Durham*. Durham: Durham University, Centre for Medical Humanities.
- Williams, N.H., Hendry, M., France, B., Lewis, R. & Wilkinson, C. (2007). Effectiveness of exercise referral schemes to promote physical activity in adults: Systematic review. *British Journal of General Practice*, 57, 979–986.
- Wilson, J. & Read, J. (2001): What prevents GPs from using outside resources for women experiencing depression? A New Zealand study. *Family Practice*, 18, 84–86.
- Woodall, J. & South, J. (2005). *The Evaluation of the CHAT Social Prescribing Scheme in Bradford South & West PCT*. Leeds: Leeds Metropolitan University.
- Yerrell, P. (2008). *TCV Green Gym National Evaluation Report: Summary of Findings*. Oxford: Oxford Brookes University.
- Zigmond, A.S. & Snaith, R.P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica*, 67(6), 361–370.
doi:10.1111/j.16000447.1983.tb09716.x

Further information:

<http://www.ucl.ac.uk/museums/research/museumsonprescription>

8



A Review of Community Referral Schemes

8 Appendices

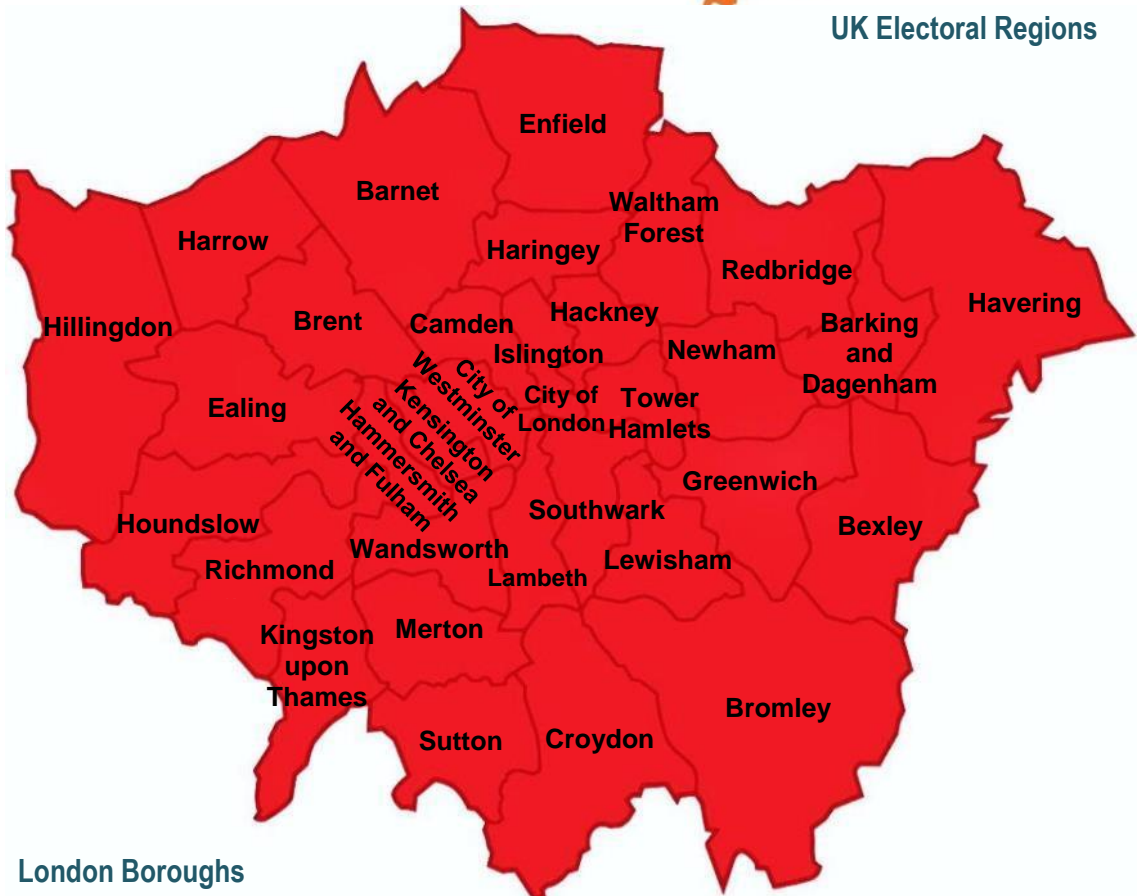
8.1 Social prescribing schemes in UK regions

Social prescribing schemes reviewed in this report within UK electoral regions have been summarised for:

- ▶ London (Appendix I)
- ▶ South East (Appendix II)
- ▶ South West (Appendix III)
- ▶ Eastern (Appendix IV)
- ▶ East Midlands (Appendix V)
- ▶ West Midlands (Appendix VI)
- ▶ Yorkshire and the Humber (Appendix VII)
- ▶ North East (Appendix VIII)
- ▶ North West (Appendix IX)
- ▶ Wales (Appendix X)
- ▶ Scotland (Appendix XI)
- ▶ Northern Ireland (Appendix XII)



UK Electoral Regions



London Boroughs

Appendix I. London social prescribing schemes

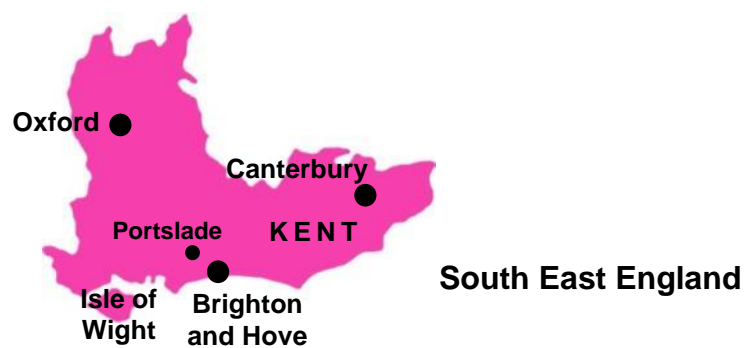
Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	Dulwich Picture Gallery 'Prescription for Art', Boroughs of Southwark and Lambeth	<ul style="list-style-type: none"> • Prescription for Art began as separate scheme after 'Good Times' older adult programme that partnered 65 organisations taking workshops into community. • Developed through GP practices where nurses with responsibility for older adults offered prescriptions to those at risk and not attending regular community groups. 	<ul style="list-style-type: none"> • Aimed to provide creative art workshops (e.g. lino printing and clay modelling) at Gallery ran by project co-ordinator, rota of artists and volunteers and attended by up to 20 participants. • Kings College Hospital 'Memory Clinic' referred patients to Gallery workshops.
	East London 'Arts on Prescription', Boroughs of Tower Hamlets, South Hackney, Newham and Waltham Forest	<ul style="list-style-type: none"> • Central theme of arts and creative expression as a non-stigmatising and protective factor in the face of racism and discrimination in the community and in mental health services. • Building of partnerships involving arts, creativity and alternative therapies, integrated with education, employment and skills training, forming the basis of an holistic approach. 	<ul style="list-style-type: none"> • Aimed to address concerns about the failure of mental health services to meet the needs of African and Caribbean men, and provided opportunities to explore the therapeutic potential of an alternative model. • Participation in arts seen as resource that empowered men to explore their histories and cultures.
Books on Prescription	Barking and Dagenham 'Books on Prescription', Barking and Dagenham Council	<ul style="list-style-type: none"> • After discussion with the patient, the GP, nurse or mental health professional issued prescription for a specific book. • 39 books available from all borough libraries could be borrowed for up to 3 weeks or reserved; if prescribed book was unavailable, staff were advised not to recommend alternatives. 	<ul style="list-style-type: none"> • Aimed to provide self-help versions of clinical treatments offering stepped programmes. • Covered mental health topics (e.g. anger, anxiety, bereavement, depression, obsessive compulsive disorder, panic, post-natal depression, sleep disorder, stress and worry).
	Barnet 'Books on Prescription' and 'Books on Prescription Dementia', Barnet Council	<ul style="list-style-type: none"> • Books on Prescription Dementia launched in 2015 at 5 out of 14 Barnet libraries; books also available without a prescription. • GP writes prescription for book and patients or carers take prescription to local library where staff are available to help to find the title. 	<ul style="list-style-type: none"> • Aimed to provide access for patients with mental health issues to books on topics such as anxiety and depression. • Residents with dementia do not pay fines on overdue books if they have registered their library card.
	'Books on Prescription' and 'Books on Prescription'	<ul style="list-style-type: none"> • Books available from 6 out of 16 Enfield libraries and, if unavailable, can be reserved free of charge • GPs and other health professionals 	<ul style="list-style-type: none"> • Aimed to provide 30 self-help titles based on CBT for common adult mental health conditions (anxiety,

Books on Prescription	Dementia', Enfield Council	prescribe books from Reading Well Books on Prescription core booklist.	depression, phobias, eating disorders), and book collection for people with dementia.
	Croydon PCT and Croydon Libraries 'Healthy Croydon Partnership', Croydon	<ul style="list-style-type: none"> • Books prescribed by GPs or self-referred after consulting user guide designed by Croydon's mental health service-user group 'Hear Us'. • Books available in Healthy Living section of all of Croydon's 13 libraries. 	<ul style="list-style-type: none"> • Aimed to provide self-help books for adults with mild to moderate mental health issues (e.g. eating disorders, obsessive compulsive behaviour, panic, phobia, stress and worry).
	Hammersmith and Fulham 'Reading Well Books on Prescription'	<ul style="list-style-type: none"> • Core list of self-help books available in all of borough's libraries since 2013. • Book recommended by GP or psychological well-being practitioner using form on user guide found in libraries and GP practices. Patients take prescription to library where book borrowed for up to 3 weeks or reserved free of charge if unavailable. 	<ul style="list-style-type: none"> • Aimed to offer books as first step, early intervention or additional treatment. • Intended to manage mild to moderate mental health conditions (e.g. anger, anxiety, bulimia nervosa, chronic fatigue, depression, health anxiety, obsessive compulsive disorder, panic, self-esteem, social phobia and stress).
	Hillingdon 'Reading Well Books on Prescription', Hillingdon Council	<ul style="list-style-type: none"> • Books prescribed by GPs or other health professionals with access to prescriber handbook to provide advice on choice of book available in 10 out of 17 Hillingdon libraries. • Patients take prescription to library where book borrowed for up to 3 weeks or reserved free of charge from another local library. 	<ul style="list-style-type: none"> • Aimed to provided self-help reading from booklist based on CBT step-by-step techniques, to assist adults in managing own health and wellbeing for range of common mental health conditions (e.g. anxiety, depression, phobias, stress and some eating disorders).
	Redbridge 'Books on Prescription' scheme and 'Bibliotherapy Readers Group', Redbridge Council	<ul style="list-style-type: none"> • GPs or wellbeing practitioners recommend books available for any library member to borrow • Bibliotherapy Readers Group held for people who might be helped mentally or emotionally by reading or listening to books being read. 	<ul style="list-style-type: none"> • Aimed to help residents with mental health issues manage wellbeing using step-by-step techniques. • Bibliography used individual relationship to the content of books as expressive therapy.
	Richmond upon Thames 'Reading Well Books on Prescription'	<ul style="list-style-type: none"> • Scheme based on titles for common mental health conditions with Books on Prescription leaflets available to explain choice of book. • Self-help advice described as suitable for competent adult readers who can understand material and follow activities using stepped techniques. 	<ul style="list-style-type: none"> • Aimed to help borough residents manage wellbeing. • Issued guide for health professionals to reinforce consultation message; GPs advised to immediately move patients to IAPT Level 2 if book not helping or wellbeing worsening.

Books on Prescription	Southwark 'Books on Prescription' Southwark Council	<ul style="list-style-type: none"> • Self-help books compiled by NHS Southwark & Maudsley, NHS Foundation Trust (SLaM) and Southwark Library, and listed on the website. 	<ul style="list-style-type: none"> • Aimed to help with mental wellbeing and also covered healthy eating, physical activity and weight loss.
	Sutton 'Books on Prescription', Sutton Council	<ul style="list-style-type: none"> • Health professional provides book prescription for patient to present to local library; staff locate book that can be borrowed free of charge for up to 12 weeks. • If book already on loan, staff are advised not to choose an alternative, instead to reserve the book free of charge. 	<ul style="list-style-type: none"> • Aimed to be seen as alternative approach for mental health workers. • Based on titles suggested by mental health staff to cover specific conditions (e.g. anger, anxiety, depression, eating disorders, panic, social phobia and stress).
Education on Prescription	Lambeth 'Mosaic Clubhouse', Lambeth	<ul style="list-style-type: none"> • Referral by GPs, mental health teams and secondary care; self-referral pathway is also possible. • Main focus on transferable skills (e.g. car maintenance, cooking, computing, financial literacy, gardening and music lessons) with view to employment and making college applications. 	<ul style="list-style-type: none"> • Aimed to provide hub for people needing non-clinical support with activities tailored to needs. • Most of 800 members had mental illness from low-level depression to severe personality disorder; people treated as assets all with something to contribute.
	Camden 'Exercise Referral Scheme', Camden	<ul style="list-style-type: none"> • Referrals from GP and other health professionals using inclusion criteria of aged 60 plus, chronic disease, and mental illness or sedentary lifestyle. People at risk of losing independence due to limited ability to go out were offered home exercise sessions. • GPs were sent feedback from sessions at 8 weeks with follow-up feedback at 9 months. 	<ul style="list-style-type: none"> • 'Active Health Team' with Level 3 qualification on Register of Exercise Professionals provided free 8-week programme (e.g. green gym, sports, Pilates). • Role of exercise leader vital in supporting engagement; barriers to attendance included negativity towards public transport highlighting the need for accessible venues.
Healthy Living Initiatives	Greenwich 'Healthy Living Service', Greenwich	<ul style="list-style-type: none"> • Service provided several free activities including weekly one-hour exercise to music sessions and a series of one-off facilitated health walks in Greenwich Park. • Also offered weekly education courses: 'Look after Me' for carers and 'New Beginnings' for adults with long term mental health conditions. 	<ul style="list-style-type: none"> • Aimed to encourage older adults aged 50 plus to manage their lives, time and health conditions using holistic methods. • Initiatives explored various skills and techniques (e.g. action planning, healthy eating, managing tiredness, problem solving and relaxation).

Museums on Prescription	Lambeth 'Cinema Museum Prescriptions' pilot, Boroughs of Lambeth and Southwark	<ul style="list-style-type: none"> • Pilot scheme (2014) gave to GPs and healthcare providers prescription pads for free entry to museum events for people they thought might benefit. • When GP ran out of prescriptions, contacted museum for more and fed back on service. 	<ul style="list-style-type: none"> • Aimed to improve community wellbeing by providing free museum entry or access to projects for older or terminally ill adults, people at risk of depression and carers (group visits normally incur charges).
	UCL and CCCU 'Museums on Prescription' (MoP), Camden, Islington, Canterbury, Maidstone and Tunbridge Wells, funded by AHRC	<ul style="list-style-type: none"> • 3-year project (2014-17) with partners in Central London and Kent provided 10 weekly 2-hour sessions for older adults 65 plus at risk of social isolation and their carers, in museum locations (e.g. gallery tours and talks, object handling, arts and crafts activities). • Participants recruited through London and Kent social and psychological services, charities such as local Age UK branches and community groups; and referred via the Project Manager who carried out phone interviews to determine suitability for referral. 	<ul style="list-style-type: none"> • Aimed to improve psychological wellbeing and social inclusion for older adults in Central London and Kent, through local healthcare and social services, and voluntary and third sector organisations • Evaluated participant, carer and facilitator experiences using measures of wellbeing and social isolation taken pre-, mid- and post-course, diary entries and interviews, and three and six month follow-up phone interviews.
Social Prescribing	Bromley by Bow Centre 'Social Prescribing', Tower Hamlets	<ul style="list-style-type: none"> • Social Prescribing Navigators acted as interface between GPs and choice of services. • As part of offer, Centre developed 'My Life' adult health and wellbeing programme delivering services for people with complex mental and physical health conditions. 	<ul style="list-style-type: none"> • Aimed to support adults of all ages, families and young people to develop confidence, achieve goals, learn new skills, find employment and improve health and wellbeing • Scheme set up with 27% medical intervention and 63% social intervention on site.
	'Claremont Project Social Prescribing' The Claremont Project, Islington, funded by local charity 'Islington Giving'	<ul style="list-style-type: none"> • Social prescribing schemes for adults aged 55 plus with mild to moderate mental and physical health issues, who attended as members with subsidised fees (£1.50-£2). • Referral from GP or other health professional using prescription, with self-referral also possible. 	<ul style="list-style-type: none"> • Aimed to connect socially isolated Islington residents to therapeutic physical and social activities. • Range of activities to improve balance, health and wellbeing, and social interaction (e.g. keep fit, tai chi, dance, creative writing and crafts).
	Earl's Court Health & Wellbeing Centre, Kensington and Chelsea	<ul style="list-style-type: none"> • Centre receptionists trained as 'navigators' to inform patients about local community services that might be of interest to them. 	<ul style="list-style-type: none"> • Aimed to meet patients' medical needs in addition to their wider social needs and the needs of the local community.

	Lewisham 'Social Prescribing Project' (LSPP), strategic partnership of Lewisham CCG with third sector agencies	<ul style="list-style-type: none"> Health professionals encouraged to phone LSPP workers to find suitable referral, involved 6 surgeries and voluntary services using Patient Introduction Forms. When patients displayed complex needs or could not be matched to schemes, interviews were set up with LSPP workers. 	<ul style="list-style-type: none"> CCG public engagement team aimed to engage local people, giving voice to those not usually involved in health dialogues (e.g. addiction recovery service-users). Recommended that LSPP workers should be placed in GP surgeries, to use extensive referral sources and carry out evaluation.
Supported Referral	Hackney WellFamily Service supported referral, Family Welfare Association	<ul style="list-style-type: none"> Family support coordinators in primary care referred patients to community resources in Hackney; further schemes set up in Croydon, Newham and Luton. Support from local and national voluntary community organisations combined with practical and emotional support for families to build resources and find ways round their problems. 	<ul style="list-style-type: none"> Aimed to offer referral to patients in need of psychosocial support with emphasis on wellness and normalisation of help-seeking behaviour. Led to long term community benefits, breaking cycle of deprivation and reducing burden on support services
	Penge and Anerley Park Practice' supported referral pilot, Borough of Bromley	<ul style="list-style-type: none"> Operated from GP practice to improve health, assist in identifying care pathways and reduce GP demand. Staff referred patients to community development worker who facilitated access to schemes, with referrals signposted and facilitated for patients who were unlikely to make contact with schemes by phone. 	<ul style="list-style-type: none"> Aimed to provide short term support and facilitation of access to local groups for patients with non-clinical needs (e.g. parents with young children, refugees and asylum seekers). Led to increased self-esteem, reduced isolation, resolution of practical issues, and support for new self-help groups.
Time Banks	Catford 'Rushey Green Time Bank', Rushey Green Group PCT, Lewisham	<ul style="list-style-type: none"> Time bank built core economy of family and community by valuing and rewarding work, and recognising all manner of skills (e.g. baking cakes or providing company on a walk). 	<ul style="list-style-type: none"> Aimed to empower residents to improve their health and wellbeing, enhance community health and achieve a cohesive and mutually reliant community.
Volunteering	Greenwich 'SPLASH', Greenwich Teaching Primary Care Trust funded by Neighbourhood Renewal Fund	<ul style="list-style-type: none"> Service targeted at GPs and health professionals who could track the progress of referred patients Referrals could also be made by anyone using the online referral forms. description, provider, cost, opening times and location. 	<ul style="list-style-type: none"> Online resource aimed to identify non-medical services and sources of support in local area (e.g. volunteering, self-help and healthy living advice)



Appendix II. South East social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
	Isle of Wight 'Time Being' arts on prescription schemes, Healing Arts, Hampshire	<ul style="list-style-type: none"> • GPs and other health professionals prescribed appropriate 2-hour weekly sessions (e.g. creative writing, dance, music, singing or visual arts) for 12 weeks, for patients with mild to moderate mental health conditions. • Questionnaires completed before and after 12-weeks. 	<ul style="list-style-type: none"> • Aimed to show impact of creativity on health, and promote understanding of individual health conditions. • Improvements in mood and self-esteem, increased levels of empowerments and social inclusion and motivation, and interest in further arts activity.
Exercise on Prescription	'Exercise Referral Scheme' Eastern and Coastal Kent PCT	<ul style="list-style-type: none"> • Health professional gave referral form to patient to phone health promotion team and answer questions related to referral and demographics. Patients received consultation with exercise professional, and health and fitness check, repeated 12 weeks later. • Developed over 14 years, scheme assessed fitness needs, produced action plan and monitored attendance for participants with mental and physical health conditions attending 1-2 weekly sessions for 12 weeks. 	<ul style="list-style-type: none"> • Aimed to improve health and well-being of inactive patients by long-term lifestyle change through physical activity. • Over intervention, 19% of patients dropped out with 50% citing reasons of: injury or ill health, lack of support, not knowing how to use gym equipment and wanting a greater choice of activities; cost of continuing after initial subsidised 12 weeks was cited as the main barrier by older adults.
Information Prescription	Brighton and Hove 'Information Prescription', East Sussex	<ul style="list-style-type: none"> • Access to local and national information (e.g. advice for carers, crisis support, education and training, employment and volunteering, families and young people, financial advice, healthy living, health conditions, health services, leisure activities, social care services, housing, support groups, voluntary organisations, and transport). 	<ul style="list-style-type: none"> • Aimed to provide online information about a range of available health and social care services for healthcare professionals and Brighton and Hove residents, with a view to improving health and wellbeing in the area.
Museums on Prescription	Canterbury, Beaney House of Art & Knowledge 'The Paper Apothecary', Canterbury Council, part of the 'Happy Museums' project funded by Arts Council England	<ul style="list-style-type: none"> • Life size 'pharmacy' created as 15-day exhibition (2013) from recycled paper and card by Animate Arts Company and staff, helped by 100 children from local schools who made images of prescriptions, and 4 diverse community groups who devised cultural treatments (such as day-care for adults with learning 	<ul style="list-style-type: none"> • 'Chemists' 'prescribed' cultural treatments to make visitors feel happier, and asked participants to feedback comments, reactions and side-effects via a tear-off section on the prescription. • Encouraged people to connect with a local museum in new and

Museums on Prescription	and the Paul Hamlyn Foundation	<p>difficulties and mothers with babies; and reading and singing groups).</p> <ul style="list-style-type: none"> • ‘Happiness Investigators’ explored museum collections to answer the question: ‘What makes you happy at the Beaney?’ 	<p>innovative way, emphasizing the importance of health and wellbeing and the idea that museums could be partners in public health interventions.</p>
	‘Memory Lane Prescription for Reminiscence’ Oxford Aspire Museums Partnership funded by ACE	<ul style="list-style-type: none"> • Reminiscence group built on existing services that started as informal monthly meetings at the museum to reminisce about a chosen theme and enjoy company in a comfortable environment; session topics often linked to a current museum exhibition theme. • Referral for older adults through local GP practices and healthcare centres, with some participants opting for the self-referral pathway. 	<ul style="list-style-type: none"> • Aimed to increase wellbeing and maintain the cognitive function of older adults in a stimulating environment, and improve physical health and reduce falls and hospital admissions by gentle exercise. • Objective to increase number of older adults benefiting from existing museum services who would otherwise be at risk of social isolation.

Appendix III. South West social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	Gloucester ‘Art Lift’ arts on prescription scheme, originally funded by Arts Council England, subsequently funded by NHS Gloucestershire	<ul style="list-style-type: none"> • 10-week intervention in primary care settings involving art activities (e.g. ceramics, drawing, mosaics and painting) delivered by a rota of 8 artists. • Health professionals referred patients with both mental and physical ill health issues to reduce anxiety, depression and stress, alleviate pain, increase self-esteem, build up social networks, and improve overall wellbeing. 	<ul style="list-style-type: none"> • Aimed to help health professionals develop an holistic approach • Scheme had better attendance and completion rates than other GP referral programmes, such as exercise but participants concerned about funding and sustainability, whether 10 weeks would be sufficient and whether they could ‘graduate’ to follow-on sessions.
	Salisbury ‘Artlift’ Arts on Prescription pilot, Whiteparish GP surgery, South East Wiltshire, and Malmesbury Primary Care Centre	<ul style="list-style-type: none"> • GP surgery trialled 10-week pilot project offering free activity sessions in visual arts and mixed media on Mondays with the option of a further 10 weeks. • Participants needed referral form signed by a medical professional. 	<ul style="list-style-type: none"> • Aimed to support mental health and wellbeing in local area through patients attending arts sessions at a local hall near the surgery. • Second pilot in Malmesbury offered similar 10-week sessions.
Exercise on Prescription	Bristol ‘Exercise Referral Scheme’ Bristol City Council	<ul style="list-style-type: none"> • Participants invited to take information leaflet to health professional for referral if to leisure centre, and contacted by centre’s Referral Instructor. • Programme involved induction with 	<ul style="list-style-type: none"> • Aimed to offer support in developing an activity routine to improve health, in partnership with Bristol’s sports and leisure centres; sessions mainly gym based but some centres offered Tai Chi, balance classes for fall



<p>Exercise on Prescription</p>	<p>South Gloucestershire 'Exercise on Prescription'</p>	<p>instructor who devised appropriate 12-week plan of physical activity with supervision; incurring costs per induction (£3-10) and per session (£2.50-3.50) varying between centres with same reduced fee for befrienders or family members.</p> <ul style="list-style-type: none"> • Scheme involved 2,500 adult participants (18-94 years, mean 53), an eighth with long term illness. Inclusion criteria were BMI greater than 30 and depression. • Patients referred by GPs or other health professionals to programme. Participant requests to be signposted to community activities after the exercise programme were endorsed by health professionals who recommended setting up community-specific groups (e.g. men over-50's exercise). 	<p>prevention and swimming.</p> <ul style="list-style-type: none"> • After 12 weeks participants were offered other choices to help them exercise regularly. • Aimed to improve psychological wellbeing and social interaction, and help with weight loss. • Reported health benefits included changes in physical self-perception and decrease in blood pressure; around half of participants continued to exercise after the end of the programme and reported more walking and gardening; those who dropped out cited lack of motivation and cost.
<p>Green Gyms</p>	<p>South West 'Green Gyms', The British Trust for Conservation Volunteers (BTCV) funded by People's Health Trust and local businesses</p>	<ul style="list-style-type: none"> • Green Gyms located in Bristol (Bradley Stoke and Knowle), Weston-Super-Mare, Gloucester; and Cornwall; organised once or twice a week by trained volunteers. • Work on local projects such as community parks and gardens, included warm up and cool down exercises for volunteer participants. 	<ul style="list-style-type: none"> • The BTCV developed scheme with the aim of improving people's health and physical fitness in addition to tackling local environmental concerns.
<p>Information Prescription</p>	<p>Brighton and Hove 'Information Prescription' scheme, East Sussex</p>	<ul style="list-style-type: none"> • Provided online access to local and national information on health and social care topics (e.g. advice for carers, crisis support, healthy living, housing, and transport). 	<ul style="list-style-type: none"> • Aimed to improve health and wellbeing outcomes for residents of the Brighton and Hove area and healthcare professionals.
<p>Museums on Prescription</p>	<p>Bath 'Recollection' pilot, Holburne Museum, Avon & Wiltshire Mental Health Partnership NHS Trust, and Bath Artists' Studios, funded by charitable trusts</p>	<ul style="list-style-type: none"> • Activities based on cultural aspects of tea-drinking using the museum's tea-related objects comprised gallery visits, tea and cakes in a traditional setting, and art skills classes in response to collections (e.g. decorating plates) • Maximum of 6 participants plus carers referred to 10 weekly sessions as part of an overall treatment plan; project ended with a 10-day public exhibition and film. 	<ul style="list-style-type: none"> • Aimed to support people with early stage dementia and their carers to access creative and therapeutic activities in a non-clinical environment. • Activities were devised to awaken memories of tea-drinking and prior interests in art; carers encouraged to think about how they could continue activities at home.

Social Prescribing	Keynsham 'Social Prescribing' pilot, Keynsham, North Somerset	<ul style="list-style-type: none"> • GPs and practice staff were asked to determine how social prescribing could integrate with existing services and reach suitable users. • 23 GPs in 3 practices asked to identify frequent attenders; which was problematic as practices used different databases and could not reliably account for frequency; instead audit of patients attending over 1 week was conducted where 7 GPs identified suitable referrals. 	<ul style="list-style-type: none"> • Aimed to reach a significant proportion of primary care users in the local area, and consider the factors influencing the role of social prescribing in primary care. • Interviews with patients showed that GPs were regarded as the people most likely to address their needs despite being embedded in medical model.
Supported Referral	'The Amalthea Project' supported referral, Avon	<ul style="list-style-type: none"> • All patients displaying psychosocial problems were considered eligible and referred by the GP and primary healthcare team to one or more activity; referrals were managed by voluntary organisation that trained and supervised project facilitators. • Patients were offered an initial assessment within 7 days of referral and follow ups at 1 and 4 months where they were given support and encouragement to continue attending; project linked 161 patients from 26 general practices with local and national voluntary support. 	<ul style="list-style-type: none"> • Aimed to compare cost of GP care alone to GP care plus referral to Amalthea; referral to Amalthea (£153) cost more than GP care alone (£133) over 4 months but cost difference minimal compared with specialist referral • Referral to Amalthea reduced negative emotions, and patients felt more positive about quality of life and ability to carry out everyday activities, although major depressive disorder was unaffected.
	Swindon 'Supported Referral', Wiltshire	<ul style="list-style-type: none"> • Primary care-based psychology and counselling service that used a 3-tier stepped referral model adapted to incorporate a range of social prescribing options, including assisted access, information referral and supported referral. • Supervised and trained volunteers helped with groups and offered individual support with no waiting list; minimum intervention involved 1-2 appointments, self-help literature and coping skills teaching. 	<ul style="list-style-type: none"> • Service was based on the premise that psychological services have a responsibility to the whole patient population to offer community support, knowledge about psychological approaches, and coping skills. • For many participants, Level 1 was sufficient; after 12 months outcomes led to reduced GP consultation and referral to secondary care, and increased patient satisfaction.



Appendix IV. Eastern social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	Cambridgeshire and Peterborough 'Arts on Prescription' by Arts & Minds, linked to Cambridgeshire and Peterborough Foundation NHS Trust and the former Cambridgeshire PCT	<ul style="list-style-type: none"> • GPs, health promotion and social workers, occupational therapists, psychologists and counsellors referred patients to Arts on Prescription using referral form, with self-referral possible via email; service administered by Arts on Prescription Manager and Research Manager. • Intervention could be instead of or additional to IAPT and consisted of taster session followed by free weekly visual arts workshops facilitated by artist and mental health counsellor. 	<ul style="list-style-type: none"> • Aimed to operate recovery model of care for adults aged 18 plus with mild to moderate depression and anxiety (without severe mental health issues), working within the arts and mental health sector to endorse the positive role of the arts in mental health care. • Participants could join partway if others left and, after completion, were signposted to other arts activities in area.
Exercise on Prescription	Bedfordshire (including Flitwick) 'Activities for Health' exercise referral	<ul style="list-style-type: none"> • Prior to referral, patients were assessed in primary care using the HADs and given a fitness test to inform a rolling exercise programme of gym-based and other activities (e.g. aqua aerobics, circuits, healthy walks and Pilates) at a reduced cost per session. • Scheme accepted patients from 4 local GP practices with a range of health issues, chiefly cardiac and weight loss. Operated out of 3 sites with Flitwick Leisure Centre the longest established. 	<ul style="list-style-type: none"> • Aimed to set up pilot project for exercise referral for patients with common mental health disorder and additional physical health needs, as part of the National Primary Care Mental Health Collaborative. • Flitwick began the project with PCT funded mental health training for 2 exercise staff and played a key role in disseminating project information to local GP practices.
	Cambridge 'Start-Up' and 'Invigorate' exercise referral schemes, Cambridge City Council's Sports Development Department	<ul style="list-style-type: none"> • Offered 2 schemes: 'Start-Up' for people with mild and emerging mental health issues and 'Invigorate' for people with established mental health issues. • Start-Up ran from two leisure and several community centres, and was staffed by Level 3 Exercise Professionals who undertook initial assessment and planned 12-week exercise programmes (e.g. aqua mobility and gym training). No free activities provided other than for home-based programmes, though a local Leisure Card scheme offered discounts. 	<ul style="list-style-type: none"> • When scheme started only GPs able to refer however with the introduction of the National Quality Assurance Framework for Exercise Referral Systems (2001), guidance was provided for allied health professionals to refer (e.g. physiotherapists and practice nurses). • After completion, participants were signposted to Invigorate which had free membership but no individualised support.



Appendix V. East Midlands social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	'Arts on Prescription', City Arts Nottingham, and Community Development Foundation, funded by Lloyds TSB, Nottingham North & East Consortium, NHS Nottingham City and Hardship Fund (originally by New Deal for Communities)	<ul style="list-style-type: none"> • GPs, health promotion and social workers, occupational therapists, psychologists and counsellors referred participants to scheme using a referral form; with self-referral route via email; service ran by Arts on Prescription Manager and Research Manager. The last 3 years of the programme were delivered in partnership with Central College and City Arts but scheme on hold as no longer guaranteed funding to support an artist to deliver the programme. • The prescription could be instead of or additional to IAPT in keeping with guidance for low-intensity IAPT that recommends signposting to art facilities as Step Two within stepped IAPT provision. 	<ul style="list-style-type: none"> • Scheme aimed to operate a recovery model of care for adults aged 18 plus with mild to moderate depression and anxiety without severe mental health issues and not a disruptive influence in their GP's opinion. • Scheme gave GPs a range of options when helping patients with complex social problems, particularly in the light of day service provision closures. Participants were able to build confidence, develop skills find meaningful occupation, express themselves and benefit from peer support.
Education on Prescription	Nottingham 'Prescription for Learning'	<ul style="list-style-type: none"> • GPs, practice nurses, health visitors and mental health nurses referred patients with symptoms of anxiety, low self-esteem and chronic pain. • Two-thirds of referrals had no academic qualifications and had not accessed any form of learning since leaving school. 	<ul style="list-style-type: none"> • Aimed to provide patients with confidence to reduce dependency on primary care professionals. • Scheme enhanced self-esteem, lifted mood, improved sleep and widened social networks; giving greater sense of control, hope and optimism; and produced healthier behaviours.
Exercise on Prescription	'Exercise Referral Prescription', Lincolnshire Sports Partnership funded by Public Health Lincolnshire	<ul style="list-style-type: none"> • Exercise practitioners employed to act as link between GPs or other health professionals. • All 7 districts of Lincolnshire offered exercise programme to residents aged 18 plus. 	<ul style="list-style-type: none"> • Aimed to improve health through sports activities • Attended by around 4000 participants per year; 3-year programme attended by over 6600 participants with just under two-thirds completion rate.



West Midlands

Appendix VI. West Midlands social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Green Gyms	Birmingham 'Green Gyms', funded by Mondelēz International Foundation	<ul style="list-style-type: none"> Referral by GPs and other health professionals, also self-referral pathway possible. The Conservation Volunteers (TCV) were supported by other local partners to deliver community programme in South Birmingham. 	<ul style="list-style-type: none"> Aimed to promoting healthier lifestyles through offering green gyms and developing community allotments. Local residents became involved in growing their own fruit and vegetables.
Information Prescription	North Staffordshire 'Signposting Project'	<ul style="list-style-type: none"> Service situated within two general practices where primary care staff made recommendations of suitable local services and resources rather than formal referral. GPs used directory to signpost patients with complex needs to Patient Advice & Liaison Service (PALS). Service used directory that was comprehensive but not exhaustive and acknowledged that services were not appropriate for all users. 	<ul style="list-style-type: none"> Aimed to promote mental health in addition to reducing social exclusion faced by mental distress. Service was valued but put an extra work load on healthcare staff. Recommended that other projects should consider training for primary care staff in contact with service-users to familiarise them with available services.

Appendix VII. Yorkshire and the Humber social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Books on Prescription	Barnsley 'Books on Prescription' and 'Bibliotherapy', Barnsley Library and Information Service, Barnsley Council	<ul style="list-style-type: none"> Carried out pilot project (2014) and launched the Books on Prescription Dementia (2015). Books were prescribed by GPs or other health professionals; patients took the prescription to a local library where a book could be borrowed for up to 3 weeks or reserved from another library. 	<ul style="list-style-type: none"> Aimed to improve health and wellbeing through self-help reading. Scheme set up alongside bibliotherapy reading groups in the libraries.
	Kirklees 'Reading Well Books on Prescription', West Yorkshire, Fresh Horizons Community Enterprise	<ul style="list-style-type: none"> Scheme situated in community managed Kirklees Library also involved a volunteer managed cinema within the library. In keeping with the Reading Agency's national scheme, Kirklees library offered freely available self-help reading for adults with mental health conditions (e.g. anxiety, depression, phobias and some eating disorders). 	<ul style="list-style-type: none"> Aimed to grow engagement with excluded groups and draw on the expertise of the Open Cinema. Provided local film-making and film-showing opportunities.



Yorkshire and the Humber

<p>Green Gym</p>	<p>Doncaster 'Green Gym', local PCT and The Conservation Volunteers (TCV)</p>	<ul style="list-style-type: none"> • Activities for people with learning difficulties with help from local community (e.g. taking over derelict allotment and planting vegetables). • People referred by local PCT were helped to take part in activities by TVC community support workers. 	<ul style="list-style-type: none"> • Projects aimed to provide healthy workout in the open air and contribute to local conservation work. • Encouraged teamwork and new skills; gardening activities provided fulfilment and satisfaction.
<p>Healthy Living Initiatives</p>	<p>Bradford and Airedale 'Health Trainer Programme'</p>	<ul style="list-style-type: none"> • Programme supported 3,500 people in health and wellbeing over 5 years (2006-11). • Employed health trainers, with qualification to practice including City and Guilds Level 3, and health professionals (e.g. nurses and pharmacists) trained to support people to make healthy choices, raise awareness of health benefits, and improve knowledge and skills. 	<ul style="list-style-type: none"> • Aimed to offer short term support with most health trainers seeing a participant for six sessions. • Found some overlap of health professional and health trainer roles.
<p>Social Prescribing</p>	<p>Bradford Community Health Advice Team 'CHAT' social prescribing scheme pilot, Bradford South and West PCT, Bradford Metropolitan Borough, West Yorkshire</p> <p>Rotherham 'Social Prescribing' pilot, South Yorkshire delivered by Voluntary Action Rotherham (VAR) on behalf of NHS Rotherham, funded by CCG</p>	<ul style="list-style-type: none"> • CHAT offered up to 3 x 40 minute sessions in two medical practices, the Ridge (Great Horton and Wibsey) and Royds Healthy Living Centre (Buttershaw) plus 10 weeks of 'Healthy Lifestyle Healthy Living' sessions at Highfield Health Centre, and acted as a bridge between primary care and voluntary sectors with workers able to spend longer with patients than healthcare staff. • Any member of the primary health care team (e.g. GPs, receptionists, nurses, district nurses and health visitors) could refer by completing referral form; patients could also self-refer by filling in a tear off slip on a leaflet available from surgery receptions and local pharmacies. <ul style="list-style-type: none"> • 2-year pilot project plus 1-year extension with 33 GP practices participating by end of scheme, administered by full time Project Manager and 5 part time Voluntary and Community Sector Advisors. • Advisors took referrals from GPs and met with patients to discuss their needs before recommending 	<ul style="list-style-type: none"> • Aimed to broaden service provision for patients with non-clinical needs and facilitate links between primary care and voluntary sector providing access to expert knowledge as part of holistic practice. • Found that over 80% of patients visited healthcare professional on fewer occasions in the 6 months after pilot than in the 6 months before it; scheme was relevant and appropriate for staff and service-users who expressed positive outcomes such as access to non-stigmatised support and reduced isolation. <ul style="list-style-type: none"> • Part of GP-led Integrated Case Management Pilot that aimed to increase capacity of GP practices to meet the non-clinical needs of their patients with long term conditions. • In first 2 years, 1607 patients were referred (c.130 per month) with majority (1,118) to services

		relevant activities or organisations, attended case management team meeting for patients with long term conditions and reported back on patients referred by the service.	funded directly by the project; most referrals were for older adults (e.g. advice, community activity and enabling).
Social Prescribing	Yorkshire and the Humber 'Social Prescribing' pilot, funded by Age UK through DH Strategic Partners Programme, and Age Concern Support Services	<ul style="list-style-type: none"> • Set up pilot that advocated partnership working between GPs and voluntary sector; project worked with 12 GP practices, 4 of which piloted weekly or fortnightly social prescription clinics in surgeries and 6 Age UK branches. • GPs referred older adults who had mild to moderate depression or were lonely and socially isolated to Age UK services (e.g. art groups, befriending, day and luncheon clubs, computer training, fitness and memory loss classes) and other organisations (e.g. transport, handyman and local community groups), incurring a small cost. 	<ul style="list-style-type: none"> • Aimed to provide in-depth assessment of older adult social, emotional and practical needs. • Age UK reported wellbeing improvement though in busy GP practices it was not always possible to keep up with the range of services that local voluntary and community sector offered; a co-ordinated approach by voluntary sector agencies was needed with one organisation taking the lead in managing assessment and referral.
Supported Referral	Doncaster 'Patient Support Service' (PSS) and 'Social Prescribing' pilot, South Yorkshire Housing Association (SYHA) and Doncaster CVS	<ul style="list-style-type: none"> • GPs or practice nurses assessed by PSS wrote a prescription for referral to the advisor to connect patient to a suitable support group in a community-based service as an adjunct to traditional general practice. • Advantages of having an advisor meant that neither GP nor patient needed to be aware of or search through all available schemes to locate an appropriate one. 	<ul style="list-style-type: none"> • GPs aimed to recognise and treat additional issues to those treated medically. • Semi-structured interviews with 11 patients and 9 staff showed PSS successfully employed the voluntary sector to support patients. PSS won an NHS Alliance Award (2014) for best Provider Collaboration.

Appendix VIII. North East social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	Durham 'Arts for Wellbeing' scheme, County Durham	<ul style="list-style-type: none"> • Service specification by County Durham PCT stated that scheme was a primary prevention service and not intended as a therapy. • Intervention comprised 6, weekly, artist-led sessions mainly for new parents, carers and people with long term conditions. 	<ul style="list-style-type: none"> • Overall aim to increase service-user resilience, confidence and self-esteem. • Principles of service were intended to be assessable, demand-led evidence-based, flexible, non-medical, preventative, and social.



North East England

<p>Arts on Prescription</p>	<p>North and South Tyneside 'Taking Part Workshops' arts on prescription pilot</p>	<ul style="list-style-type: none"> • Two year pilot initiated by two Newcastle GPs to give tuition in South Asian music and singing for patients with mild anxiety. • Referral routes through health care professionals or self-referral route to 10 weekly sessions. Post-course assessment from referrer, and signposting to further arts activities and volunteering opportunities. 	<ul style="list-style-type: none"> • Aimed to connect mental health referrals from primary care to arts studios. • GPs and other referrers used Short Form (SF-36) to assess progress but most participants considered the questionnaire intrusive, stress-inducing and at odds with the intention to induce relaxation.
<p>Social Prescribing</p>	<p>Newcastle upon Tyne 'People Powered Health' Metropolitan Borough Tyne and Wear, NESTA funding with five voluntary and community sector partners</p>	<ul style="list-style-type: none"> • HealthWorks social enterprise scheme worked with Newcastle CCG to provide health trainers and volunteer champions as part of a service that was delivered over 15 months with a project manager to support the social prescribing activities and health trainers. • Vulnerable people with multiple needs were referred to non-clinical community services; inclusion criteria for referral were primarily, aged 50 plus with one long term condition and secondarily, being a smoker, having a BMI over 30, or living in a deprived ward. 	<ul style="list-style-type: none"> • Aimed to develop a link worker service with voluntary organisations, develop a web information resource and raise awareness in health professionals. • In a high population area where over fifth were major users of health and social care services with long term conditions (e.g. social phobia and anxiety) many people had high level needs, so recommendations were made to change assessment criteria and give health trainers further training.
	<p>North Tyneside 'Taking Part Workshops' social prescribing, subsequently (2007) described as 'Community Interest Company'</p>	<ul style="list-style-type: none"> • Workshops comprised adult education classes (e.g. art, bike riding, choirs, computing, creative writing, drama, exercise, gardening, knitting personal development and relaxation). • Options more restricted in Morpeth, Hexham, Alnwick and Berwick upon Tweed and sessions only free in North Tyneside and Newcastle 	<ul style="list-style-type: none"> • Aimed to offer workshops to people at risk of common mental disorders (e.g. anxiety and depression) in conjunction with GPs, community health professionals, social workers and third sector agencies.
	<p>Teesdale 'Good for the Soul' pilot, Teesdale and Wear Valley District Councils, County Durham</p>	<ul style="list-style-type: none"> • Social prescribing pilot project carried out and report of pilot findings written by Councils. • Report recommended that induction training should be given by experts in arts, arts development and health to those intending to work on similar future projects such as coordinators, managers and artists. 	<ul style="list-style-type: none"> • Aimed to consider participant progression on pilot project. • Council report on pilot project concluded that impact on participant progression should have been monitored before during and after participation, and that an independent longitudinal evaluation should have been commissioned.



The North West

CHESHIRE & MERSEYSIDE

Appendix IX. North West social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Arts on Prescription	Salford 'Start: Time Out' arts on prescription	<ul style="list-style-type: none"> • Signposted services for adults with mental health issues. • Self-referral process in place but recommended that potential participants should ask GP or another health professional to refer them to scheme 	<ul style="list-style-type: none"> • Scheme aimed to use creativity to help vulnerable people improve skills, gain confidence and become valued members of community.
Facilitated Referral	Manchester 'Referral Facilitation Service' Family Welfare Association (FWA)	<ul style="list-style-type: none"> • Employed Family Support Coordinators to provide advice, support and counselling services for individuals and families. • Service anonymous therefore less stigmatising than statutory social services. 	<ul style="list-style-type: none"> • Aimed to offer referral facilitation service in primary care setting. • Over 1200 referrals in 2.5 years; uptake for emotional and minor mental health issues (53%) and material problems such as housing (41%).
	Bolton 'Social Prescribing', Metropolitan Borough of Bolton in Greater Manchester	<ul style="list-style-type: none"> • Social Prescribing Directory, disseminated to GP practices and health centres, compiled listings of non-clinical services and how to make referral, • Self-referral route possible other than for exercise referral. 	<ul style="list-style-type: none"> • Aimed to address social and emotional issues using regeneration monies. • Difficulties encountered were lack of time to commit to training and changes to working practices.
Social Prescribing	'Social Prescribing' Cheshire and Merseyside Public Health Collaborative Service (CHAMPS) working jointly with Cheshire and Merseyside Strategic Clinical Network (CMSCN)	<ul style="list-style-type: none"> • Preventative service for patients with sub-clinical, low wellbeing aligned to NICE Step 1 care as adjunct to clinical treatment and part of wellbeing maintenance and recovery for Steps 2, 3 and 4. • CHAMPS (2015) published integrated social prescribing commissioning model to scale up provision. 	<ul style="list-style-type: none"> • Aimed to provide access to non-medical (social and psychological) sources of primary care via social prescribing. • Recovery approach adopted by mental health trusts often mirrored social prescribing offer for higher intensity patients.
	East Lancashire 'North West Social Prescribing Development Project', North West Care Services Improvement Partnership	<ul style="list-style-type: none"> • Launched at 4 pilot sites (Sefton, Stockport, East Lancashire and the Fylde Coast). In East Lancashire, a multi-agency partnership was established to develop local service provider commitment to social prescribing that drew the existing schemes (arts, bibliotherapy, citizens' advice in primary care, physical activity and voluntary sector) into a coherent model. 	<ul style="list-style-type: none"> • Aimed to incorporate social prescribing into county-wide plans to develop local information gateways. • Scheme received an Impact Award for good collaboration between health and voluntary sectors.

Social Prescribing	Fylde Coast 'North West Social Prescribing Development Project', Lancashire, North West Care Services Improvement Partnership	<ul style="list-style-type: none"> • Launched at 4 pilot sites (Sefton, Stockport, East Lancashire and the Fylde Coast). The Fylde Coast site was accepted as a Local Area Agreement target. • Green exercise schemes were set up in partnership with North Lancashire PCT, borough councils and local service providers, and Lancashire Wildlife Trust. 	<ul style="list-style-type: none"> • Aimed to incorporate social prescribing into county-wide plans to develop local information gateways. • Scheme received an Impact Award for good collaboration between health and voluntary sectors.
	Salford 'Refresh' social prescribing, Salford Health Matters, Greater Manchester	<ul style="list-style-type: none"> • Patients referred to scheme through GP practices. • Funding for scheme ended Oct 2011 although patients continued to be signposted to activities via website. 	<ul style="list-style-type: none"> • Aimed to tackle health concerns through community activities to complement medical treatment. • Led to fewer GP visits and reduced number of medical prescriptions.
	Sefton 'North West Social Prescribing Development Project' pilot, Sefton Metropolitan Borough of Merseyside North West Social Prescribing Development Project and Public Health Partnership Mental Health Group	<ul style="list-style-type: none"> • Activities included 'Active Sefton' (adult mental health) and 'Active Lifestyle' (young adult mental health) exercise referral schemes led by Sefton Leisure Services; 'Relax & Revive' (adult mental health) physical activity programme led by Sefton PCT; Active Reading (mental health) self-help open-access bibliotherapy and audio resource jointly run by Sefton PCT and library service; Citizens' Advice Bureau 'Health Outreach' project in GP practices and community centres; and 'Creative Alternatives', an arts on prescription scheme led by Sefton Council Arts Services. 	<ul style="list-style-type: none"> • Aimed to co-ordinate existing social prescribing schemes. • Implemented a stepped care recovery model, seeking firstly to treat service-users at the lowest appropriate service tier and only 'stepping up' to intensive or specialist services as required; and practice-based commissioning to secure a sustained commitment to social prescribing. • Exit strategy for 'Creative Alternatives' called moving forward provided an invitation to join mainstream arts activities plus home activity pack.
	Stockport 'North West Social Prescribing Development Project' pilot, Greater Manchester, North West Care Services Improvement Partnership	<ul style="list-style-type: none"> • Stockport was selected as it had already developed and evaluated an Arts on Prescription scheme (15-week basic skills course) located in a PCT-funded health promotion service. Patients were referred by GPs and other health workers to local arts organisations. • Stockport had a high-street-based wellbeing centre offering information and range of activities, and developed a Books on Prescription and an Exercise on Referral scheme focused on coronary heart disease. 	<ul style="list-style-type: none"> • Aimed at adults with mild to moderate mental health needs referred by a mental health worker. • Participants were primarily women; those who completed both courses could join a self-managed 'Move On' group with support offered by a mental health worker to individual participants.



Appendix X. Wales social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Books on Prescription	Wales 'Museums, Libraries and Archives', Welsh Assembly's Culture and Poverty Report investment (2015)	<ul style="list-style-type: none"> Report announced investment to widen access to museums, libraries and archives and encourage use of collections. Funding to enhance 'Sharing Treasures Programme' (where local museums partner larger museums), modernise 7 public libraries into community hubs; and set up a national digital library. 	<ul style="list-style-type: none"> Aimed to increase users in the 100 most disadvantaged communities in Wales ('Communities First' areas). Report explored how social justice could be promoted through arts, culture and heritage, and recommended joint-working to ensure accessibility of culture to all Welsh communities.
Exercise on Prescription	Wales 'National Exercise Referral Scheme' (NERS), funded by Welsh Government	<ul style="list-style-type: none"> Each intervention consisted of 16 supervised weekly, 2-hour group sessions carried out in leisure or community centres with some outdoor activities (cost £1.50-£2). Scheme targeted at patients with or at risk of developing chronic disease, referred by range of health professionals, with self-referral route possible. 	<ul style="list-style-type: none"> Aimed to standardise exercise referral across the 22 Local Authorities and Local Health Boards in Wales. Led to increased levels of physical activity with positive effects on depression and anxiety; economic evaluation demonstrated cost per quality adjusted life years (QALY) of £12,111.

Appendix XI. Scottish social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Green Gyms	Scotland 'Green Gyms', TVC, funded by Scottish Natural Heritage (SNH) and Scottish Government	<ul style="list-style-type: none"> Developed volunteering opportunities across Scotland to manage and improve projects on designated sites and in local community green spaces including deprived areas. 	<ul style="list-style-type: none"> Aimed to support network of community-based organisations to take practical action locally with access to training and skills development opportunities.
Healthy Living Initiatives	Aberdeen 'Healthy Living Network', north-east Scotland	<ul style="list-style-type: none"> Developed 3 main health improvement programmes: 'Cash in your Pocket', 'Active Futures' and 'Working for Families Fund' Participants were referred through voluntary and statutory sector rather than primary care, to community activities (e.g. arts and creativity, benefits advice, complementary therapies, and parenting support) 	<ul style="list-style-type: none"> Aimed to improve financial circumstances, life choices and skills of local people in addition to having greater influence on local health policy and services. Supported local communities and groups wanting to establish opportunities and make changes in people's lives.

Scotland



Healthy Living Initiatives	Bute 'Healthy Living Initiative', Western Scotland, funded by Heritage Lottery coordinated by Health Inequality Specialist, Argyll & Bute NHS Highland	<ul style="list-style-type: none"> • Isle of Bute centre offered a variety of self-referral programmes and previously ran 20-week activity programme for adults aged 60 plus. • Formal referral process by GPs and community psychiatric nurses for exercise referral with plan to develop pilot project for art therapy. 	<ul style="list-style-type: none"> • Aimed to increase health and wellbeing through activities for all ages (e.g. arts and crafts, community allotment, community café, complementary therapies, gardening and walking for health, and self-help groups).
	'Community Food and Health Scotland' (CFHS) (Community Diet Project) funded through Scottish Government	<ul style="list-style-type: none"> • Worked with disadvantaged communities at geographical level (e.g. neighbourhoods) and common interest level (e.g. mental health service users and travellers). • Ran programmes around capacity building, engagement, impact, inclusion and practice within an asset-based approach. 	<ul style="list-style-type: none"> • Aimed to ensure everyone had the opportunity, ability and confidence to access healthy and acceptable diet • Supported work with low-income communities that addressed health inequalities and barriers (availability, affordability, skills and culture).
	Dundee 'Healthy Living Initiative', NHS Tayside and Dundee City Council, Big Lottery Fund	<ul style="list-style-type: none"> • Community development and health activities offered around 90 weekly sessions (e.g. cooking skills, community health, exercise, first aid, health checks, healthy lifestyle, mental health, smoking cessation, and weight reduction. 	<ul style="list-style-type: none"> • Aimed to work with disadvantaged communities to tackle health inequalities. • Approach used principle of social model of health where people identify their own health needs and solutions.
	Eymouth 'Healthy Living Group', Scottish Borders	<ul style="list-style-type: none"> • Weekly classes in Yoga, Exercise for Fun, and Chi Gong plus Tai Chi with fees £20 pounds per term plus £5 to access further course or one-off sessions at £2 each. 	<ul style="list-style-type: none"> • Aimed to improve the health and wellbeing of people living in the Port of Eyemouth through community-based activities at a subsidised cost.
Information Prescription	Mearns and Coastal 'Healthy Living Network' and 'Signposting Project', Aberdeenshire	<ul style="list-style-type: none"> • Network established in partnership with statutory and voluntary and community organisations. • Provided services (e.g. shopping, transport and handyperson) incurring small charge. 	<ul style="list-style-type: none"> • Aimed to improve health and increase older adults' mental capacity through the 'Older People's Network', training, information and intergenerational activities.
	Sandyford 'Health Screen and Information Prescription', Greater Glasgow and Clyde	<ul style="list-style-type: none"> • Specialist sexual and reproductive health service offered counselling at community-based hubs in belief that good emotional and mental health, were central to good sexual health. • Following health screening participants given information prescription to take to library to 	<ul style="list-style-type: none"> • Aimed to increase people taking control of own health through use of library and free internet. Staff trained by to develop expertise in caring for people with experience of abuse and trauma. • In 2011 provided 4,600



Northern Ireland

		access material on wide range of health issues, as well as details of local groups and resources.	sessions for 1,100 adults supported with issues affecting emotional and mental health.
	Aberdeenshire 'Signposting Project' and extension of scheme, 'Signposting Out and About Project'	<ul style="list-style-type: none"> Referral through GP surgeries, community hospitals and self-referral route to patients, carers and families at risk of developing deterioration in mood. Extension of scheme linked like-minded people with shared interests, individually or as part of group, for company and support. 	<ul style="list-style-type: none"> Aimed to increase engagement and access to local resources, reduce isolation and enhance coping skills. Enabled people with mild to moderate mental health issues to access services within community to enhance quality of life and shared interests.
Supported Referral	East Ayrshire 'CHIP Lifestyle Referral Scheme' South-west Scotland, Community Health Improvement Partnership (CHIP)	<ul style="list-style-type: none"> GP and other health professionals referred for chronic physical health, risk factors and mental health issues, with self-referral possible. CHIP team conducted consultations and agreed activity and goals with participants. 	<ul style="list-style-type: none"> Aimed to link participants with advice and support on healthy eating, physical activities and smoking cessation. CHIP offered advice and support through CHIP van, classes and walks.
	Lothian Bridges 'Focus on Recovery' supported referral, East Scotland	<ul style="list-style-type: none"> Activities (e.g. arts and crafts, complementary therapies, visits and walks) focused on developing skills, making new friends, managing time, trying new activities and thinking about the future. Referral through GPs and community mental health nurses, with self-referral route possible. 	<ul style="list-style-type: none"> Recovery project aimed at reducing social isolation among people with mental illness in the rural area of Edinburgh so they could move on with their lives. Less reliance on health services led to reduction in GP visits and medication; some participants moved to education or work.
	'Pilmey Development Project' (PDP), Leith, funded by City of Edinburgh Council and local fundraising	<ul style="list-style-type: none"> Community voluntary organisation worked with local people to identify and deliver actions contributing to sustainable development. Free activities included 'Drop in on Tuesdays', 'Older Men's Group' and 'Women's Group'. 	<ul style="list-style-type: none"> Aimed to support residents and encourage active engagement with health and care service providers, and self-help in resolution of problems. Improved quality of life, and supported local groups.

Appendix XII. Northern Ireland social prescribing schemes

Type of scheme	Provider and funder	Description and referral process	Aims and outcomes
Green Gyms	Northern Ireland 'Ecotherapy'	<ul style="list-style-type: none"> Referral by health and social service providers, with self-referrers finding out about schemes via word of mouth, posters and websites Survey of 89 ecotherapy pilot projects (e.g. gardening) was carried out, with responses from over half of 46 service providers. 	<ul style="list-style-type: none"> Aimed to assess potential for extending research to test effectiveness of eco-therapy for alcohol-related problems Key outcomes included developing confidence, leadership and communication skills, and working with others.

8.2 Non-UK social prescribing schemes

Twelve examples of social prescribing and community referral schemes from non-UK literature were selected as illustrations of different strategies and methodologies used to assess their effectiveness.

Appendix XIII. Summary of findings from evaluated non-UK schemes

Country	Scheme	Authors	Evaluation Summary
Australia	Australian 'Exercise Referral' study	Wand & Murray (2008)	<ul style="list-style-type: none"> Physical health of mental health service-users related to negative symptoms and lifestyle (e.g. detrimental side-effects of medication, and lack of confidence or skill in relation to physical health) acknowledged as requiring urgent action. Found significant benefits of exercise implying that mental health nurses and support staff should play an active role in health promotion, primary prevention, early detection and management of service-user physical health.
Canada	Vancouver and North Vancouver 'Arts, Health and Seniors' project	Phinney, Moody, Pickersgill, Solorzono & Naylor (2012)	<ul style="list-style-type: none"> Involved 51 participants aged 65-86 at 4 sites. Project found improved physical wellbeing, greater social inclusion, increased confidence and an enhanced sense of accomplishment. Significant improvements in areas of perceived health status, chronic pain and sense of community. Some participants felt that the questions did not make sense or that they did not fit the mould.
Denmark	Vejle and Ribe 'Exercise on Prescription'	Sorensen, Kragstrup, Skovgaard & Puggaard (2008)	<ul style="list-style-type: none"> RCT (2005-06) in primary health care compared effects of counselling alone (low intensive group) for 52 participants, and with supervised exercise (high intensive group) for 275 participants referred by GPs in counties of Vejle and Ribe. Low intensive group attended 4 motivational sessions whereas high intensive group attended 5 motivational sessions plus 4 months of supervised, group-based exercise training. Found no significant differences between groups.
New Zealand	Auckland study of GP attitudes to community-based resources (social prescribing)	Wilson & Read (2001)	<ul style="list-style-type: none"> Explored issues GPs discussed with mental health patients to determine which treatments and support services to use, and examined referral barriers for community-based resources. 86 out of 217 Auckland GPs responded to vignette case study of woman with depression in absence of suicide risk; 55 to questionnaires (Likert scales and 3 open-ended questions), and 12 to interviews. Qualitative analysis found that GPs valued biological or psychological solutions, and reported limited referral to outside resources.

Spain	Cáceres exercise referral walking programme	Gusi, Reyes, Gonzalez-Guerrero, Herrera & Garcia (2008)	<ul style="list-style-type: none"> • RCT examined the cost-utility of standard primary care plus a supervised walking programme for older women compared with primary care alone. Inclusion criteria were age 60 plus, with moderate depression (6-9 points on 15-item Geriatric Depression Scale) or overweight (BMI 25-39.9 kg/m²) and able to walk for more than 25 minutes. Exclusion criteria were poor health, debilitating medical issues, an unstable cardiac condition, or attention or comprehension deficits. • 55 participants were assigned to intervention group (6-month walking-based program of 3 x 50-minute weekly sessions) and 51 to control group (life as usual). 86% completed programme. Outcome measures were healthcare costs and QALY using EuroQol (EQ-5D). Over 6 months, treatment cost for an intervention participant was €41 more than a control participant. Each extra QALY gained by intervention programme relative to primary care alone cost €311, which was regarded as cost effective.
Taiwan	Taiwan 'prescribed exercise'	Ma, Lane & Laffrey (2008)	<ul style="list-style-type: none"> • Tested theoretical model of barriers to physical activity for 239 Taiwanese adults with anxiety. Used structural equation modelling to examine direct and indirect influences of 11 personal and cognitive-emotional factors on physical activity. • Final model provided a good fit to the data where 9 variables explained 23.3% of variance in physical activity. Perceptions of life stress events, benefits of activity and self-efficacy directly influenced participation. Suggested that variables should be addressed in designing physical activity treatment programs for people with anxiety in Taiwan.
United States of America	North Carolina Modern Dance trial	Batson (2010)	<ul style="list-style-type: none"> • Feasibility study of 11 adults aged 61-84 (mean 72.5) with early-to-middle-stage Parkinson's disease took part in dance classes with GP clearance to participate. No control group. • Pre-post comparisons Fullerton Advanced Balance scale showed significant improvement. Cost effective means of expressive exercise compared with other interventions. Participants found pace too fast for complex steps and music needed to be at higher volume for everyone to hear.
	Richmond, Virginia 'East End Exchange' time bank	TimeBanking UK (2011)	<ul style="list-style-type: none"> • East End Exchange (E3) developed to strengthen families, neighbourhoods and businesses in East End of Richmond into a connected and self-supporting community that celebrated diversity. E3 was named after a time bank set up in Portland, (Maine Time Dollar network) in late 1990's and catalyst for more time banks across Maine, New England, New York and Pennsylvania over 15 years. • Time bank involvement reduced hospital admissions, visits to casualty and asthma services, saving \$217,000 over 2 years.

United States of America	Washington DC 'The Creativity and Aging Study'	Cohen, Perlstein, Chapline & Kelly (2006)	<ul style="list-style-type: none"> • RCT aimed to measure impact of community-based cultural programmes on general health, mental health and social activity of 300 adults aged 65-103 (mean 80) split between intervention group (weekly arts programme for 2 years) and matched control group (life as usual) over 3 sites (Washington DC, Brooklyn, and San Francisco). Participants interviewed at the start and after 1 and 2 years. • Intervention group reported better health, fewer doctor visits, and less medication use; more positive responses on mental health measures; and more involvement in overall activities.
	Washington DC Choir singing	Cohen, Perlstein, Chapline, Kelly, Firth & Simmons (2006)	<ul style="list-style-type: none"> • RCT aimed to measure impact of community-based cultural programmes on general health, mental health and social activity of adults 65 and over, with 90 participants in intervention group (professionally conducted choir) and 76 in control group (usual activities) in Washington DC area. • Intervention group reported higher overall rating of physical health, fewer doctor visits, less medication use, fewer falls, better morale and less loneliness than control group who showed significant decline in total number of activities.
	USA 'Exercise Referral'	Diehl & Choi (2008)	<ul style="list-style-type: none"> • Evidence-based approach demonstrated that exercise affected health, mental health, disease prevention and productivity; this was an important topic because in the USA at that time less than 50% of the total population exercised on regular basis. • Lack of physical activity linked to an overall decline in health with increased rates of obesity and chronic disease.
United States of America and Serbia	'Exercise Referral'	McCormick, Frey, Lee, Chun, Sibthorp, Gajic, Stamatovic-Gajic & Maksimovich (2008)	<ul style="list-style-type: none"> • Hierarchical analysis of two mental health service-user groups in USA and Serbia referred through community mental health centres carried out to explore the effects of exercise on mood. Random samples of mood were taken over 7 days from 10 American and 12 Serbian participants using programmed time signals from a wrist watch to assess activity, behaviour and cognitions in response to 17 questions. Physical activity was measured by an 'accelerometer' worn on right hip. • Showed that people with mental distress had low levels of physical activity. The analysis found a positive association of physical activity with mood after accounting for individual variation in exercise level.



UCL



A Review of Community Referral Schemes

Linda J. Thomson, Paul M. Camic
& Helen J. Chatterjee