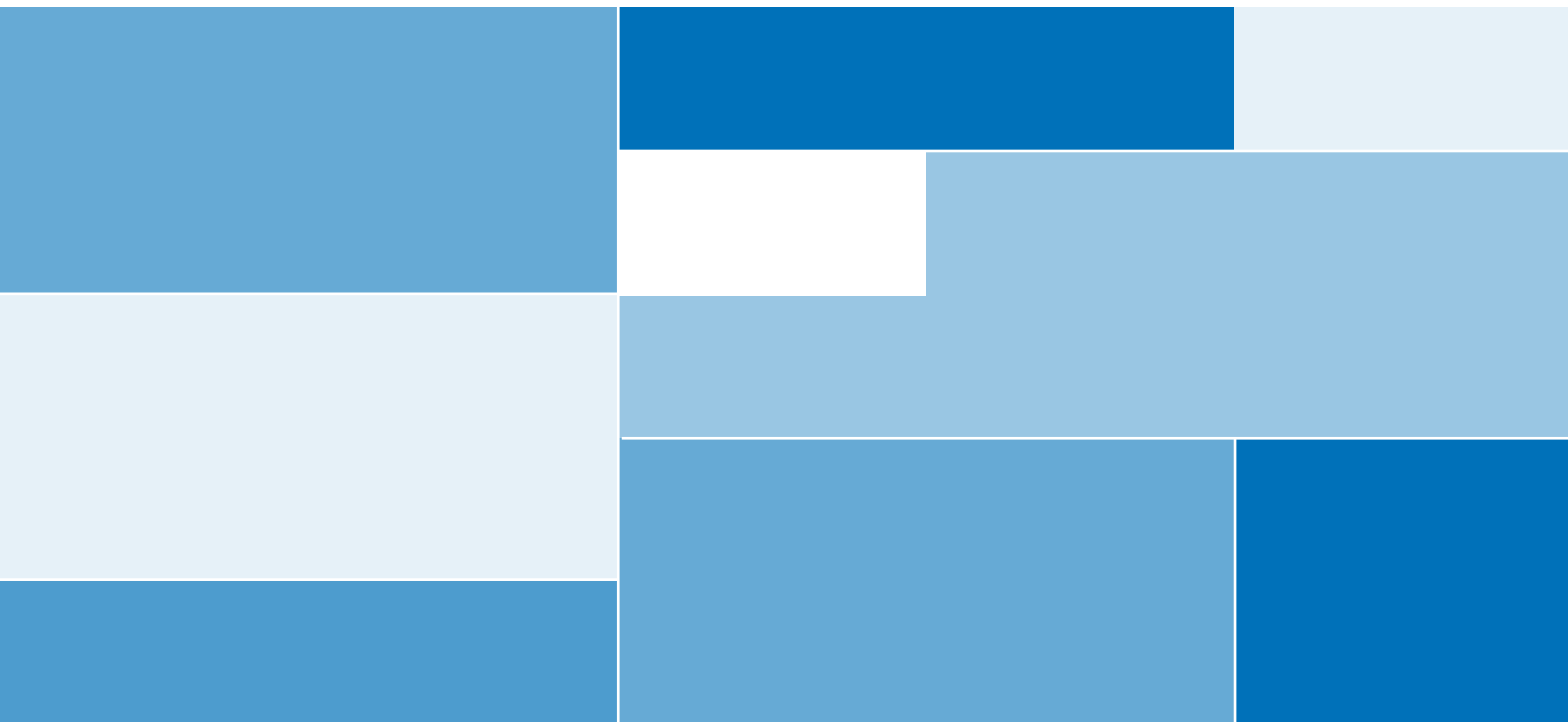


# Social prescribing for mental health – a guide to commissioning and delivery



# Contents

<b>1 Introduction</b>	<b>2</b>
<b>2 What is social prescribing?</b>	<b>3</b>
<b>3 Who is social prescribing for?</b>	<b>5</b>
<b>4 What are the outcomes of social prescribing?</b>	<b>7</b>
<b>5 Commissioning social prescribing</b>	<b>9</b>
<b>6 Policy context</b>	<b>19</b>
<b>7 Delivering social prescribing interventions</b>	<b>27</b>
<b>8 Examples of social prescribing initiatives</b>	<b>36</b>
<b>9 The North West Social Prescribing Development Project</b>	<b>48</b>
<b>10 Measuring success</b>	<b>54</b>
<b>11 Conclusions</b>	<b>56</b>
<b>References</b>	<b>57</b>

This guidance is a result of the CSIP North West Social Prescribing Development Project with East Lancashire Primary Care Trust (PCT), North Lancashire PCT, Sefton PCT and Stockport PCT. It has been jointly funded by CSIP North West Development Centre and the CSIP National Primary Care Programme.

Author: Lynne Friedli  
with Catherine Jackson, Hilary Abernethy  
and Jude Stansfield

# 1 Introduction

This guidance describes the use of non-medical interventions, sometimes called 'social prescribing' or 'community referral', to improve mental health and wellbeing. Social prescribing supports improved access both to psychological treatments and to interventions addressing the wider determinants of mental health.

Social prescribing has 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. These include leisure, welfare, education, culture, employment and the environment (for example urban parks, green gyms and allotments).

This guide:

- describes social prescribing and its benefits;
- outlines the policy context and evidence base for social prescribing;
- gives guidance on commissioning social prescribing;
- provides information on interventions and how to deliver social prescribing; and
- describes the findings of a social prescribing development project commissioned by Care Services Improvement Partnership (CSIP) North West.

Overall, the guidance aims to support localities in developing, implementing and evaluating social prescribing schemes, with a special focus on mental health and wellbeing.<sup>1</sup> It will be of particular interest to those with roles in commissioning services for the treatment and prevention of mental health problems and the promotion of mental health, and for managers and practitioners wishing to set up social prescribing initiatives. It will also be of interest to community and voluntary sector organisations and those working in sports, leisure, arts, education and sustainable development.

1 This guidance draws centrally on research carried out by Lynne Friedli for two publications: Friedli, L., Watson, S. (2004) *Social prescribing for mental health*, published by the Northern Centre for Mental Health, and the Scottish Development Centre for Mental Health (2007) *Developing social prescribing and community referrals for mental health in Scotland*, a report commissioned by the Scottish Government and written in partnership with the Scottish Development Centre for Mental Health ([www.sdcmh.org.uk](http://www.sdcmh.org.uk)). See [www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing](http://www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing). We are grateful to the Scottish Development Centre for Mental Health for permission to reproduce this material.

## 2 What is social prescribing?

Social prescribing is a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems. Social prescribing is usually delivered via primary care – for example, through ‘exercise on prescription’ or ‘prescription for learning’, although there is a range of different models and referral options.

Social prescribing for mental health provides a framework for:

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

### Social prescribing projects

The most common examples of social prescribing are primary care-based projects that refer at-risk or vulnerable patients to a specific programme: for example, **exercise on prescription**, **prescription for learning** and **arts on prescription**. However, it also includes a very wide range of initiatives in which primary or secondary care staff provide a signposting or gateway service, linking patients with sources of information and support within the community and voluntary sector.

Social prescribing includes a range of perspectives on the causes and treatment of mental health problems and different definitions of both mental health and mental disorders. The broader, holistic framework evident in social prescribing, with an emphasis on personal experiences, relationships and social conditions, may be more compatible with lay understandings of mental wellbeing and mental distress than a medical model (Rogers and Pilgrim 1997), although there is also considerable support among GPs for more holistic approaches.

### Expanding treatment options

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

While both medication and psychological therapies have a role, social prescribing provides a further opportunity to respond effectively, and at an early stage, to symptoms of mental distress, as well as to initiate a more proactive approach to mental health promotion.

# 3 Who is social prescribing for?

Social prescribing has been quite widely used for people with mild to moderate mental health problems, and has shown a range of positive outcomes, including emotional, cognitive and social benefits. Social prescribing may also be a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Bates 2002; Gask et al. 2000).

Broadly, social prescribing is one route to providing psychosocial and/or practical support for:

- vulnerable and at risk groups, for example low-income single mothers, recently bereaved elderly people, people with chronic physical illness, and newly arrived communities;
- people with mild to moderate depression and anxiety;
- people with long-term and enduring mental health problems; and
- frequent attenders in primary care.  
(Frasure-Smith 2000; Greene 2000; Harris et al. 1999)

Social prescribing may be particularly appropriate for isolated or marginalised groups, and for groups whose needs may be best met from within the voluntary and community sector (VCS). Some women and lesbian, gay, bisexual and transsexual people may find support from the VCS more accessible (Hutchison et al. 2003). Some black and minority ethnic (BME) communities have also expressed a strong preference for support provided within the BME voluntary sector (Mental Health Act Commission 2001; Department of Health 2003). In these cases, social prescribing via a referral facilitator or link worker can facilitate understanding between primary care providers and BME communities (Gillam and Levenson 1999).

## Expanding treatment options

*Looking Forwards* is a resource produced by Manchester PCT that includes information for patients and healthcare workers on bibliotherapy, exercise referral and computerised cognitive behavioural therapy (CCBT), together with details of how to access a wide range of support from the VCS. It also includes simple lifestyle guidance.

Overall, social prescribing is a means of extending the range of options available to people who present to primary care with psychosocial problems and, in doing so, making best use of specialist mental health resources (see Table 1).

**Table 1: Social prescribing as a route to strengthening protective factors for mental wellbeing**

Classification	Intervention impact	Social prescribing example
Strengthening psychosocial, life and coping skills of individuals	Interventions to promote self-expression, self-efficacy, self-esteem, opportunities to learn new skills, stress/anger/anxiety management and relaxation	Community education groups Arts/learning/exercise on referral Self-help groups/resources CCBT Bibliotherapy
Increasing social support as a buffer against adverse life events	Initiatives that help build social contacts through self-help groups, networks, collective action and opportunities for new friendships	Self-help groups Group activities on referral, e.g. walking, green gyms Volunteering Time banks
Increasing access to resources and services which protect mental wellbeing	Initiatives to promote benefit uptake, good quality employment, support in adversity (e.g. domestic violence, crime), and access to mainstream services and opportunities	Signposting to information and advice, e.g. on debt, benefit, housing, immigration, violence and crime Support with seeking help Supported education/employment Time banks

(adapted from Friedli 2003)

# 4 What are the outcomes of social prescribing?

Social prescribing is an emerging field and the evidence base for the effectiveness of different approaches and interventions varies (see Section 8). The long-term aim of social prescribing is to improve mental health and quality of life and/or to ameliorate symptoms.

Short- and medium-term outcomes include:

- increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of positive steps for mental health;
- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services;
- increased levels of social contact and social support among marginalised and isolated groups;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression, in line with National Institute for Health and Clinical Excellence (NICE) guidelines (NICE 2004);
- reduced waiting lists for counsellors and psychological services; and
- reduced levels of frequent attendance (defined as more than 12 visits to GP per year).

Assessment of social prescribing outcomes will include a combination of indicators designed to capture changes in:

- individual mental health;
- population mental health, e.g. within a local authority ward, prison or workplace;
- individual behaviour, e.g. physical activity, sensible drinking;
- quality of life;
- use of services, e.g. adult education, gyms, counselling; and
- professional practice, e.g. prescribing patterns.

There is a growing number of scales available for measuring different aspects of mental wellbeing, often referred to as 'positive mental health', in addition to scales that are used to detect a diagnosable disorder.<sup>2</sup> Measures for different indicators include:

- individual mental health improvement, e.g. General Questionnaire 12 (GHQ12), Well Being Questionnaire 12 (WBQ12), Affectometer 2;
- individual reduction in symptoms, e.g. Revised Clinical Interview Schedule (CIS-R);
- social support/social functioning, e.g. Social Support Questionnaire – Brief (SSQ-B);
- population or group mental health improvement, e.g. Warwick Edinburgh Mental Wellbeing Scale (WEMWBS),<sup>3</sup> Positive and Negative Affect Schedule (PANAS);
- health behaviours, e.g. health and lifestyle surveys, GP practice records; and
- quality of life, e.g. Delighted-Terrible Scale, Global Quality of Life Scale (GQOL).

More information on evaluating social prescribing is included in Section 10 (see also Section 5 on commissioning).

2 For a review of and guide to selecting mental wellbeing scales validated for use in the UK, see NHS Health Scotland (2008) *Selecting scales to assess mental wellbeing in adults* [www.healthscotland.com/documents/2403.aspx](http://www.healthscotland.com/documents/2403.aspx)

3 WEMWBS is a 7- or 14-item scale developed to capture positive mental health, including positive affect, satisfying personal relationships and positive functioning. On the basis of their responses, people receive a score from 14 (lowest level of positive mental health) to 70 (highest).

# 5 Commissioning social prescribing

*"The introduction of social prescribing both as a concept and a service in our locality has been a catalyst for enabling us to think much more creatively and holistically about addressing people's wide-ranging mental health and social care needs within a non-stigmatising and empowering approach. The principles associated with social prescribing now underpin our developing commissioning intentions for mental health."*

Local commissioner

## 5.1 Why commission?

The case for commissioning social prescribing for mental health is based on the strength of the relationship between mental health and other outcomes and on growing evidence of the need for a wider range of early responses to psychosocial problems (National Institute for Mental Health in England (NIMHE) 2005).

Social prescribing can strengthen provision for those with mental health needs across the spectrum of disorders, offer greater patient choice, and improve the wide range of health and social outcomes that are linked to mental wellbeing (Friedli and Parsonage 2008). It is consistent with a range of current policy guidance and recommendations and has the potential to save future costs through early intervention.

Social prescribing is also a means for localities to extend the options available to people who present to primary care with psychosocial difficulties, and in doing so to make best use of specialist mental health resources.

### **Social prescribing can:**

- improve primary care provision for those with mental health needs;
- offer greater choice to patients; and
- provide a gateway to community-based resources.

The key activities that social prescribing involves – arts and creativity, learning, training and volunteering, access to the natural environment, sports and leisure – are consistent with wider goals for localities to:

- improve health, wellbeing and quality of life;
- reduce inequalities; and
- regenerate deprived communities.

Social prescribing can contribute to:

- increasing participation among those most deprived and marginalised;
- reducing social exclusion;
- helping people to actively manage their own health; and
- promoting employability.

## **5.2 Who can benefit?**

Social prescribing can support:

- vulnerable and at-risk groups;
- people who are lonely, isolated or excluded;
- people with mild to moderate depression and/or anxiety;
- people with long-term and enduring mental health problems; and
- frequent attenders in primary care.

## **5.3 What are the potential outcomes?**

Potential benefits of social prescribing include:

- increased mental wellbeing;
- reduced depression and anxiety;
- improved levels of recovery from mental illness; and
- increased social inclusion.

Outcomes will vary according to the project, but could include:

- increased positive affect – mood, self-esteem, optimism and confidence;
- improved cognitive function – problem-solving, coping and self-efficacy;

- increased social networks, contact and sense of belonging; and
- enhanced knowledge, skills and motivation.

These outcomes are also associated with improved physical health.

## 5.4 Measuring progress

Outcomes can be measured using scales designed to detect diagnosable disorder, e.g. the Beck Depression Inventory (BDI), the Hospital Anxiety and Depression Scale (HADS) or CIS-R.

There is also growing scope for using scales that capture different dimensions of wellbeing that are associated with improved health and social outcomes – for example:

- life satisfaction/quality of life;
- positive affect/happiness;
- optimism/hopefulness;
- resilience/coping;
- spirituality/meaning in life;
- social integration/social function; and
- emotional intelligence.

The choice of scale will depend on a wide range of factors. A recent review of wellbeing scales validated for use in the UK recommends nine scales for assessing mental wellbeing in adults, with Affectometer 2 described as the most promising instrument for measuring overall mental wellbeing (NHS Health Scotland, 2008). For a brief measure of emotional wellbeing, the Short Depression–Happiness Scale (six-item) offers good content validity and reliability.<sup>4</sup>

In Scotland, WEMWBS is being used to track changes in mental wellbeing across the whole population.<sup>5</sup> A similar population study is being planned for the North West region. WEMWBS is currently being piloted in a wide range of settings and could, for example, be used to identify changes in the wellbeing of a whole cohort of patients referred through social prescribing.

4 Full details of the strengths and weaknesses of these scales and how to obtain permission to use them are provided in NHS Health Scotland (2008) *Selecting scales to assess mental wellbeing in adults*.

5 Information on the development of WEMWBS can be found at [www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx](http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx)

### Benefits of improving mental wellbeing

Positive mental health contributes to preventing mental illness and leads to better outcomes in physical health, health behaviours, educational performance, employability/earnings and crime reduction. These beneficial outcomes are not just the result of the absence of mental illness but are due wholly, or in some degree, to aspects of positive mental health. Subjective well-being increases life expectancy by 7.5 years, provides a similar degree of protection from coronary heart disease to giving up smoking, improves recovery and health outcomes from a range of chronic diseases (e.g. diabetes) and, in young people, significantly influences alcohol, tobacco and cannabis use. While the best outcomes are generally associated with the absence of mental illness, the presence of positive mental health brings additional benefits, including for people with mental health problems.

(Friedli and Parsonage, 2007, p6)

Table 2 sets out a combination of indicators that might be used to capture social prescribing outcomes.

**Table 2: Summary of social prescribing outcome indicators**

Outcome	Indicator	Measure
1. Improve population mental health	Increased levels of mental wellbeing	WEMWBS (increase in mean score)
2. Improve population quality of life	Increased levels of life satisfaction	Local survey including question on how satisfied individuals are with their life as a whole nowadays
3. Improve individual mental health	Increased levels of mental wellbeing	Affectometer 2
	Increased levels of social contact and social support	SSQ-B
	Increased uptake of activities	Patient questionnaire
	Increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of 'positive steps for mental health'	Patient questionnaire
4. Ameliorate symptoms of mental distress	Reduced depression and anxiety	CORE 10 Patient Health Questionnaire (PHQ9 and GAD7) HADS BDI Beck Anxiety Inventory (BAI) GHQ12 – for possible mental health problem CIS-R – for depression and anxiety

Outcome	Indicator	Measure
	Improved levels of recovery from mental illness	Work and Social Adjustment Scale (W&SA) Health-Related Quality of Life (EQ5D, SF6-D) Social support/social functioning, e.g. SSQ-B
5. Improve range and choice of, and access to, primary care provision	Reduction in waiting lists for counsellors and psychological services	Service provider system
	Number of patients who attend less than 12 times per year	Primary care data system
	Reduction in inappropriate prescribing of antidepressants for mild to moderate depression, in line with NICE guidelines (NICE, 2004)	Primary care data system
	Increase in the range of voluntary and community providers	Commissioning system

### 5.5 Establishing partnerships

Effective social prescribing depends on the quality of partnership, joint working and co-operation between primary care staff and a wide range of voluntary and community groups, as well as local government. Social prescribing provides an opportunity for primary care to work more closely with agencies concerned with the broader determinants of mental health and to develop alternative responses to, and sources of support for, mental distress.

## 5.6 Outcomes for primary care

Social prescribing can contribute to:

- improved access to psychological therapies;
- reduced levels of frequent attendance;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression;
- reduced waiting lists for counsellors and psychological services; and
- improved range, choice and availability of primary care provision.

### Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT) programme is a Department of Health initiative aimed at ensuring that people presenting in primary care with mild or moderate depression have greater access to a range of psychological therapies (Department of Health 2006). IAPT is a key priority for PCTs, who will be performance-managed on achieving the target waiting time (currently 18 weeks) for psychological therapies.

A number of social prescribing interventions are included within the range of recognised psychological therapies:

- facilitated self-help;
- personal skills development;
- bibliotherapy – library reading groups; and
- computerised/web-based therapy.

Social prescribing can therefore increase capacity – particularly at Step 2 of the stepped care model (see Figure 1, page 16) – to enable people to access a broader range of psychological therapies more quickly, thereby reducing the overall average waiting time in localities.

Social prescribing will support delivery of IAPT through:

- increasing access to a broader range of psychosocial interventions;
- increasing the range of providers, including voluntary and community involvement; and
- increasing capacity to respond at an earlier stage.

For many people, the social contact provided by referral to (for example) a walking group will be sufficient.

### Frequent attenders

Social prescribing can:

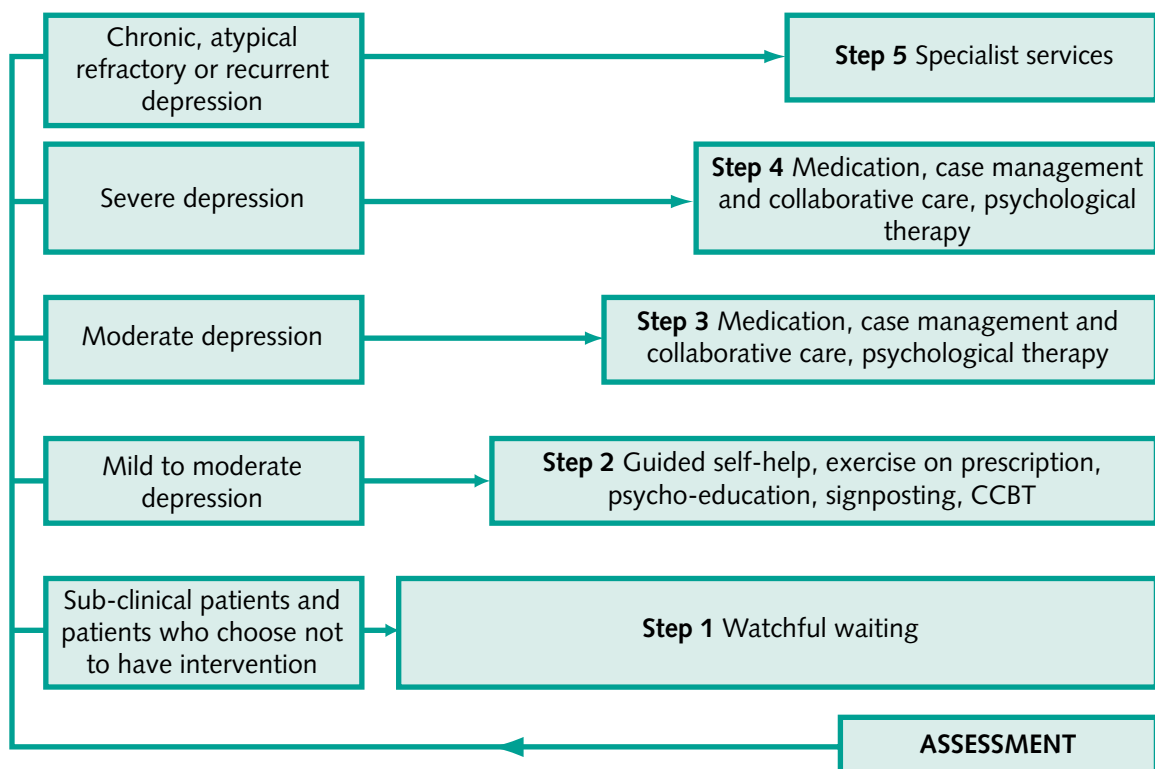
- improve effectiveness in responding to frequent attenders; and
- tackle underlying issues of frequent attendance.

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

The reasons for frequent attendance are complex but there is some evidence that it is related to unresolved mental health issues. Depressive symptoms are the major predictor of frequent attendance and several studies identify the importance of addressing psychological problems and low levels of wellbeing among frequent attenders in general practice (Dowrick et al. 2000; Heywood et al. 1998).

Frequent attenders are therefore a further potential target group for social prescribing.

**Figure 1: A stepped care approach to treating depression**



(NICE 2004)

## 5.7 Outcomes for recovery and secondary mental health care

Social prescribing can contribute to:

- increased recovery from mental illness;
- support of self-management and personalisation of services; and
- social inclusion of people with mental health problems.

Action to tackle the social exclusion of people with mental health problems is fundamental to achieving improved quality of life for service users, which in turn supports recovery and improved clinical outcomes (Social Exclusion Unit 2004). A predominant theme in the research literature is the importance of social networks, friendship, acceptance and opportunities to participate in and enjoy the same range of everyday activities as everyone else (Faulkner 1997 and 2002; Mental Health Foundation 2000).

Social prescribing is one element of a broader social inclusion agenda and uses primary care as a gateway to increase opportunities for people with long-term mental health problems to access everyday sources of support, leisure, friendship and activity within the community.

## 5.8 Key elements to include in commissioning social prescribing

Social prescribing is already happening in some localities, although it may not be described in this way. A whole-system approach to social prescribing will build on existing arrangements, improving co-ordination, simplifying referral procedures and enabling measurement of impact. A central lead can help to drive forward implementation, engage and co-ordinate the many potential partners and facilitate sign-up to the programme. A steering group including representation from all stakeholders can support the establishment and ongoing development, monitoring and evaluation of a programme.

Key elements include:

- training and support for primary care staff, which may include identification of dedicated referral/link worker;
- co-ordination of all potential referrers and referral pathways;
- clear protocols with criteria for referral;
- a mechanism for updating the range of resources, agencies and facilities to which referrers can signpost clients;

- potential to provide capacity building/support for the VCS;
- performance monitoring, referrer feedback and evaluation of outcomes; and
- raising public awareness of social prescribing.

# 6 Policy context

The principles of social prescribing are relevant to and supported by a wide range of government policy on the arts and culture, employment, lifelong learning, employability, volunteering and sustainable environments, as well as on health, sport and physical activity.<sup>6</sup>

*Our health, our care, our say* (Department of Health 2006) sets out the government agenda for shifting resources towards prevention of ill health, increasing the range of interventions available to people, and promoting partnership between statutory health, social and third sector services. It supports *Choosing health*, the public health White Paper (Department of Health 2004), which prioritises the improvement of mental wellbeing.

*Our health, our care, our say* identifies social prescribing as a mechanism for promoting good health and independence and ensuring that people have easy access to a wide range of services, facilities and activities. Lord Darzi's final report reviewing the NHS (Department of Health 2008) further prioritises local provision of preventative services to improve mental wellbeing and to tackle the wider determinants of health. From 2008, PCT local delivery plans will not be agreed by strategic health authorities (SHAs) or the Department of Health unless there is a clear strategy for the development of, and shift of resources to, primary and community care. There will also be the option of setting targets for the percentage shift of resources from secondary care to primary and community care.

## 6.1 Information prescriptions

*Our health, our care, our say* states that, from 2008, information prescriptions will be given to everyone with a long-term condition or social care need, in consultation with a health or social care professional. Information prescriptions will guide people to relevant and reliable sources of information to allow them to feel more in control and better able to manage their condition and maintain their independence. A whole-system approach to social prescribing can facilitate the implementation of information prescriptions, particularly in supporting people to address social determinants of health and wellbeing.

<sup>6</sup> See also the current cross-government programme dedicated to producing a vision for 'maximising mental capital and wellbeing in the 21st century' – [www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp](http://www.foresight.gov.uk/OurWork/ActiveProjects/Mental%20Capital/Welcome.asp)

### **Information prescriptions**

Information prescriptions will contain a series of links or signposts to guide people to sources of information about their health and care – for example, information about conditions and treatments, care services, benefits advice and support groups. They will include addresses, telephone numbers and website addresses that people may find helpful, and show where they can go to find out more. They will help people to access information when they need it and in the ways that they prefer.

## **6.2 Local area agreements and local strategic partnerships**

Local area agreements (LAAs) set out the priorities for a local area agreed between central government and the local authority, local strategic partnership (LSP) and other key partners at the local level.

Social prescribing referrals and access to social interventions can be useful local indicators (see case studies on page 21) to meet outcomes relating to improving mental wellbeing, increasing social contact and support, enhancing independence and reducing inappropriate prescribing. Social prescribing can also help meet national indicators (Department for Communities and Local Government 2007).

## Case studies – local area agreements

### Lancashire LAA

In Lancashire the LAA includes a target for implementing social prescribing across the three PCTs in the county, and this has been a catalyst for some cross-county developments. Key issues for developing mental health within the LAA are:

- the need to reduce inequalities;
- the fact that people with poor mental health are more likely to experience inequalities;
- the fact that many of the areas of work in mental health and the LAA overlap;
- the need to focus on promoting mental wellbeing and to introduce wellbeing indicators into the next refresh process; and
- using the LAA to introduce measurable interventions that promote mental wellbeing.

The target includes:

- the number of PCTs implementing comprehensive social prescribing referral pathways linked into the stepped care model for treating depression; and
- the establishment of a baseline and measurable indicators.

The focus is on four activities – bibliotherapy, exercise on referral, education on referral, and supported employment.

### Stockport LAA

As in Lancashire, key issues are the level of inequalities that exist within the borough, their impact on mental health, and the need to measure activity and outcomes. Social prescribing has been identified as a way of implementing and measuring activity that promotes mental health and helps address emotional distress.

The indicator agreed is that 'people have access to a wide range of sources of support for emotional and psychological difficulties'.

### 6.3 Making it possible

*Making it possible* (NIMHE 2005) provides national guidance and examples of good practice to support the development and delivery of action to improve mental health and wellbeing. It proposes a range of indicators for measuring success – those most relevant to social prescribing include:

- ensuring that people are well informed and motivated to look after their own and others' mental health;
- people having access to a wide range of sources of support for emotional and psychological difficulties; and
- reduction in inequalities in access to non-pharmacological sources of support, notably for BME communities and older people.

*Making it possible* also highlights 'positive steps' that individuals can take to promote and protect mental health.<sup>7</sup> These steps provide a foundation for everyone's mental health and include:

- keeping physically active;
- eating well;
- drinking in moderation;
- valuing yourself and others;
- talking about your feelings;
- keeping in touch with friends and loved ones;
- caring for others;
- getting involved and making a contribution;
- learning new skills;
- doing something creative;
- taking a break; and
- asking for help.

7 For a review of the strength of the evidence for these steps, see Friedli et al. (2007) *Mental health improvement: evidence based messages to promote mental wellbeing*. Edinburgh: NHS Health Scotland; [www.healthscotland.com/documents/2188.aspx](http://www.healthscotland.com/documents/2188.aspx); [www.healthscotland.com/documents/2191.aspx](http://www.healthscotland.com/documents/2191.aspx)

Social prescribing can strengthen opportunities for individuals to take positive steps, notably in the case of those who are vulnerable, excluded, at risk and in need of additional support.

## 6.4 Commissioning framework for health and well-being

The *Commissioning framework for health and well-being* (Department of Health 2007a) builds on *Our health, our care, our say* and promises to help people stay healthy and independent, to give people choice in their care services, to deliver services closer to home, and to tackle inequalities.

The framework advocates involving the local community in providing services that meet its needs, extending beyond merely treating people when they are ill to also keeping them healthy and independent; and it has a particular focus on partnership working.

The commissioning of social prescribing supports the following objectives of the commissioning framework:

- a shift towards services that are personal and sensitive to individual need, and that offer choice and increased control over health;
- a strategic reorientation towards promoting health, independence and wellbeing, investing now to reduce future costs of ill health;
- a stronger focus on joint commissioning of services and interventions across health and local government, with a focus on outputs and outcomes; and
- involvement of a much wider range of stakeholders than in a traditional health or social care model – including not just the third sector but also the business community, and education, leisure and other community services.

Individual choice and control are being addressed through the personalisation of services and support. For example, self-directed support allows service users to tailor their own care and support package to meet their specific needs. A social prescribing framework can provide a 'menu' of quality-controlled services that individuals can purchase according to their needs.

Social prescribing can form part of the creative use of practice-based commissioning, enabling practice teams to work with patients, families and carers to design care packages better suited to their needs. It will meet the World Class Commissioning vision of delivering better health and wellbeing outcomes for all.

## 6.5 NICE guidance

NICE clinical guidelines on managing anxiety and depression include self-help and self-management approaches (NICE 2004a and 2004b). They also state that:

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

In particular, the guidelines recommend that further trials should be undertaken of the efficacy of a range of social support interventions for socially isolated and vulnerable people with depression.

The NICE guidelines on depression (NICE 2004b) state that:

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

For milder depression, the guidelines state that:

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

For chronic depression, the guidelines state that:

- chronic depression is diagnosed when a person meets the diagnostic criteria for depression for at least two years;
- such patients may require combination treatments and attention to social and support factors that may maintain or ameliorate their difficulties;

- patients who have had chronic depression may require rehabilitation to help them regain confidence to return to more independent living;
- patients who have had chronic depression may have been out of work for some time, so may require special help in returning to work;
- work provides a number of protective factors for depression, including structure to a day, social contacts and self-esteem;
- for patients with chronic depression who would benefit from additional social support, befriending should be considered as an adjunct to pharmacological or psychological treatments; and
- befriending should be by trained volunteers providing, typically, at least weekly contact for between two and six months.

The NICE guidelines on anxiety (NICE 2004a) provide specific information on self-help approaches, as follows:

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

The guidance also advocates a stepped care approach to treating depression, based on the principle of offering the least intensive intervention first, and stepping up care to more intensive interventions if needed. Social prescribing has a potential role to play within each of the steps (see Figure 1, page 16), but the main benefits are in building capacity at step two. The interventions recommended at step two (guided self-help, exercise on prescription, psycho-education, signposting and CCBT), together with problem-solving therapy and forms of bibliotherapy, are all elements that could form part of a social prescribing programme.

## **6.6 High quality care for all: NHS Next Stage Review final report**

The Darzi Report, *High quality care for all* (Department of Health 2008), follows a review of the NHS across the ten SHAs. It calls for the future NHS to focus on promoting health and ensuring easier access to quality services.

The report identifies as an immediate step that every locality should commission comprehensive wellbeing and prevention services to improve people's mental health, personalised to meet the specific needs of the local population. It also

emphasises engagement with local authorities and the third sector; increased choice, control and empowerment; and the development of innovative services and a strong outcome focus.

The commissioning of social prescribing supports the following elements of *High quality care for all*:

- delivery of wellbeing and prevention services;
- tailor-made, personalised interventions that meet individual needs and circumstances and promote increased self-management of mental ill health and control over making healthy choices;
- ability to be incorporated into personalised care plans for patients with long-term conditions in order to improve their wellbeing;
- increase in the range of services available, and increased access;
- incorporation of vocational advice that will support people in staying healthy at work and returning to work;
- support for GPs in helping individuals and their families to stay healthy;
- facilitating of a partnership approach with the local authority and third sector, enabling mixed market delivery; and
- tackling the determinants of health (including wider determinants), which enables a health outcomes focus.

# 7 Delivering social prescribing interventions

This section provides:

- guidance on addressing some of the practical challenges in setting up social prescribing schemes; and
- examples of a wide range of initiatives, together with evidence of their effectiveness.

Key stages in design and delivery of social prescribing will depend on the approach adopted – for example, self-referral and signposting through the provision of information; indirect referral via an adviser or link worker; or formal, direct referral by a member of the primary care team.

Many primary care settings currently collate information on local self-help groups, in addition to providing a wider range of data on community-based support and services within education, leisure and welfare, for example. This might take the form of a local directory, patient information leaflets, noticeboards or internet access, in addition to the more proactive provision of space and facilities for community groups within primary care practices. (See, for example, the Greenwich Splash website, which links residents in Greenwich, London with a wide range of organisations and activities that promote mental wellbeing – [www.greenwichsplash.nhs.uk](http://www.greenwichsplash.nhs.uk).)

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

Practical challenges in implementing social prescribing include:

- agreeing referral routes and criteria;
- accountability and liability for referred patients;
- voluntary sector capacity;
- maintaining up-to-date information on sources of voluntary and community support;
- recording and evaluating impact and outcomes;

- increased GP workload (initially); and
- identifying resources for link worker/referrals facilitator.

## 7.1 Referral

Effective referral is crucial, whether setting up a single programme – for example, exercise on prescription – or a range of social prescribing options. Key issues include:

- referral routes – who can do referrals and how will people access the service (e.g. exercise class, literacy course, bibliotherapy, debt advice, benefits support)?
- referral criteria – who qualifies for the scheme?
- referral feedback – how will what happens to referred patients be recorded?

It may make good operational sense to focus on establishing a whole-system approach, using just one route as a 'gatekeeper', even if there are plans to extend the programme fully in the long term. Figures 2, 3 and 4 on pages 33–5 provide examples of different models for referral.

Potential referrers for health promotion include:

- any statutory agency working with at risk people;
- any voluntary sector agency working with at risk people; and
- self-referrals.

Potential referrers for early intervention include:

- primary care mental health workers;
- GPs;
- primary care-based mental health nurses;
- practice nurses; and
- health visitors.

Potential referrers for recovery include:

- care programme approach care co-ordinators;

- community mental health team members (psychiatrists, nurses, social workers and community support workers); and
- inpatient unit staff.

Each locality will decide whether or not to open up social prescribing referrals to all potential referral routes. Factors influencing this decision will include:

- commissioning commitment;
- financial resources;
- project management capacity;
- capacity in the co-ordination phase of the system;
- effectiveness of existing collaborative working arrangements; and
- the level of understanding of social prescribing evidence by referrers.

### **Referral criteria, risk assessment and liability**

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

Some schemes will want to use protocols for referral (for example, to exercise facilities) although general guidance for primary care may also be effective. In the case of physical activity some evidence suggests that, for the general population, guidance about how to include more exercise in day-to-day life, combined with a supportive environment for walking and casual recreation, is more effective than being sent to a sports/leisure facility for a prescribed programme (NICE 2006a).

Liability issues are often a concern to GPs. The Department of Health distinguishes between recommending – for example, that a patient try to be more active – and specifically directing a patient through a referral process (Department of Health, 2001). In the case of exercise, when the patient is specifically referred, responsibility for safety, management, design and delivery passes to the exercise professional – who should be a member of the professional register for exercise and fitness. The referrer is responsible for the transfer of relevant information to the person conducting the exercise intervention. In all cases, the patient must give informed consent.

## 7.2 Level of intervention

Models for social prescribing range from **supported access to information** to a more comprehensive system of **supported referral**. Choice of level will be influenced by:

- severity of symptoms;
- complexity of social needs;
- level of motivation; and
- individual choice.

### Supported access to information/signposting

Supported access to information/signposting – level one in the social prescribing model – involves providing details about voluntary agencies, self-help groups, and leisure, sporting, cultural and educational activities within the community (Blastock, et al. 2005). This may involve developing a paper or web-based directory of information about local resources, often in combination with opportunities for patients to access information about health issues, as well as computer-assisted self-help and therapy packages. Book prescription schemes may also fall into this category of intervention.

A feasibility study for Greenwich PCT concluded that supported access to information was suitable for the least vulnerable target groups (Sanders et al. 2002). More vulnerable or disadvantaged patients may be unlikely or unable to access community-based opportunities without additional support, and would require a more intensive method, such as an information prescription or supported referral.

With the right information, many people will be able to choose and access the most appropriate services for their needs.

Supported access to information and signposting are difficult to evaluate because identifying whether patients have acted on information, and to what effect, is complex and time-consuming.

### Information prescriptions

From 2008, information prescriptions will be given to everyone with a long-term condition or social care need, in consultation with a health or social care professional. Information prescriptions will guide people to relevant and reliable sources of information to allow them to feel more in control and better able to

manage their condition and maintain their independence. Social prescribing can facilitate the implementation of information prescriptions, particularly in addressing the social and cultural determinants of health and wellbeing and supporting self-management.

### Supported referral

There are a number of options for the supported referral model, depending on the level of support required. Most models involve a dedicated worker whose role includes liaison with providers and support to enable referred patients to access the service prescribed. This might include assistance with overcoming practical barriers (e.g. transport or childcare) and/or moral support (e.g. accompanying the patient to the first meeting of a self-help group or arranging for a 'buddy' to introduce the patient at the leisure centre or green gym).

## 7.3 Social prescribing co-ordination

Many of the social prescribing interventions described in this document will already be happening in some localities, although they may not use such terminology to describe themselves. A whole-system approach to social prescribing will build on existing arrangements, improve co-ordination, and simplify referral procedures and evaluation. A central lead for the programme can help to drive forward implementation, engage and co-ordinate the many potential partners, and facilitate sign-up to the programme. A steering group including representation from all stakeholders enables the establishment and ongoing development, monitoring and evaluation of a programme.

Central co-ordination can improve the efficiency and effectiveness of the service through:

- providing co-ordination of all potential referrers and referral pathways;
- updating the range of resources/directories of agencies and facilities to which referrers can signpost clients;
- identifying potential resources for assessing and addressing identified needs within a supported referral framework;
- performance monitoring, referrer feedback and evaluation of outcomes;
- volunteer support; and
- publicising and raising awareness of the service.

The co-ordination function can be provided by several routes, requiring different levels of investment, including:

- an electronic database of interventions, updated by the agencies involved and including contact and referral details, disseminated to potential referral agencies;
- a paper directory of interventions, updated by the agencies involved and including contact and referral details, disseminated to potential referral agencies;
- a multi-agency co-ordination function (different agencies providing different elements of co-ordination, e.g. volunteers, performance monitoring, assessments, information updates and marketing); and
- a social prescribing function, as a job role or set of responsibilities within one of the partner agencies, or commissioned from the third sector, combining all of the above.

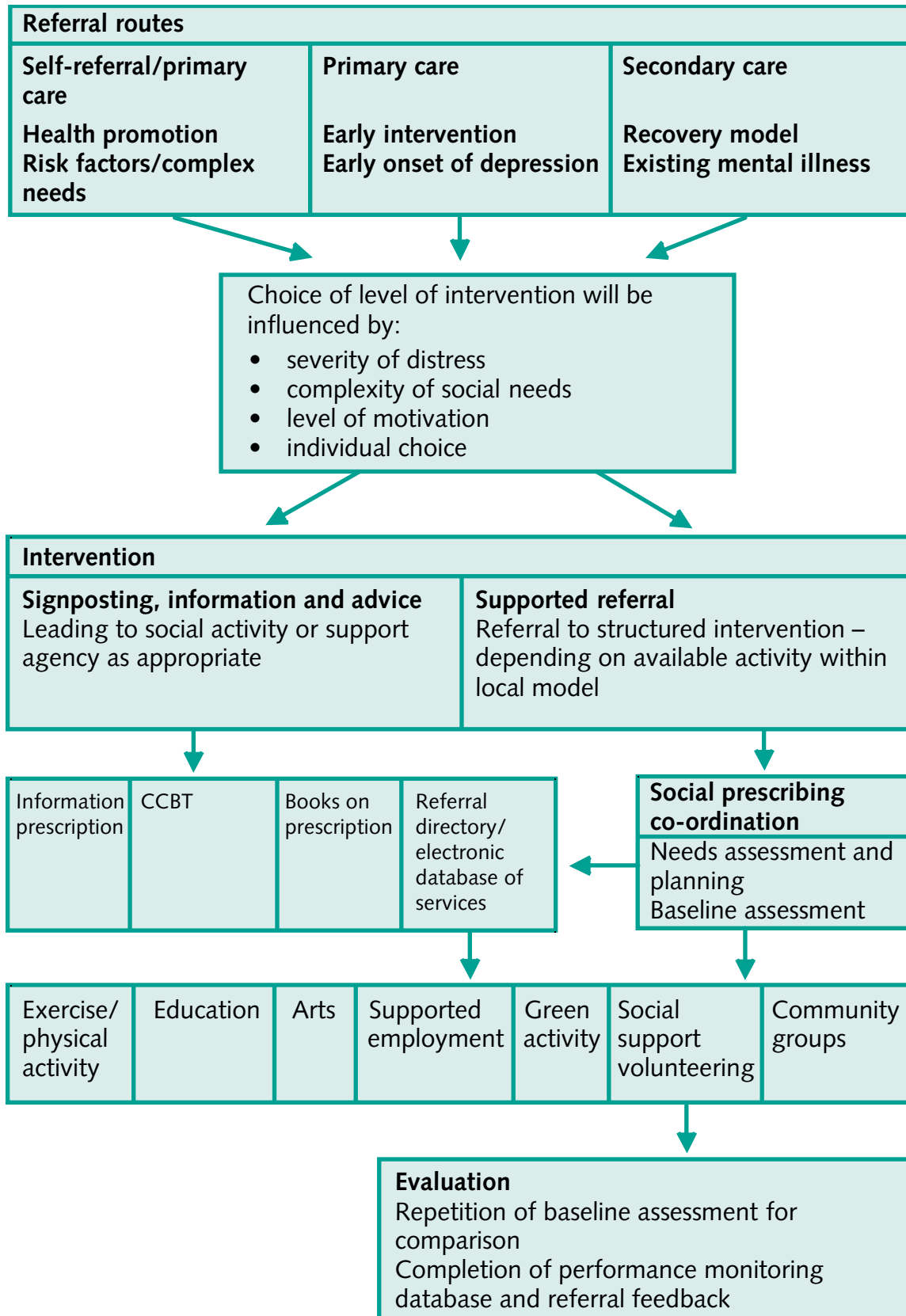
## 7.4 Volunteers

Volunteers can be a valuable resource for building capacity within a social prescribing programme. Volunteers can fulfil many roles:

- supporting the co-ordination element of the programme;
- offering a 'buddying', befriending, care navigating or signposting function within the programme;
- providing administrative support;
- supporting access to computerised CBT;
- supporting access to other social prescribing interventions (co-facilitating groups; accessing education, physical activity or other classes; accessing community facilities);
- assisting clients in undertaking social needs self-assessment and identifying goals; and
- supporting clients in accessing help (such as debt counselling, housing advice etc.).

Volunteers should be employed by an agency (usually third sector) and should have employee rights. They should be fully trained and supervised and supported in carrying out their role.

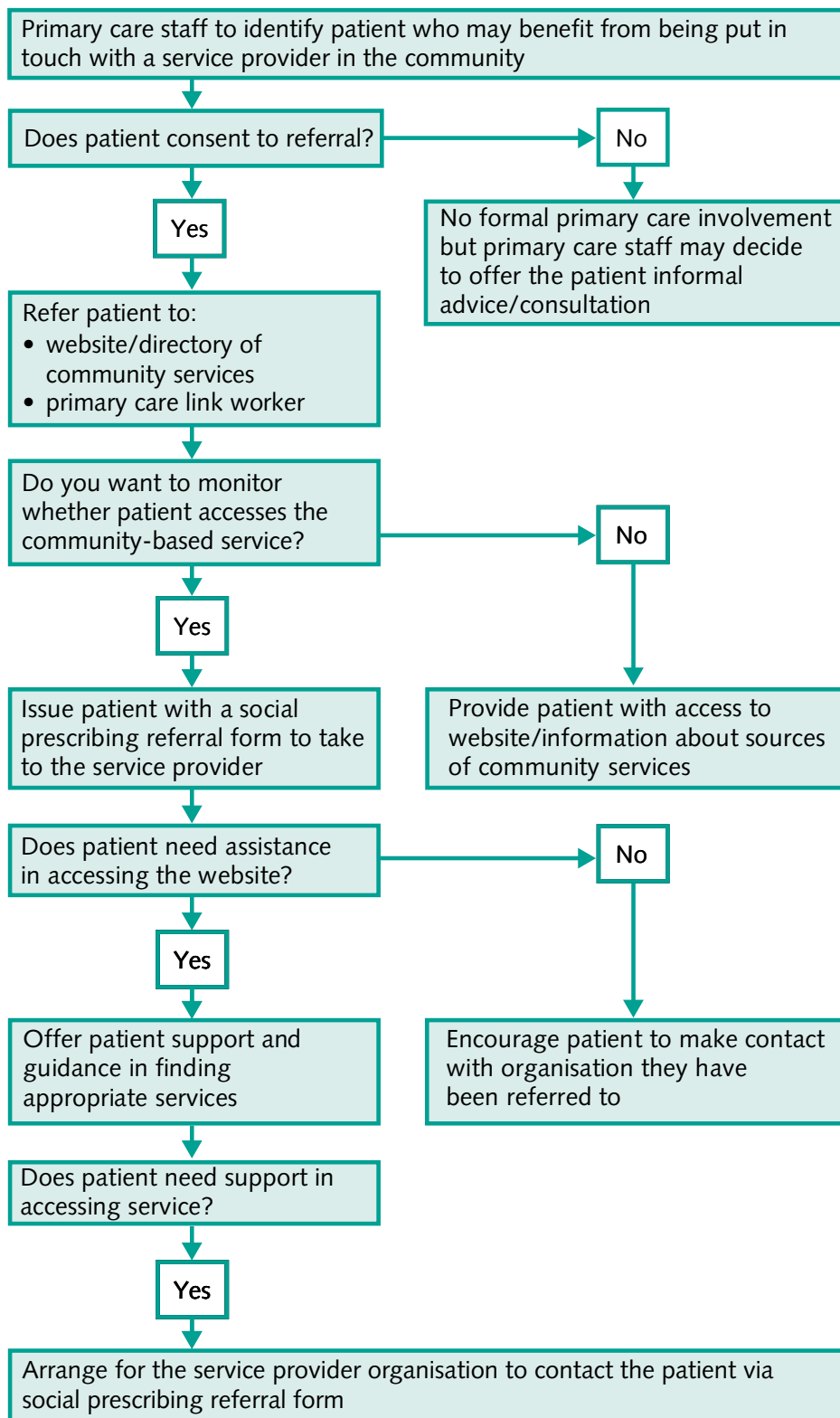
Figure 2: Social prescribing care pathway – a model



A model derived from North West demonstration sites

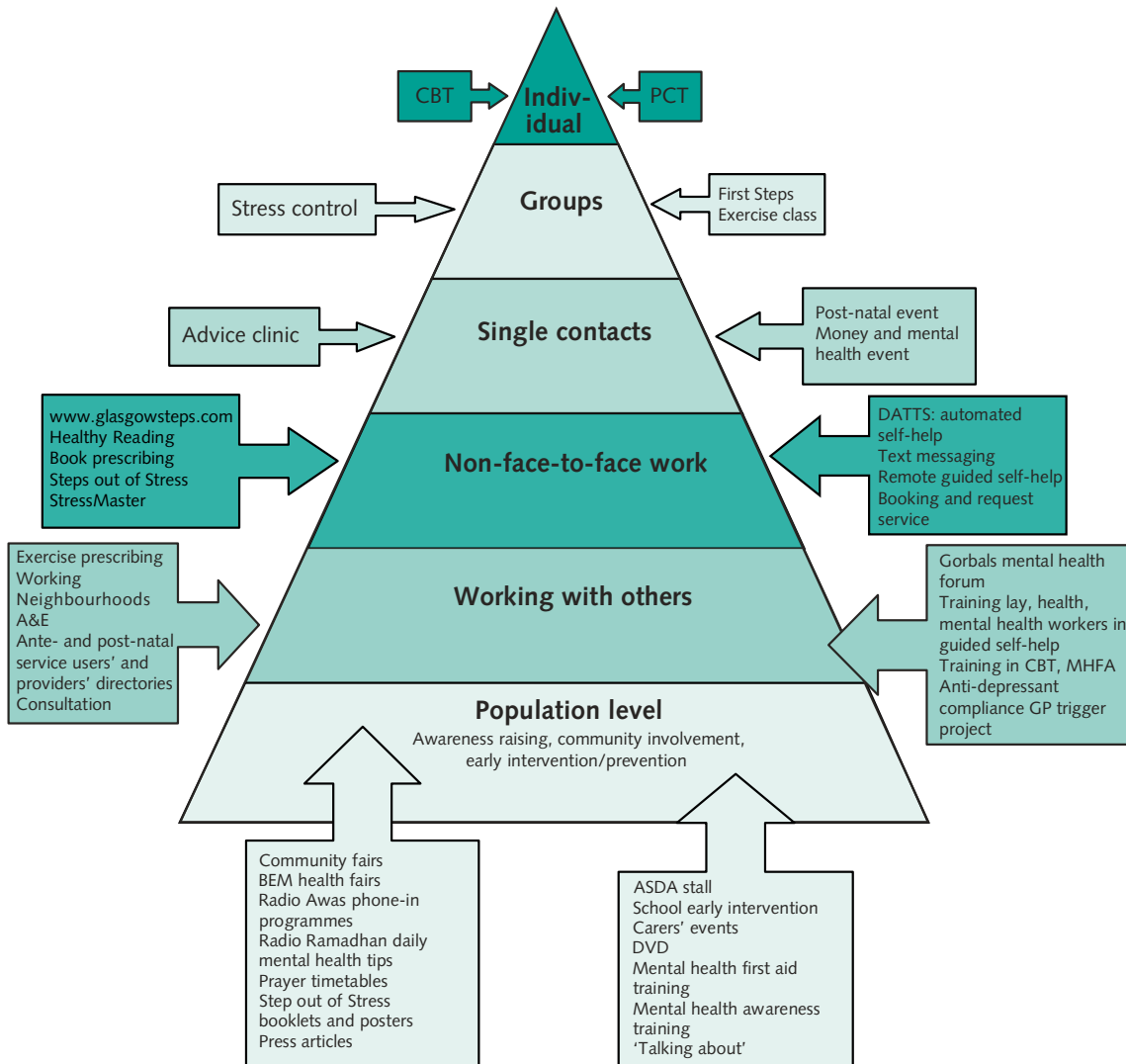
**Figure 3: Social prescribing flowchart for primary care staff (Greenwich)**

The aim of this flow chart is to ensure a smooth, efficient and standardised approach for primary care staff to choose which social prescribing options to offer their patients.



A model derived from Greenwich

Figure 4: STEPS primary care model (South East Glasgow)



(White et al. 2008)

# 8 Examples of social prescribing initiatives

This section includes a range of social prescribing initiatives drawn from across the UK and summarises some of the emerging research evidence on effectiveness. Much of the literature is confined to small-scale evaluation of individual projects, and the quality of the evidence varies. While the results of the case studies included here are promising, more research is required in all areas. Where more robust evidence of effectiveness is available, this is indicated.

## 8.1 Computerised therapy

Computers and internet-based programmes have the potential to make psychological assessment and treatment more cost-effective. Internet support groups may also be effective and have advantages over face-to-face therapy, although research is limited.

### Rationale/evidence base

A recent review from NICE found good evidence for the effectiveness of some CCBT for depression and anxiety – for example, Beating the Blues™ (NICE 2006b).

### Beating the Blues™

NICE (2006) has recommended Beating the Blues™ as a treatment option for people with mild or moderate depression. The programme consists of an eight-session self-help treatment designed for use by patients with no previous computer experience. Beating the Blues™ uses interactive modules, animations and voice-overs to motivate and engage the user. A major feature is a series of filmed case studies of fictional patients who model the symptoms of anxiety and depression and help demonstrate the treatment by CBT.

Beating the Blues™ is only available on licence, and can only be accessed through a healthcare professional. It is currently available in over 300 NHS PCTs, community mental health trusts and specialist CBT services.

For further information contact [ultrasis@ultrasis.com](mailto:ultrasis@ultrasis.com).

## FearFighter™

FearFighter™ is a self-help computer program for treating phobias, panic and anxiety and is recommended by NICE as a treatment for anxiety and phobias. It is an 8- to 12-week course of therapy delivered online – either at home or at any other venue with internet access. It 'interviews' the individual to assess their anxieties and fears, helps plan a self-treatment schedule, monitors progress and gives feedback.

The makers, CCBT Limited (ST Solutions) have entered into a framework agreement with the NHS to deliver the internet-based programme, and FearFighter™ is purchased on a cost per capita basis.

For further information visit [www.ccbt.co.uk](http://www.ccbt.co.uk).

## Free CBT websites

There are several free-to-access CBT sites available on the internet. Powell and Clarke (2006) found that the internet had been used as a source of mental health information by over 10% of the population, and by over 20% of those with a history of mental health problems. The majority (90%) of these users were 18- to 29-year-olds, both people in employment and students.

One of the difficulties in recommending such a site within a social prescribing model is to ensure the effectiveness, validity and appropriateness of the site. The British Association for Behavioural and Cognitive Psychotherapies has published a useful review of these sites (Gournay 2006). The review identified free-to-access websites:

- MoodGym (<http://moodgym.anu.edu.au>)
- Living Life to the Full ([www.livinglifetothefull.com](http://www.livinglifetothefull.com)).

It also makes the following recommendations to PCTs:

- CCBT, including free-to-access programmes, may provide users with substantial benefits.
- Although the free-to-access programmes may provide some benefit if used on their own, the benefits may increase if the user is encouraged to use the site by a professional.
- Information about all three of these websites should be made freely available.

- Information about these websites should be made available to mental health professionals who may have contact with people suffering from depression or anxiety.
- These professionals should be encouraged to access and navigate their way through the websites to understand what is on offer.
- The websites may be used as an adjunct to any of the steps within a stepped care model, and health professionals providing interventions to people with depression and anxiety should be encouraged to offer access to the websites as an adjunct to evidence-based approaches.
- Potential users should be advised that the benefits of these websites generally come with increasing use.
- PCTs should continue to monitor the development of internet-based programmes.

## 8.2 Books on prescription/bibliotherapy

Bibliotherapy usually takes the form of:

- a 'prescription' for a particular book to be borrowed from a public library, or from a GP or mental health worker; or
- recommendation by a GP or mental health worker of a list of books or other self-help materials that the patient can obtain from their local library.

Over half of the library authorities in England are currently operating some form of bibliotherapy (Hicks 2006). Other opportunities for developing bibliotherapy within a social prescribing model include referral to reading groups using self-help materials, or literature with a personal development theme.

### Rationale/evidence base

A review of research evidence for self-help interventions for people with mental health problems (Lewis and Anderson 2003) found that most studies reported a significant benefit from use of self-help materials based on CBT approaches for treatment of depression, anxiety, bulimia and binge eating disorder. It suggested that the use of self-help materials was 'probably safer' if supported by a healthcare professional and suggested that self-help interventions could be a very useful first step in a stepped care approach.

Frude (2004) found that bibliotherapy had high patient acceptability, a tendency to continued improvement over time and low relapse rates. Bibliotherapy is also

cost-effective (Hicks 2006), although the level of effectiveness depends on the quality of the book and the motivation and application (as well as the literacy) of the user.

### Further information

Reading Agency (2003) *Reading and health mapping research project*. St. Albans: Reading Agency. [www.readingagency.org.uk/new-thinking/newthinking-uploads/Reading\\_and\\_health\\_project.pdf](http://www.readingagency.org.uk/new-thinking/newthinking-uploads/Reading_and_health_project.pdf).

## 8.3 Exercise on prescription

Exercise on prescription involves referring clients to supported exercise programmes that can include:

- gym-based activity;
- guided/health walks;
- green activity (see also section 8.5);
- cycling;
- swimming and aquatherapy;
- team sports; and
- exercise and dance classes.

### Rationale/evidence base

There is robust evidence (Fox 2000) to support the mental health benefits of physical activity in four areas:

- as a treatment or therapy for existing mental health problems;
- to improve the quality of life of people with mental health problems;
- to prevent the onset of mental health problems; and
- to improve the mental wellbeing of the general public.

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

A number of trials have suggested that patients respond positively to GP advice to take more exercise (Killoran et al. 1994). National consensus statements on

physical activity and mental health (Grant et al. 2000) show that exercise prevents clinical depression and is as effective as psychotherapeutic interventions.

Exercise also reduces anxiety, enhances mood and improves self-esteem (Fox 2000; Mutrie 2000). A meta-analysis demonstrates that regular exercise enhances cognitive functioning, reduces mental health problems, and improves the mental health of older people (Etnier et al. 1997).

An evaluation of GP exercise prescription schemes has found that a ten-week programme of exercise prescribed by a GP significantly reduces depression and anxiety and increases quality of life and self-efficacy (Darbishire and Glenister, 1998). In the study, 68% of clinically depressed patients achieved non-clinical depression scores within three months.

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

## 8.4 Arts and creativity

Definitions of creative activities and interests are broad and sometimes overlap with learning, but may include: arts and performance (including writing, painting, sculpture, photography, music, poetry, drama, dance and other performance arts, and film); libraries; museums; heritage; and cultural tourism. 'Arts on prescription' is distinct from art therapy, a professional discipline with a long tradition as a psychological therapy (Kalmanowitz and Lloyd 1997).

### Rationale/evidence base

Evidence of effectiveness addresses three key areas:

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

A number of studies have suggested that creative activity has positive mental health benefits. These may relate to the development of self-expression and self-esteem, to opportunities for social contact and participation (Huxley 1997), and/or to providing a sense of purpose and meaning and improved quality of life (Oliver et al. 1996; Callard and Friedli 2005; Tyldesley and Rigby 2003).

Reviews by the Health Education Authority (1999) and Matarasso (1997) demonstrated improvements in wellbeing as indicated by:

- enhanced motivation;
- greater connectedness to others;
- a more positive outlook; and
- a reduced sense of fear, isolation or anxiety.

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

- self-expression;
- an enhanced sense of value and attainment; and
- pride in achievement.

Evaluation of the Stockport Arts on Prescription scheme showed a moderate impact on self-esteem and social functioning. However, the increase in involvement in social activities, particularly participative activities, was statistically significant, with some evidence that the use of GPs, social workers and other services was reduced (Huxley, 1997; Health Education Authority 1998; Tyldesley and Rigby, 2003). A further case study on people referred to arts activities by health and social services found that participants used in-patient and other hospital services less often and that the risk of relapse was reduced (Department for Culture, Media and Sport 1999).

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

In spite of encouraging findings, however, much existing evaluation is based on short-term or intermediate outcomes, and many studies are anecdotal and based

on small-scale surveys, lack a longitudinal dimension and fail to identify arts-specific aspects of the programmes (Coulter 2001).

### Further information

**Department of Health (2007b)** *Report of the Review of Arts and Health Working Group*; [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_073590](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073590).

**Department of Health/Arts Council England (2007)** *A prospectus for arts and health*; [www.artscouncil.org.uk/publications/publication\\_detail.php?browse=recent&id=581](http://www.artscouncil.org.uk/publications/publication_detail.php?browse=recent&id=581).

**Arts Council England (2007)** *The arts, health and wellbeing*; [www.artscouncil.org.uk/documents/publications/phpC1AcLv.pdf](http://www.artscouncil.org.uk/documents/publications/phpC1AcLv.pdf).

## 8.5 Green activity/ecotherapy

'Green activity' or 'ecotherapy' denote schemes in which participants become both physically and mentally healthier through contact with nature. This can include:

- gardening and horticulture;
- growing food;
- walking in parks or the countryside;
- involvement in nature conservation work (e.g. green gyms); and
- developing community green spaces.

### Rationale/evidence base

'Green exercise' (physical exercise in a natural environment) is associated with increases in self-esteem, positive mood and self-efficacy (Pretty et al. 2003; Countryside Recreation Network 2005) An evaluation of green gyms (British Trust for Conservation Volunteers 2002) demonstrated a range of physical and mental health benefits, including reductions in symptoms on HADS and improvements in quality of life. 'Being out in the countryside' emerged as a significant motivating factor, supporting other findings on the potential therapeutic value of the natural environment.

BTCV (2002) found a significant improvement in mental health in the first three months of participation (as measured by the SF-12 health-related quality of life instrument). Factors motivating continued participation in green activity included

the social aspect of working with a group, increased awareness of conservation and countryside issues, and doing something worthwhile. The green gym was viewed by participants as being beneficial to their mental health and wellbeing.

A report commissioned from the University of Essex by Mind (Mind 2007) suggests that ecotherapy is an accessible, cost-effective complement to existing treatment options for mild to moderate mental health problems. For further information visit [www.mind.org.uk/mindweek2007/report/](http://www.mind.org.uk/mindweek2007/report/).

## 8.6 Learning/education on prescription

Learning/education on prescription involves referral to a range of formal learning opportunities, including literacy and basic skills. It can involve the use of learning advisers placed within educational establishments, day services, mental health teams or voluntary sector organisations to identify appropriate educational activities for individuals and to support their access.

### Rationale/evidence base

Opportunities for learning may impact positively on health (NIACE 2003) by improving an individual's:

- socioeconomic position;
- access to health services and information;
- resilience and problem-solving; and
- self-esteem and self-efficacy.

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

- exercise taken;
- life satisfaction;
- race tolerance;
- authoritarian attitudes;
- political interest;
- number of memberships (of, for example, community groups); and
- voting behaviour.

Evaluation of prescription for learning in Nottingham, assessing the health impact on 196 participants, found the following benefits:

- improved confidence and self-esteem;
- lifted mood;
- improved sleeping;
- increased activity;
- wider social networks;
- greater sense of control;
- hope and optimism; and
- improved health behaviours.

These findings are particularly significant as over two-thirds of referrals were for people with no qualifications, who had not accessed any form of learning since leaving school (James 2001).

## 8.7 Volunteering

Volunteering has two potential roles to play within a framework for social prescribing:

- encouraging people to volunteer because of the benefits to their own mental health; and
- use of volunteers to support people within a social prescribing intervention.

### Rationale/evidence base

Evidence of the mental health benefits of volunteering is mixed with some evidence that older volunteers are more likely to gain psychological benefits from volunteering than younger people (Friedli et al. 2007). One major review found no relationship between volunteering and happiness or life satisfaction across 34 countries (Dolan et al. 2006). Thoits and Hewitt (2001) found a positive relationship with wellbeing, but also concluded that people with high levels of wellbeing tend to do more voluntary work. Some studies show that volunteering benefits volunteers in addition to the receiver/community (Wilson 2000). Other research shows:

- enhanced mental health;
- reduced depression and depressive symptoms in the presence of stressors; and
- self-reported benefits for those experiencing mental health problems.

A review of 37 studies by Wheeler, Gore and Greenblatt (1998) found that 70% of older volunteers scored higher on quality-of-life measures than their peers who did not volunteer. Additionally, the quality of life of 85% of the people the volunteers worked with also improved as a result of becoming less isolated and depressed. Greenfield and Marks (2004) found that, among a subset of older people, volunteering was associated with a more positive effect.

While the evidence is mixed, encouraging and facilitating access to volunteering activity may be empowering for some patients and a potential route to developing valued skills and opportunities for social contact.

## 8.8 Employment

Support with employment includes two main approaches – vocational advice and support (as part of primary prevention), and supported employment (as part of secondary/tertiary prevention).

### Vocational advice

Vocational advice schemes typically employ advice workers as part of a mental health team, providing vocational advice and support (including job retention) to care co-ordinators, clients and, where appropriate, employers (see [www.socialinclusion.org.uk/good\\_practice/index.php?subid=59](http://www.socialinclusion.org.uk/good_practice/index.php?subid=59)).

Social prescribing can support people in retaining or returning to employment, by enabling referral to any of the interventions described in this report. It is possible to target people who are, or are at risk of being, socially excluded as a result of experiencing emotional distress. This includes unemployment, risk of job loss and factors of social isolation. Social prescribing provides early intervention to keep people in work and maintain social contacts. Once a person has reached crisis point, it is much more difficult and costly to restore their employment and social status, with a subsequent exacerbation of economic and health inequalities.

### Supported employment

Organisations that support people back into employment can also be included within social prescribing. The most effective model is individual placement and support (IPS). IPS can be delivered through job brokers or existing voluntary and statutory employment schemes. Integration with the community mental health team is a critical requirement.

### Social enterprises/social firms

Social firms and other social enterprises offer a road to recovery and employment opportunities to people with mental health problems. A social firm is a type of social enterprise, the specific social purpose of which is to employ people disadvantaged in the labour market. Other types of social enterprise include development trusts, co-operatives, credit unions and community businesses.

Social firms subscribe to three core values (Social Enterprise Coalition 2005):

- enterprise – social firms are businesses that combine a market orientation and a social mission ('businesses that support' rather than 'projects that trade');
- employment – social firms are supportive workplaces that provide all employees with support, opportunity and meaningful work; and
- empowerment – social firms are committed to the social and economic integration of disadvantaged people through employment. A key means to this end is economic empowerment through the payment of market wages to all employees.

Social firms and social enterprises can provide employment opportunities within a social prescribing model. They can also be established to deliver mental health services – the Government is keen to see more public sector services delivered by social enterprise.

For further information see [www.socialenterprise.org.uk](http://www.socialenterprise.org.uk) and [www.socialfirms.co.uk](http://www.socialfirms.co.uk).

### Time banks

A time bank is a 'virtual' bank where people can deposit the time they spend helping each other and withdraw that time when they need help themselves. Everyone's time is of equal value and transactions are facilitated and recorded by a time broker. The time bank is essentially a mutual volunteering scheme, using time as a currency.

Time banks have been widely used within broader regeneration and urban renewal programmes. There are also a number of examples of their use in primary care, in recognition that feelings of isolation may be a significant source of poor health status and that many presenting problems are social, rather than medical, in origin.

### Rationale/evidence base

Time banks have shown a positive impact on confidence and self-esteem, have provided opportunities for elderly and disabled people to contribute, and have strengthened community-based self-help and mutual aid. The main impact comes from sustained befriending and intensive or frequent volunteering.

Other outcomes (Seyfang and Smith 2002; Seyfang 2003; New Economics Foundation 2002) include:

- improved quality of life through social interaction and having practical needs met;
- support, confidence, friendship and new skills;
- an alternative for people reluctant or unable to use psychological therapies, although time banks also work well alongside talking treatments;
- helping to increase people's understanding and tolerance of depression and mental illness;
- supporting of primary care workers by creating a system of social support for more vulnerable patients; and
- referral providing access to a much wider range of services.

# 9 The North West Social Prescribing Development Project

The North West Social Prescribing Development Project was launched by CSIP North West in October 2006. Interested localities were invited to participate if they met the criteria of:

- a lead manager in place;
- agreed funding for, or existing, investment in initiatives;
- local sign-up to a stepped care model;
- systems/capacity for evaluation;
- multi-agency partnership arrangements in place; and
- agreement to disseminate findings of the project.

The four chosen pilot sites were Sefton, Stockport, the Fylde Coast and East Lancashire.

## 9.1 Social prescribing – Stockport

### Starting point

In 2006 Stockport had already successfully developed and evaluated an arts on prescription scheme. An exercise on referral programme (with a coronary heart disease focus) and a books on prescription scheme were already up and running, and Stockport also had a high-street-based wellbeing centre, which offered information and a range of activities.

### Progress

Although all the schemes were independent and unrelated, there was easy acceptance of changes in referral criteria to include mental health – anxiety and depression are now the most common reasons for referral for exercise.

A working group was established that developed good working relationships between a range of partners. Public health involvement allows for effective systems of communication with all stakeholders. Social prescribing has been integrated within the stepped care approach and the joint commissioning strategy.

Information prescriptions are about to be launched – a brand has been developed and this links intrinsically into social prescribing and concepts of self-help.

There has been consistent investment in bibliotherapy with generic health developments, and a bid for health innovations money has been made to enlarge the choice of books and increase publicity.

The scheme has been branded and marketed to referrers. There is a good infrastructure but the scheme is still not accessed to full potential by health staff – there is room for further publicity and marketing of information providers to the health sector.

Although there are common elements to the different social prescribing projects, there is currently no central co-ordination and funding is being sought for this. Offering social interventions alongside psychological therapies has the potential to maximise the effectiveness of the IAPT scheme.

### Future plans

Future plans include developing central co-ordination of all social prescribing activity, and further promoting the scheme to health professionals.

Contact: Elysabeth.Williams@stockport-pct.nhs.uk

## 9.2 Social prescribing – Sefton

### Starting point

This project arose from the need to establish a more co-ordinated, robust and validated structure for the existing and developing social prescribing programmes in Sefton. The Public Health Partnership Mental Health Group was forward-thinking, looking at the mechanisms under stepped care and practice-based commissioning to secure a wider, sustained commitment to social prescribing. The Mental Health Group is responsible for the performance management of the social prescribing programmes in Sefton, which report regularly to it. Existing activities include:

- the Active Sefton exercise referral scheme, led by Sefton Leisure Services, that includes mental health referral criteria. This scheme was one of the case studies in the Mental Health Foundation report on exercise and mental health, *Up and running?* (Mental Health Foundation 2005). Active Sefton uses the Dartmouth Coop Charts evaluation measure and reports quarterly on progress;

- the Active Lifestyle exercise referral scheme for youths who are experiencing mental health problems, run by Sefton Leisure Services;
- Relax & Revive – a physical activity programme targeting adults with mental health problems. This was funded by Neighbourhood Renewal until March 2008, and led by Sefton PCT;
- Active Reading – a self-help open-access bibliotherapy programme jointly run by the PCT and the library service, which reports quarterly;
- Citizens Advice Bureau Health Outreach – a programme in GP practices and community centres, which reports quarterly; and
- Creative Alternatives – an arts on prescription scheme that is just commencing, led by Sefton Council's Arts Services.

### Progress

Although the exercise referral scheme had been running for some time, a change in referral criteria was instigated and the scheme was integrated into PCT and borough council working. A third of referrals are mental health-related and there is now a designated person for mental health, liaising with community mental health teams – although there is still a perception on the part of some potential referrers that the scheme is focused on coronary heart disease.

Active Reading has been very well received – it produces lots of data, is sustainably funded from the library budget and is to be expanded to include children and adolescents.

A multi-stakeholder social prescribing forum has been developed and is continuing the development of schemes to make them more robust. The forum has developed a model for Sefton (based on the one included in this guidance) to include co-ordination for supported referral.

Social prescribing has been integrated into care pathways for mental health services, although not as a single coherent service. Three administrative posts have been identified to co-ordinate and collect data.

### Future plans

PCT decisions are awaited on mainstreaming of existing short-term schemes and further funding for co-ordination.

Other plans include:

- further development and marketing of the 'Active' brand – Active Solutions, Active Sefton;
- further marketing of the services; and
- agreement on evaluation methods and resource sharing between partners.

Contact: Pat.Nicholl@seftonpct.nhs.uk

### 9.3 Social prescribing – Fylde Coast

#### Starting point

The Fylde Coast scheme initially covered the PCT footprints of Blackpool, Wyre and Fylde. Following the PCT reconfigurations in October 2006, Wyre and Fylde merged with Lancaster District to become North Lancashire PCT, while Blackpool remained a separate unitary local authority and PCT.

Social prescribing was integrated into the stepped care pathway for primary care and had just begun to take referrals from secondary care. A multi-agency partnership group had agreed to oversee the developments. Small amounts of short-term funding had been used to employ a part-time volunteer/social inclusion co-ordinator, working within a voluntary sector organisation in partnership with health and social services. A social prescribing website was available, which included a database of local organisations to which to signpost clients. Community groups were running in partnership with the local adult education college.

Various exercise schemes with a coronary heart disease focus were running across the different PCTs with different levels of funding, but all expanded their criteria to include mental health.

#### Progress

Two of the four LSPs have included social prescribing in their community plans and it has been accepted as an LAA target in Lancashire. Green exercise schemes have been established in partnerships with the PCT, two borough councils and LSPs and Lancashire Wildlife Trust. Social prescribing has been incorporated into county-wide plans to develop local information gateways. The scheme has received an Impact award for good collaboration between health and voluntary sectors.

### Future plans

- To extend the programme to the Lancaster area.
- To incorporate social prescribing principles – particularly supported referral – into new designs for mental health day services.
- To sustainably fund a comprehensive social prescribing model.

Contact: Hilary.Abernethy@northlancs.nhs.uk

## 9.4 Social prescribing – East Lancashire

### Starting point

A multi-agency partnership group was established to develop a model. Existing schemes included:

- arts and health;
- physical activity;
- bibliotherapy;
- citizens advice in primary care; and
- voluntary sector relationships.

However, there was no real sense of a coherent, branded model.

### Progress

Social prescribing is being expanded within borough council footprints, and has been incorporated into county-wide plans to develop local information gateways, which have been a catalyst for improvements.

PCT funding has been allocated for developments, and voluntary sector leadership has been obtained for development plans. There is also LSP commitment to social prescribing.

### Future plans

- To incorporate plans into a gateway model.

Contact: Maureen.Morton@eastlancspct.nhs.uk; dianne.gardner@eastlancspct.nhs.uk

## 9.5 North West Social Prescribing Development Project outcomes

The project involved meeting with locality steering groups and advising on the development of social prescribing schemes. The locality leads of the project also met to discuss the main factors in successful developments and identify barriers to implementation. The main barrier was a lack of capacity to co-ordinate referrals and record activity and outcomes, and so bring coherence to the local schemes. The recommendations for development were:

- **development of a social prescribing care pathway** flexible enough to meet the needs of different geographic and demographic area profiles;
- **improved social prescribing co-ordination** to manage the efficiency and effectiveness of the service across the locality and between referrers, providers and patients; and
- **social marketing** of social prescribing to promote benefits and increase use.

The discussions and recommendations have been brought together into this document, led by the project co-ordinator, Hilary Abernethy.

# 10 Measuring success

Questions about the effectiveness of social prescribing and community referrals are part of an ongoing debate about 'who defines success?' and the challenge of developing measures and methodologies that can capture valued outcomes in a wider range of domains than symptoms. Such outcomes might include:

- individual personal goals – for example, employment, independence, friendships, quality of life and life satisfaction;
- lay/community definitions of mental health and wellbeing; and
- 'experts by experience' perspectives on living and coping with mental health problems.

Within clinical settings, the preferred focus may be on assessing effectiveness in terms of reduced symptoms or improved mental health scores, using tools such as GHQ12, BDI and Social Functioning 36. Increasingly, however, there is a case for complementing a focus on clinical outcomes with broader measures: for example, quality of life and social inclusion. There is a growing interest in measures that capture mental wellbeing, whether or not symptoms persist. WEMWBS is one example, developed to track changes in positive mental health in Scotland and designed for use at a population level (Parkinson 2006).<sup>8</sup> WEMWBS is currently being piloted in a wide range of settings and can be used (for example) to identify changes in the wellbeing of a whole cohort of patients referred through social prescribing. There is a range of scales validated for use in the UK that measure different elements of mental wellbeing (NHS Health Scotland 2008). These include, for example:

- life satisfaction/quality of life;
- positive affect/happiness;
- optimism/hopefulness;
- resilience and coping;
- spirituality/meaning in life;
- social integration/social function; and
- emotional intelligence.

<sup>8</sup> Information on the development of WEMWBS can be found at [www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx](http://www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx)

The choice of scale will depend on a wide range of factors. A recent review of wellbeing scales recommends nine scales, with Affectometer 2 described as the most promising instrument for measuring overall mental wellbeing (NHS Health Scotland 2008). For a brief measure of emotional wellbeing, the Short Depression–Happiness Scale (six items) offers good content validity and reliability. Scales for use in the evaluation of interventions need to be responsive (e.g. WBQ12).<sup>9</sup>

A whole-system approach to social prescribing provides the potential to use a consistent framework for evaluating the impact of different types and levels of intervention in a way that allows comparison. The dataset allows recording of the scores from a range of diagnostic tools to measure impact on mental wellbeing, and has the facility to baseline and measure post-intervention.

9 Full details of the strengths and weaknesses of these scales and how to obtain permission to use them are provided in NHS Health Scotland (2008) *Selecting scales to assess mental wellbeing in adults*. Edinburgh: NHS Health Scotland.

# 11 Conclusions

Social prescribing can contribute significantly to improving primary care provision for those with mental health needs, can offer greater choice to patients and can also provide a gateway to community-based resources. Social prescribing supports improved access to psychological treatments as well as to services and interventions addressing the wider determinants of mental health. It has considerable potential to improve mental health and wellbeing.

Improving mental health is an important factor in achieving a wide range of clinical goals for physical health; mental wellbeing contributes fundamentally to the extent to which people feel able and motivated to exercise choice and control and to adopt healthy lifestyles. Mental health is also increasingly seen as relevant to achieving broader strategic goals in health, education, regeneration, crime reduction, community cohesion, sustainable development, employment, culture and sport (NIMHE 2005).

Social prescribing may be of particular value because it addresses the social and economic context for the psychological skills and attributes that make up 'positive mental health' (Friedli, in press). A preoccupation with individual characteristics may lead to a 'disembodied psychology' that separates what goes on **inside people's heads** from social structure and context (Clinical Psychology Forum, 2006). The key therapeutic intervention then becomes to 'change the way you think', rather than to refer people to sources of help for key catalysts of psychological problems: poverty, debt, poor housing, violence, crime (Scottish Development Centre for Mental Health 2007; Popay et al. 2007).

Social prescribing can contribute to greater awareness of the relative contribution to mental wellbeing of individual psychological skills and attributes (e.g. autonomy, positive affect and self-efficacy) and the circumstances of people's lives: housing, employment, income and status.

It is recommended therefore that social prescribing is available as part of prevention and early intervention within primary care, and also to support recovery from severe mental distress. The North West project found that central co-ordination would improve the efficiency and effectiveness of social prescribing. New commissioning arrangements and increased access to psychological therapies within primary care provide opportunities to enable the progression of this work.

# References

Aldridge, F. and Lavender, P. (2000) *The impact of learning on health*. Leicester: National Institute of Adult Continuing Education.

Anglia Polytechnic University/University of Central Lancashire research team (2005) *Mental health, social inclusion and arts: developing the evidence base*. London: National Social Inclusion Programme/Care Services Improvement Partnership.

Anthony, W.A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16(4): 11–23.

Arts Council England (2004) *Arts in health: A review of the medical literature*. London: Arts Council England. [www.artscouncil.org.uk/documents/projects/php8fqKnd.doc](http://www.artscouncil.org.uk/documents/projects/php8fqKnd.doc)

Arts Council England (2007) *The arts, health and wellbeing*. London: Arts Council England.

Arts for Health (2006) *Invest to save: Arts in health literature review*. Manchester: Manchester Metropolitan University. [www.miriad.mmu.ac.uk/investtosave/research/Lit%20Review%20MASTER.pdf](http://www.miriad.mmu.ac.uk/investtosave/research/Lit%20Review%20MASTER.pdf)

Bates, P. (ed.) (2002) *Working for inclusion: Making social inclusion a reality for people with severe mental health problems*. London: Sainsbury Centre for Mental Health.

Blastock, D., Brannelly, T., Davis, A. and Howes, D. (2005) *Signposting evaluation report*. Leeds: National Institute for Mental Health in England.

Bridges, K.W. and Goldberg, D.P. (1985) Somatic presentation of DSM-III psychiatric disorders in primary care. *Journal of Psychosomatic Research* 29: 563–9.

BTCV (2002) *Green gym research summary*. Oxford: Oxford School for Healthcare Research and Development, Oxford Brookes University.

Callard, F. and 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.

Clinical Psychology Forum (2006) June, 162: 25–8. [www.bps.org.uk](http://www.bps.org.uk)

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. [www.countrysiderecreation.org.uk/pdf/CRN%20exec%20summary.pdf](http://www.countrysiderecreation.org.uk/pdf/CRN%20exec%20summary.pdf)

Darbishire, L. and Glenister, D. (1998) The Balance for Life scheme: Mental health benefits of GP recommended exercise in relation to depression and anxiety. Cited in: Scottish Development Centre for Mental Health (2007) *Developing social prescribing and community referrals for mental health in Scotland*. Edinburgh: Scottish Government.

Department for Communities and Local Government (2007) *The New Performance Framework for Local Authorities and Local Authority Partnerships*. London: Department for Communities and Local Government.

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 of Health (2001) *Exercise referral systems: a national quality assurance framework*. London: Department of Health. [www.dh.gov.uk/assetRoot/04/07/90/09/04079009.pdf](http://www.dh.gov.uk/assetRoot/04/07/90/09/04079009.pdf)

Department of Health (2004) *Choosing health: Making healthy choices easier*. London: Department of Health.

Department of Health (2006) *Our health, our care, our say: A new direction for community services*. London: Department of Health.

Department of Health (2007a) *Commissioning framework for health and well-being*. London: Department of Health.

Department of Health (2007b) *Report of the Review of Arts and Health Working Group*. London: Department of Health.

Department of Health (2008) *High quality care for all: NHS Next Stage Review final report*. London: The Stationery Office.

Department of Health/Arts Council England (2007) *A prospectus for arts and health*. London: Department of Health.

Dolan, P., Peasgood, T. and White, M. (2006) *Review of research on the influences on personal well-being and application to policy making*. London: Department for Environment, Food and Rural Affairs. [www.defra.gov.uk/science/project\\_data/DocumentLibrary/SD12005/SD12005\\_4017\\_FRP.pdf](http://www.defra.gov.uk/science/project_data/DocumentLibrary/SD12005/SD12005_4017_FRP.pdf)

- Dowrick, C.F., Bellon, J.A. and Gomez, M.J. (2000) GP frequent attendance in Liverpool and Granada: The impact of depressive symptoms. *British Journal of General Practice* 50(454): 361–5.
- Etnier, J.L., Salazar, W., Landers, D.M., Petruzzello, S.J., Han, M. and Nowell, P. (1997) The influence of physical fitness and exercise upon cognitive functioning: A meta-analysis. *Journal of Sport and Exercise Psychology* 19: 249–77.
- Faulkner, A. (1997) *Knowing our own minds*. London: Mental Health Foundation.
- Faulkner, A. (2002) User-led research. In: Bates P (ed.) *Working for inclusion: Making social inclusion a reality for people with severe mental health problems*. London: Sainsbury Centre for Mental Health.
- Faulkner, G. and Biddle, S. (1999) Exercise as an adjunct treatment for schizophrenia: A review of the literature. *Journal of Mental Health* 8(5): 441–57.
- Feinstein, L., Hammond, C., Woods, L., Preston, J. and Bynner, J. (2003) *The contribution of adult learning to health and social capital*. London: Centre for Research on the Wider Benefits of Learning.
- Fox, K.R. (2000) Self-esteem, self-perceptions and exercise. *International Journal of Sport Psychology* 31: 228–40.
- Frasure-Smith, N. (2000) Social support, depression, and mortality during the first year after myocardial infarction. *Circulation* 101: 1919–24.
- Friedli, L. (2003) *Making it effective: A guide to evidence based mental health promotion*. London: mentality.
- Friedli, L. (in press) *Mental health, resilience and inequalities*. London/Copenhagen: WHO and Mental Health Foundation.
- Friedli, L. and Parsonage, M. (2008) *Mental health promotion: Building an economic Case*. Belfast: Northern Ireland Association for Mental Health. [www.niamh.co.uk/](http://www.niamh.co.uk/)
- Friedli, L. and Watson, S. (2004) *Social prescribing for mental health*. Durham: Northern Centre for Mental Health.
- Friedli, L., Griffiths, S. and Tidyman, M. (2002) The mental health benefits of arts and creativity for African and Caribbean young men. *Journal of Mental Health Promotion* 1(3): 32–45.

- Friedli, L., Oliver, C., Tidyman, M. and Ward, G. (2007) *Mental health improvement: Evidence based messages to promote mental wellbeing. A report for NHS Health Scotland*. Edinburgh: NHS Health Scotland. [www.healthscotland.com/documents/2188.aspx](http://www.healthscotland.com/documents/2188.aspx), [www.healthscotland.com/documents/2191.aspx](http://www.healthscotland.com/documents/2191.aspx)
- Frude, N. (2004) Bibliotherapy as means of delivering psychological therapy. *Clinical Psychology* 39: 8–10.
- Gask, L., Rogers, A., Roland, M. and Morris, D. (2000) *Improving quality in primary care: A practical guide to the national service framework for mental health*. Manchester: National Primary Care Research and Development Centre, University of Manchester.
- Gillam, S. and Levenson, R. (1999) Link workers in primary care: An untapped resource. *British Medical Journal* 319: 1215.
- 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. and Hine, C. (2000) A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *British Medical Journal* 320: 419–23.
- Greater Manchester Arts and Health Network (2005) *Social prescribing guidance*. Manchester: Greater Manchester Arts and Health Network. [www.wlct.org/gmahn/socpres.pdf](http://www.wlct.org/gmahn/socpres.pdf)
- Greene, J. (2000) Prescribing a healthy social life. *Hippocrates* 14(8): 1–8.
- Greenfield, E.A. and Marks, N.F. (2004) Formal volunteering as a protective factor for older adults' psychological well-being. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 59: S258–S264.
- Harris, T., Brown, G.W. and Robinson, R. (1999) Befriending as an intervention for chronic depression among women in an inner city. 1: Randomised controlled trial. *British Journal of Psychiatry* 174: 219–24.
- Harris, T. and Craig, T. (2004) *Evaluation of the Rushey Green time bank: Final report to the King's Fund*. London: Socio-Medical Research Group, St. Thomas' Hospital.
- Health Education Authority (1998) *Community action for mental health*. London: Health Education Authority.
- Health Education Authority (1999) *Art for health: A review of good practice in community based arts projects and interventions which impact on health and wellbeing*. London: Health Education Authority.

- Heywood, P.L., Cameron Blackie, G., Cameron, I.H. and Dowell, A.C. (1998) An assessment of the attributes of frequent attenders to general practice. *Family Practice* 15(3): 198–204.
- Hicks, D. (2006) *An audit of bibliotherapy/books on prescription activity in England*. London: Arts Council England.
- Hutchison, C., Porter, S. and Le Voil, S. (2003) *Live to tell: Findings from a study of suicidal thoughts, feelings and behaviours amongst young gay and bisexual men in Edinburgh*. Edinburgh: Gay Men's Health/LGBT Scotland.
- Huxley, P. (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.
- Kalmanowitz, D. and Lloyd, B. (1997) *The portable studio: Art therapy and political conflict – initiatives in the former Yugoslavia and Kwa Zulu, Natal, South Africa*. London: Health Education Authority.
- Katon, W. (2003) Clinical and health services relationships between major depression, depressive symptoms and general medical illness. *Biological Psychiatry* 54(3): 216–26.
- Kessler, D., Lloyd, K. and Lewis, G. (1999) Cross sectional study of symptom attribution and recognition of depression and anxiety in primary care. *British Medical Journal* 318: 436–9.
- Keyes, C.L.M. (2004) The nexus of cardiovascular disease and depression revisited: the complete mental health perspective and the moderating role of age and gender. *Aging & Mental Health* 8(3): 266–74.
- Killoran, A., Fentem, P. and Caspersen, C. (eds) (1994) *Moving on: International perspectives on promoting physical activity*. London: Health Education Authority.
- Kroenke, K. (2002) Psychological medicine: Integrating psychological care into general medical practice. *British Medical Journal* 324: 1535–7.
- Lewis, G. and Anderson, E. (2003) *Self-help interventions for people with mental health problems*. London: Department of Health.
- Matarasso, F. (1997) *Use or ornament? The social impact of participation in the arts*. Stroud: Comedia.

Mental Health Act Commission (2001) *National consultation on mental health issues and black and minority ethnic communities: Regional support for the North*. East Lancaster: University of Lancashire.

Mental Health Foundation (2000) *Strategies for living: A report of user-led research into people's strategies for living with mental distress*. London: Mental Health Foundation.

Mental Health Foundation (2005) *Up and running? Exercise therapy and the treatment of mild or moderate depression in primary care*. London: Mental Health Foundation.

Mind (2007) *Ecotherapy: The green agenda for mental health*. London: Mind. [www.mind.org.uk/mindweek2007/report](http://www.mind.org.uk/mindweek2007/report)

Mutrie, N. (2000) The relationship between physical activity and clinically defined depression. In: Biddle, S.J.H., Fox, K.R. and Boutcher, S.H. (eds) *Physical activity and psychological wellbeing*. London: Routledge.

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. [www.niace.org.uk](http://www.niace.org.uk)

National Institute for Health and Clinical Excellence (2004a) *Management of panic disorder and generalised anxiety disorder in adults*. London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (2004b) *Depression: The management of depression in primary and secondary care*. London: National Institute for Health and Clinical Excellence/National Collaboration Centre for Mental Health.

National Institute for Health and Clinical Excellence (2006a) *Four commonly used methods to increase physical activity*. London: National Institute for Health and Clinical Excellence.

National Institute for Health and Clinical Excellence (2006b) *Computerized cognitive behaviour therapy for depression and anxiety. Review of Technology Appraisal no. 51*. London: National Institute for Health and Clinical Excellence.

National Institute for Mental Health in England (2003) *Employment for people with mental health problems*. Briefing paper. London: Department of Health.

National Institute for Mental Health in England (2005) *Making it possible: Improving mental health and well-being in England*. Leeds: Care Services Improvement Partnership.

- New Economics Foundation (2002) *Rushey Green Time Bank evaluation report*. London: New Economics Foundation. [www.timebanks.co.uk](http://www.timebanks.co.uk)
- NHS Health Scotland (2008) *Mental Health Improvement: Evidence and practice – guide 5. Selecting scales to assess mental wellbeing in adults*. Edinburgh: NHS Health Scotland. [www.healthscotland.com/documents/2403.aspx](http://www.healthscotland.com/documents/2403.aspx)
- Oliver, J.P.J., Huxley, P.J., Bridges, K. and Mohammed, H. (1996) *Quality of life and mental health services*. London: Routledge.
- Parkinson, J. (2006) *Measuring positive mental health: Developing a new scale*. Glasgow: NHS Health Scotland.
- Popay, J., Kowarzik, U., Mallinson, S., Mackian, S., Barker, J. (2007) Social problems, primary care and pathways to help and support: Addressing health inequalities at the individual level. Part I: the GP perspective. *Journal of Epidemiology and Community Health* 61: 966–71.
- Powell, J. and Clarke, A. (2006) Internet information seeking in mental health: Population survey. *British Journal of Psychiatry* 189: 273–7.
- Pretty, J., Griffin, M., Sellens, M. and 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 2003-1. Chelmsford: University of Essex.
- Reading Agency (2003) *Reading and health mapping research project*. St. Albans: Reading Agency. [www.readingagency.org.uk/new-thinking/newthinking-uploads/Reading\\_and\\_health\\_project.pdf](http://www.readingagency.org.uk/new-thinking/newthinking-uploads/Reading_and_health_project.pdf)
- Rethink (2005) *A report on the work of the recovery learning sites and other recovery-orientated activities and its incorporation into the Rethink plan 2004–08*. London: Rethink.
- Rogers, A. and Pilgrim, D. (1997) The contribution of lay knowledge to the understanding and promotion of mental health. *Journal of Mental Health* 6(1): 23–35.
- Sanders, J., Parsons, C., Ryder, P. and Hide, M. (2002) *Social prescribing in Greenwich: A partnership approach*. London: Greenwich PCT/Partnerships Work.
- Scottish Development Centre for Mental Health (2007) *Developing social prescribing and community referrals for mental health in Scotland*. Edinburgh: Scottish Government. [www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing](http://www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/communityprescribing).

Scottish Executive (2004) *A literature review of the evidence base for culture, the arts and sport policy*. Edinburgh: Scottish Executive. [www.scotland.gov.uk/Publications/2004/08/19784/41518](http://www.scotland.gov.uk/Publications/2004/08/19784/41518)

Secker, J., Hacking, S., Spandler, H., Kent, L., Shenton, J. (2007) *Mental health, social inclusion and arts: Developing the evidence base*. London: National Social Inclusion Programme/Care Services Improvement Partnership. [www.socialinclusion.org.uk/publications/Phase%201%20report.pdf](http://www.socialinclusion.org.uk/publications/Phase%201%20report.pdf)

Seyfang, G. (2003) Growing cohesive communities one favour at a time: Social exclusion, active citizenship and time banks. *International Journal of Urban and Regional Research* 27(3): 699–706.

Seyfang, G. and Smith, K. (2002) *The time of our lives: Using time banking for neighbourhood renewal and community capacity building*. London: New Economics Foundation.

Shaw, I. and Middleton, H. (2001) Recognising depression in primary care. *Journal of Primary Care Mental Health* 5(2): 24–7.

Snaith, R.P. (1993) What do depression scales measure? *British Journal of Psychiatry* 163: 293–8.

Social Enterprise Coalition (2005) *There's more to business: A manifesto for social enterprise*. London: Social Enterprise Coalition.

Social Exclusion Unit (2004) *Mental health and social exclusion*. London: Office of the Deputy Prime Minister.

Staricoff, R. (2004) *Arts in health: A review of the medical literature*. London: Arts Council England. [www.artscouncil.org.uk/documents/publications/phpc0eMaS.pdf](http://www.artscouncil.org.uk/documents/publications/phpc0eMaS.pdf)

Thoits, P.A. and Hewitt, L.N. (2001) Volunteer work and wellbeing. *Journal of Health and Social Behavior* 42: 115–31.

Tyldesley, R. and Rigby, T. (2003) *The Arts on Prescription Postnatal Depression Support Service: An evaluation of a twelve week pilot*. Stockport: Stockport PCT.

van Willigan, M. (2000) Differential benefits of volunteering across the life course. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 55: s308–s318.

Wheeler, F.A., Gore, K.M. and Greenblatt, B. (1998) The beneficial effects of volunteering for older volunteers and the people they service: A meta-analysis. *International Journal of Ageing and Human Development* 47: 91.

White, M. and Angus, J. (2003) *Arts and adult mental health literature review*. Durham: Centre for Arts and Humanities in Health and Medicine, University of Durham. [www.dur.ac.uk/resources/cahbm/reports/Arts%20and%20Mental%20Health%20Report%20MW%202003.pdf](http://www.dur.ac.uk/resources/cahbm/reports/Arts%20and%20Mental%20Health%20Report%20MW%202003.pdf)

White, J., Joice, A., Petrie, S., Johnston, S., Gilroy, D., Hutton, P., and Hynes, N. (2008) STEPS: Going beyond the tip of the iceberg: a multi-level, multi-purpose approach to common mental health problems. *Journal of Public Mental Health* 7 (1): 42–50.

Wilson, J. (2000) Volunteering. *American Review of Sociology* 26: 215–40.