A Review of Community Referral Schemes

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Foreword - Sir Peter Bazalgette

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

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

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

Foreword - Shirley Cramer CBE

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

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

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

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

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

Social prescribing in the United Kingdom (UK) has been brought about by decentralisation of healthcare decision making from national to local government, an emphasis on the notion that prevention is better than cure, and the organisation of multi-agency and holistic approaches to healthcare. Recent government initiatives and key policy reports have provided a climate for development of social prescribing within local communities; these include: the inception of Clinical Commissioning Groups and Improving Access to Psychological Therapy (IAPT); findings from the Marmot Review; the concept of the Big Society; the Foresight Report on Mental Capital; and the National Institute for Health and Clinical Excellence (NICE) guidelines.

Just over 40% of the UK social prescribing schemes reviewed here have been subject to evaluation. Around two-thirds of the evaluated schemes reviewed employed qualitative analysis of questionnaires, interviews, surveys or focus groups whereas the other third used statistical analysis of measures from reliable and validated clinical scales; three of these schemes employed randomised controlled trials (RCT) and another scheme compared physiological measures. Robust evaluation of social prescribing schemes is recommended, as nearly 60% of the programmes included in this review have not been subject to any formal means of assessment.

Outcomes of social prescribing have produced benefits for participants including:

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

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

2.1 Aims and objectives

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

2.2 What is social prescribing?

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

A report commissioned by the Lewisham Clinical Commissioning Group (CCG) (Malcolm-Smith & Richards, 2014: 10) defined social prescribing as ‘A means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. Often these services are provided by voluntary, community and faith sector (VCFS) organisations with in depth knowledge of local communities and how best to meet their needs of specific groups’. The Care Services Improvement Partnership North West (2009: 25) found that social prescribing schemes represented an ‘innovative approach to engaging with health inequalities’ that ‘used partnership working to address the social causes of mental ill health’. The Care Services Improvement Partnership stressed that recovery was a central principle in mental health care and advocated that referring and signposting should be a continuous process to maintain throughput for schemes and onward referral for continuing participation.

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

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

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

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

'A valuable complement to other recent and ongoing developments within the NHS to promote access to psychological treatments and interventions’
Scottish Development Centre for Mental Health (2007: 5)
Friedli, Jackson, Abernethy and Stansfield (2009: 2) described social prescribing as a non-medical intervention that was helpful for ‘vulnerable and at risk groups... people with mild to moderate depression and anxiety; people with long-term and enduring mental health problems; and frequent attendees in primary care.’ Friedli et al. noted that most social prescribing models were primary care-based where patients were referred to specific programmes or signposted to information or support from community, voluntary or local authority services.

2.3 Background to social prescribing

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

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

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

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

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

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

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

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

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

Community aspects of social prescribing align with the ‘Big Society’ initiative launched by the UK Coalition Government (2010) that emphasized partnerships and voluntary or third sector delivery. The ‘Big Society’ aimed to create a climate to empower local communities.

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

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

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

Mental wellbeing was defined as ‘a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community’ Foresight (2008: 10). Mental wellbeing was linked to ‘mental capital’, involving cognitive and emotional resources including cognitive ability, flexibility and learning efficiency, and ‘emotional intelligence’ comprising social skills and resilience to stressors. Key factors such as purposeful activity, health, social support and self-esteem were seen to build individual and community resilience by exploiting mental wellbeing and mental capital.
The CentreForum Mental Health Commission (2014: 7) identified five policy shifts:

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

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

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

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

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

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

McManus et al. (2009)

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

Andrews et al. (2005)

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

Mental Health Policy Group (2012: 1)

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

Spector et al. (2012: 244).
3 Models of social prescribing

3.1 Main types of scheme

**Arts on Prescription**

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

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

**Books on Prescription**

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

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

In February 2012, the Public Library Health Offer Group received funding from the Library Development Initiative to pilot its ‘Reading Well: Books on Prescription’ scheme. Due to its popularity, the scheme was launched nationally as part of the Universal Health Offer for Libraries across 84% of English library authorities in May 2013. It was supported by the DH; Society of Chief Librarians; the Reading Agency; and Arts Council England (Department for Culture, Media and Sport, 2013). ‘Reading Well: Books on Prescription’ pooled all bibliotherapy schemes into a single and consistent offer across England to provide benefits for people with mild to moderate mental health conditions. National schemes were already running in Wales and parts of Scotland, and the Universal Health Offer was based on a Cardiff scheme developed by clinical psychologist, Prof. Neil Frude (2005).
The aim of the Reading Agency and Society of Chief Librarians was to make optimal use of resources by creating a shared model for Books on Prescription, incorporating quality assurance, best practice and creation of a national evidence base. The core collection of 30 titles was developed by researching best practice and consulting health partners comprising the British Association for Behavioural & Cognitive Psychotherapies, the British Psychological Society, the DH IAPT programme, Mind, the Royal College of General Practitioners, the Royal College of Nursing, and the Royal College of Psychiatrists. The Reading Agency worked with the Public Library Health Offer Group to develop central resources and materials for libraries which operated as co-ordinators working directly with local partners, GPs and community health nurses. Although the scheme was based on self-help reading, it was hoped participants would be signposted to other aspects of the library health offer such as Reading Well Mood-boosting Books (novels and poetry) and reading groups.

In March 2014, Library Services in England estimated that, based on loan figures of recommended titles, over 100,000 people with mental health issues had engaged with Reading Well Books on Prescription since its launch. Additionally, loans increased by 145% in the first three months of the scheme. Following the success of Books on Prescription, Arts Council England agreed to fund further work on how libraries could support people with dementia. In January 2015, the Reading Agency launched ‘Reading Well Books on Prescription for Dementia’ as part of the national library strategy to support development of dementia-friendly communities, build understanding and awareness of the condition, and provide support for people with dementia, their carers and anyone wanting to find out more or worried about symptoms in the absence of a formal diagnosis.

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

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

**Education on Prescription**

Education on Prescription consists of referral to formal learning opportunities, including literacy and basic skills. It can involve the use of learning advisers placed within educational establishments, day services, mental health teams or voluntary sector organisations to identify appropriate educational activities for individuals and support access. Opportunities for learning can impact positively on health by improving an individual’s socioeconomic position, access to health services and information, resilience, problem-solving, self-esteem and self-efficacy (National Institute for Adult Continuing Education, 2003).
A longitudinal American study (Vemuri et al., 2014) examined the relationship between lifetime intellectual enrichment and cognitive decline in older adults. The authors found that higher education or occupation scores were associated with higher levels of cognition, particularly in later life. They concluded that lifetime intellectual enrichment might delay the onset of cognitive impairment and be used as a successful preventive intervention for dementia. Their calculations indicated that carriers of the apolipoprotein E (APOE) gene on chromosome 19, the major genetic source of common forms of late-onset Alzheimer’s, who had experienced high lifetime intellectual enrichment, onset of cognitive impairment was later (by about 8.7 years) than those with a low lifetime intellectual enrichment.

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

Morrison and Clift (2006) evaluated the effect of supported further education for 148 mature students (mean age 39.5 years) with a long term mental health diagnosis. The students typically lacked concentration, had poor organisational abilities, poor long and/or short-term memory, negative mood, inconsistent attendance and required frequent breaks. The supported education which began off-campus in NHS day services, led to an introductory course on campus and then to a mainstream course with continued support. Students were referred through NHS staff and a coordinating occupational therapist acted as a link between referrers and personal tutors. Morrison and Clift’s evaluation was based on the Antonovsky’s Salutogenic (1993) model of health.

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

**Exercise on Prescription**

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

The Mental Health Foundation (2005) report ‘Up and Running?’ highlighted the need to promote exercise therapy for depression as a realistic and readily available tool for GPs and an option which patients could self-select. In a review of research into effects of exercise on mental health and wellbeing, Callaghan (2004) reported reductions in anxiety, depression and negative mood with increases in self-esteem and cognitive functioning, and concluded that exercise was a neglected intervention in mental health care. Previous studies indicated a positive association of physical activity with health-related quality of life and wellbeing among people with moderate to severe mental health diagnoses (Biddle & Mutri, 2001).
The biological basis for exercise referral is that regular exercise releases naturally-occurring morphine-like neuropeptides (endorphins) produced by the central nervous system and pituitary gland that inhibit the transmission of pain signals and produce a feeling of euphoria similar to that produced by other opioids (e.g. Vaughan, Wallis, Polit, Steele, Shum & Morris, 2014; Hillman, Erickson & Kramer, 2008).

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

The National Quality and Assurance Framework (DH, 2001) set out a clinical, operational and legal framework for exercise referral stressing the difference to GPs between recommending and prescribing exercise. The Mental Health Foundation (2005; 2009) carried out two surveys of perceptions of exercise referral with a UK sample of 200 NHS GPs (c. 77% England; 10% Scotland; 10% Wales; 3% Northern Ireland). In the first survey they found that 42% of GPs thought they had access to an exercise referral scheme; none said they used it 'very frequently' for patients with mild or moderate depression and 15% said they used it 'fairly frequently' (2005: 6).

Of those who indicated ‘not very frequently’ or ‘not at all’, 43% said they were not convinced it was an effective treatment, leading the Mental Health Foundation to conclude that GPs lacked sufficient information and knowledge about exercise referral schemes.

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

NICE (2014) updated previous public health guidelines (NICE, 2006) on exercise referral for adults aged 19 years and over. NICE identified gaps in research such as lack of RCT evidence and cost effectiveness for multiple health conditions and mental health; whether effects were maintained long term; how practitioners identified participants suitable for physical activity; levels of participation in under-represented groups and short and long term benefits including the ‘feel good factor’ (2014: 43). They concluded that exercise referral had limited benefit compared with other interventions (e.g. providing information about local opportunities to be active).

Pavey et al. (2011) carried out a systematic review of exercise referral studies (6 UK; 2 non-UK) that met RCT inclusion criteria comparing exercise with usual care or other interventions for over 5000 participants pooled across studies.

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

‘Physical activity can play an important role in preventing and managing health conditions such as coronary heart disease, type two diabetes, stroke, mental health problems, musculoskeletal conditions and some cancers. It also has a positive effect on wellbeing and mood, providing a sense of achievement or relaxation and release from daily stress’
NICE (2014: 5)
Pavey et al. found weak evidence to support exercise referral comprising a short term increase in physical activity and reduction in levels of depression of sedentary individuals after participation in a 10-12 week leisure centre programme compared with usual care. They found inconsistent research in support of exercise referral for other outcomes (e.g. health related quality of life) though concluded that despite limited evidence, exercise referral was a potentially valuable primary care intervention for promoting physical activity.

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

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

**Green Gyms**

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

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

In a national review of 52 UK green gym projects (Yerrell, 2008), 194 out of 703 participants completed both the introductory and continuation questionnaires using the Short Form Health Survey (SF-12) and demonstrated improved physical and mental health. In the projects reviewed, 80% of participants were aged 25-64 and 60% were male. Green gyms had the greatest impact on participants with the poorest health on joining; those with the lowest physical health scores were nine times more likely to improve, and those with the lowest mental health scores were three times more likely to improve. Yerrell (2008: 3) found that the highest rated factors for joining were ‘being outdoors’ and ‘improving the environment’ and the lowest rated factors were ‘losing weight’ and ‘being with family or partner’.
Pretty, Peacock, Hine, Sellens, South and Griffin (2007) reviewed the effects of ten green exercise studies (e.g. conservation activities, cycling, horse-riding and walking) for 263 participants across four UK regions. Even though participants were mostly active and healthy, green exercise led to significant improvements in self-esteem and reduction in measures of negative mood regardless of the duration, intensity or type of exercise, indicating the potential of green schemes as public health interventions for mental health.

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

Healthy Living Initiatives

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

Information Prescriptions

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

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

Several museums have piloted prescription schemes, with the first of its kind at Tate Britain (Art-based Information Prescription: Shaer et al., 2008); others include the Beaney House of Art & Knowledge, Canterbury (Paper Apothecary, 2013); the Cinema Museum, Lambeth, London (Cinema Museum Prescriptions, 2014); the Holburne Museum, Bath (Recollection, 2014); and Oxford University Museums (Memory Lane Prescription for Reminiscence, 2015).

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

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

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

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

Time Banks
Time banks are mutual volunteering schemes; people deposit time spent helping others and withdraw time when they need help. All time is valued equally and transactions are recorded by a time broker. The use of time banks within urban renewal recognised that isolation might be a source of poor health, and problems could be social rather than medical in origin. Over 290 UK time banks provided referral to services in parallel with IAPTs, and the DH worked with Timebanking UK to explore practical aspects of rolling out time banks in GP surgeries (National Endowment for Science, Technology and the Arts: NESTA, 2013).

Seyfang and Smith (2002) found that time banks attracted socially excluded groups such as disabled or retired people and compared with traditional volunteers around twice as many time bank volunteers were not in formal employment. Frequent volunteering impacted positively on self-esteem and quality of life through social interaction. Volunteering (under ‘Give’) was one of the ‘Five Ways to Wellbeing’ (New Economics Foundation, 2009).
3.2 Case Studies
A selection well known of social prescription programmes are explored below; these have been highlighted to demonstrate a diversity of popular referral models.

Bromley by Bow Centre ‘Social Prescribing’ London

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

Since 1997, the Centre has worked jointly with the Bromley by Bow Health Partnership to create a new and unique delivery model which employs a holistic approach derived from combining primary care with around non-clinical social projects delivered at the same venue. In response to Marmot’s (2010) contention that 70% of health outcomes are attributable to socio-economic factors, the Centre created a programme to bring together primary care provision, public health programmes, social care and non-clinical services to address the wider determinants of health. The Centre is set up with 27% medical intervention and 63% social intervention which form a blended offer. Healthcare practitioners lease consultancy spaces from the Centre. The integration of the health centre led to the creation of an ‘intelligent waiting room’ to engage with patients and connect them to wider services on offer including a social prescription scheme where health professionals (e.g. GPs, psychologists, nurses, counsellors, and phlebotomists) refer patients to the Centre’s non-clinical services (e.g. arts on prescription, crafts including stained glass, stonemasonry and gardening). The Centre employs paid and voluntary staff to facilitate its social prescribing offer including Social Prescribing Navigators at the interface between healthcare practice and non-medical services offered by charities and voluntary sectors. Local artists were amongst the first people to get involved with the Centre, consequently arts on prescription is central to social referral activities and is key to service-user creativity self-esteem. The Centre’s aim is to enable people to remain independent, active and safe, and achieve the things that matter to them most such as accessing work, learning new skills or building self-confidence.
The Claremont Project is a resource centre in the London Borough of Islington that carried out two, one-year social prescribing schemes (2012-14) and is now in its third year. The schemes are funded by ‘Islington Giving’, a local charity. The Claremont Project aims to facilitate social prescribing to connect older adult residents at risk of isolation with social, physical and therapeutic activities in a community setting. The centre offers a range of activities including keep fit, tai chi, dance, gentle exercise, creative writing and crafts for older adults who participate as members with subsidised fees (£1.50 - £2 per class). The objective of social prescribing was to reach a sub-set of isolated people aged 55 years and over, especially those 70 years and over, older men, people who were mobile but not currently engaged in any community services, and people from black and ethnic minorities. Referral criteria also included those experiencing mild to moderate mental health issues (e.g. anxiety and depression) and physical ailments (e.g. balance or co-ordination difficulties). It was envisaged that referral would be by GPs and practice nurses who would issue patients with a ‘Claremont Prescription’, though many prescriptions are issued by other health professionals (e.g. physiotherapists, occupational therapists or keyworkers) with a minority of self-referrals.

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

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

Oxford Museums ‘Prescription for Reminiscence’, South East England

The Prescription for Reminiscence Project links into museum services across the Oxford Aspire Museums Partnership, a consortium of Oxford University Museums and Oxfordshire County Council Museums Service (and one of 16 Renaissance Major Partner Museum Services funded by ACE to support excellence and resilience within regional museums). Lead partners are the Museum of Oxford and Oxford Aspire; delivery partners are Oxford University Museums Outreach Service, the Ashmolean Museum, Pitt Rivers Museums, Oxford Museum of Natural History, Museum of the History of Science, Oxford Botanic Gardens and ‘Hands on Oxfordshire Heritage’ (Oxfordshire County Council Museum Service); referral partners are Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Guideposts Trust, Young Dementia UK and Oxfordshire County Council Dementia Advisors.
Older adults are referred by local healthcare professionals to the Reminiscence Officer and self-referral is also possible. Referrers are given a referral leaflet about the project that includes information for participants. Potential participants are contacted by the Reminiscence Officer and offered an introduction and access to the Museum of Oxford’s ‘Memory Lane Group’ monthly meetings and other suitable museum services. The social prescribing scheme is linked to the Memory Lane reminiscence group that began in 2010 as an informal monthly meeting at the Museum of Oxford (or nearby museum and heritage locations) to reminisce about a chosen theme and enjoy company in a comfortable environment. Evaluation of projects highlighted that taking part provides participants with great enjoyment and a sense of belonging and making a contribution (e.g. The Morris Motors Centenary Reminiscence Project, 2013, commemorated the start of Morris Car production in Oxford. Participants took part in seven reminiscence events at Morris Motors’ related sites. Memories and stories were collected to contribute to a BBC Radio documentary aired on BBC Radio Oxford, Dec 2013).

‘Arts on Prescription’ Arts and Minds, Cambridgeshire and Peterborough

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

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

‘The reminiscence sessions are hugely beneficial to older people in that they encourage them to explore and share their memories in a friendly and supportive environment’
Arts Coordinator, Oxford University Hospitals NHS Trust

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

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

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

#### Table 1. Social prescribing timeline

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</tr>
</tbody>
</table>

**Key to colour coding**

- National
- London
- South East
- South West
- Eastern
- East Midlands
- West Midlands
- Yorkshire and the Humber
- North East
- North West
3.3 Timeline of social prescribing

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

Table 1. Social prescribing timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>Stockport: North West Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Doncaster: ‘Green Gym’</td>
</tr>
<tr>
<td></td>
<td>Bolton Social Prescribing’</td>
</tr>
<tr>
<td>2006</td>
<td>Isle of Wight: ‘Time Being 2’ Arts on Prescription</td>
</tr>
<tr>
<td>2007</td>
<td>Doncaster: ‘Green Gym’</td>
</tr>
<tr>
<td>2008</td>
<td>North Staffordshire Signposting Project</td>
</tr>
<tr>
<td>2009</td>
<td>Bedfordshire Activities for Health Exercise Referral</td>
</tr>
<tr>
<td>2010</td>
<td>Camden Exercise Referral Scheme</td>
</tr>
<tr>
<td>2011</td>
<td>Teesdale and Wear Valley: ‘Good for the Soul’ Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Books on Prescription</td>
</tr>
<tr>
<td>2012</td>
<td>Nottingham Arts on Prescription</td>
</tr>
<tr>
<td>2013</td>
<td>Doncaster: Patient Support Service and Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Bradford and Airedale: ‘Health Trainer Programme’</td>
</tr>
<tr>
<td></td>
<td>Fylde Coast: ‘North West Social Prescribing’</td>
</tr>
<tr>
<td></td>
<td>Sefton: ‘North West Social Prescribing’</td>
</tr>
<tr>
<td>2014</td>
<td>Salford: ‘Refresh’ Social Prescribing and ‘Start: Time Out’ Arts on Prescription</td>
</tr>
<tr>
<td></td>
<td>Salford Signposting website</td>
</tr>
<tr>
<td>2015</td>
<td>Keynsham Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Gloucester: ‘Art Lift’</td>
</tr>
<tr>
<td>2016</td>
<td>Durham: ‘Arts for Wellbeing’</td>
</tr>
<tr>
<td></td>
<td>Lincolnshire Exercise Referral</td>
</tr>
<tr>
<td></td>
<td>Cambridgeshire &amp; Peterborough Arts on Prescription</td>
</tr>
<tr>
<td></td>
<td>Durham: ‘Recollection’</td>
</tr>
<tr>
<td></td>
<td>Oxford: ‘Memory Lane’</td>
</tr>
<tr>
<td></td>
<td>Reading Well Dementia</td>
</tr>
<tr>
<td></td>
<td>Reading Well Books on Prescription</td>
</tr>
<tr>
<td></td>
<td>Reading Well Dementia</td>
</tr>
<tr>
<td></td>
<td>Reading Well Dementia</td>
</tr>
<tr>
<td></td>
<td>Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>‘People Powered Health’ Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Rotherham Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Lambeth: ‘Mosaic Clubhouse’</td>
</tr>
<tr>
<td></td>
<td>Cheshire &amp; Merseyside Social Prescribing</td>
</tr>
<tr>
<td></td>
<td>Lewisham: ‘Social Prescribing’</td>
</tr>
<tr>
<td></td>
<td>Bath: ‘Recollection’</td>
</tr>
</tbody>
</table>

SOCIAL PRESCRIBING REVIEW
4 Evidence base

4.1 Evaluated UK schemes

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

4.2 Key findings

Ten key findings have emerged from the summarised evidence:

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

In addition to those that have included evaluation, all of the social prescribing schemes included in this review have been summarised and tabulated according to UK electoral regions (Section 8: Appendices I - XII). Twelve further examples of social prescribing and community referral schemes from non-UK literature have been selected as illustrations of different strategies and methodologies used to assess the effectiveness of social prescribing schemes (Appendix XIII). Compared with the UK, so-called local non-UK schemes have considered much larger geographic areas with participants from much more scattered and isolated populations. In terms of evaluation, non-UK evaluation appeared to have placed a greater emphasis on the inter-relationship between mental and physical health with several interventions being appropriate for people with both types of ill health and taking the view that benefits to physical health and appearance can only bring about benefits to mental health. The majority of RCTs with waiting list controls in the UK have been for exercise referral whereas non-UK social prescribing schemes have carried out RCTs for a wider range of cultural activities.
Table 2. Summary of researched and evaluated UK schemes

<table>
<thead>
<tr>
<th>UK region</th>
<th>Scheme</th>
<th>Authors</th>
<th>Summary of findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>Camden 'Exercise Referral Scheme'</td>
<td>Stathi, Milton &amp; Riddoch (2006)</td>
<td>• Participant positive feedback with self-reported improvement in mental health, positive mood, confidence and self-esteem. • Pre- and post-intervention analysis of health (SF-12) and exercise level (IPAQ). • Improved confidence, recognition of being unwell and feeling in good physical health.</td>
</tr>
<tr>
<td></td>
<td>Dulwich Picture Gallery 'Prescription for Art'</td>
<td>Harper &amp; Hamblin (2010) Oxford Institute of Ageing</td>
<td>• Review of ‘Good Times’ (from which ‘Prescription for Art’ emerged) recognised that older people with mental or physical disability should be able to tackle similar creative challenges as other adult groups.</td>
</tr>
<tr>
<td></td>
<td>East London 'Arts on Prescription'</td>
<td>Griffiths (2002)</td>
<td>• Qualitative study of views and experiences of young African and Caribbean men; showed importance of arts and creative expression as protective factors in the face of racism and discrimination.</td>
</tr>
<tr>
<td></td>
<td>Hackney 'Well Family Service' supported referral</td>
<td>Goodhart &amp; Graffy (2000)</td>
<td>• Focus on family provided an opportunity to support hard-to-reach people in a sympathetic and accessible environment, contributing to a family-centred approach.</td>
</tr>
<tr>
<td></td>
<td>Islington 'Claremont Project Social Prescribing'</td>
<td>Claremont Social Prescription Manager &amp; Counselling Psychologist</td>
<td>• Pre-post assessment of exercise and creative activities for older adults using WEMWBS at two, 3-week intervals. • Real and perceived barriers broken down through classes, participants felt less lonely and isolated, and socialised more.</td>
</tr>
<tr>
<td></td>
<td>Penge and Anerley Park Practice supported referral pilot</td>
<td>Sykes (2002)</td>
<td>• Signposting to services; complemented primary care and bridged gap between primary care and voluntary sector. • Participant outcomes included increased self-esteem, reduced isolation and resolution of practical issues.</td>
</tr>
<tr>
<td></td>
<td>Lewisham 'Rushey Green Time Bank'</td>
<td>Boyle, Clark &amp; Burns (2006)</td>
<td>• Aimed to build core economy of family and community by valuing and rewarding work. • Involvement in time banks associated with reduced level of medication/hospitalisation.</td>
</tr>
</tbody>
</table>
| South East | Canterbury, Beaney House of Art & Knowledge ‘Paper Apothecary’ museums on prescription | ‘Happiness Investigators’ and ‘Chemists’ (2013) | ‘Happiness Investigators explored collections to answer ‘What makes you happy at the Beaney?’ 300 participants responded to: ‘How did you feel after the cultural treatment? 37% felt happy, 15% very happy, 14% had fun, 12% were inspired and 10% felt peaceful.  
• In-depth questionnaire with 40 participants showed that responses aligned with NEF’s ‘Five Ways to Wellbeing’. |
| Eastern and Coastal Kent ‘Exercise Referral Scheme’ | Milton (2008) | Over 6,500 patients referred in 3 years; showed physical benefits though some participants thought they were prescribed inappropriate programmes, were unable to perform the exercises or felt demotivated at not achieving their fitness aims. |
• Review of 53 pre-post intervention questionnaires from participants with mild to moderate mental health issues showed improvements in self-esteem, renewed motivation, social contact, decreased anxiety and interest in further arts activity. |
| South West | Avon ‘The Amalthea Project’ supported referral | Grant, Goodenough, Harvey & Hine (2000) | RCT primary outcomes: psychological wellbeing (HADS) and social support (Duke-UNC Functional Social Support Questionnaire); secondary outcomes: quality of life (Dartmouth COOP/WONCA Functional Health Assessment, Delighted-Terrible Faces); economic evaluation of contact costs with primary care.  
• Found reductions in anxiety and negative emotion, patients were more positive about general health and quality of life. |
| Gloucester ‘Art Lift’ arts on prescription | Crone, O’Connell, James, Tyson & Clark-Stone (2011) | Nearly 50% participants completed 10 weekly sessions giving better rate than for exercise referral. Pre-post quantitative analysis showed significant improvement in wellbeing of those who completed.  
• Artists identified benefits and thought that the project gave them more credence with health professionals. |
### South West

#### Keynsham ‘Social Prescribing’ pilot
- **Brandling & House (2007)**
  - Semi-structured interviews with 8 practice staff, 11 patients, and 2 community members explored acceptability of scheme.
  - Patient insight limited; patients saw GP as person most likely to address needs despite being embedded in medical model.

#### South Gloucestershire ‘Exercise on Prescription’
- **Flannery, Loughren, Baker & Crone (2014)**
  - Self-reported pre-post measures found increase in 30 minute weekly exercise sessions with decrease in systolic blood pressure and waist measurement.
  - Interviews with 14 patients and 10 practice nurses identified weight loss, and increased self-perceptions and social interaction.

#### Swindon ‘Supported Referral’
- **Howells (2001)**
  - Included assisted access, information referral supported referral, self-help literature and coping skills.
  - GHQ over 12 months showed reduction in GP consultation and referral to secondary care, and increase in patient satisfaction.

### Eastern

#### Bedfordshire ‘Activities for Health’ exercise referral
- **The Mental Health Foundation (2009)**
  - Referral from GPs for patients with anxiety and depression as part of the National Primary Care Mental Health Collaborative.
  - HADS evaluation and fitness tests identified physical health needs among mental health patients.

#### Cambridge ‘Start-Up’ and ‘Invigorate’ exercise referral
- **The Mental Health Foundation (2009)**
  - Referral for arthritis, back pain, obesity, diabetes and mental health. 60% patients completed 12-week exercise programme.
  - Reasons given for non-completion included lack of time, not enjoying and/or limited choice of activities.

#### Cambridgeshire and Peterborough ‘Arts on Prescription’
- **Potter (2013, 2015)**
  - Waiting list RCT, 12 weekly sessions, pre-post measures: anxiety (GAD-7); depression (PHQ-9); mental wellbeing (WEMWBS); social isolation (SI), and analysis of semi-structured interviews.
  - Positive outcomes for 78% of patients: increase in mental wellbeing (83%); decrease in social isolation (44%), anxiety (61%) or depression (67%).
  - Independent cost analysis of IAPT or IAPT plus arts intervention showed scope to be cost effective in reducing risk of persistent moderate or severe depression for 30% of participants.

#### McDaid & Park (2013)
  - Independent cost analysis of IAPT or IAPT plus arts intervention showed scope to be cost effective in reducing risk of persistent moderate or severe depression for 30% of participants.
<table>
<thead>
<tr>
<th>Region</th>
<th>Program Name</th>
<th>Authors</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>Lincolnshire 'Exercise Referral Programme'</td>
<td>Henderson and Mullineaux (2013, unpublished)</td>
<td>• Evaluated completion rates (62%) for 6600 participants showed significant relationship between participants who completed programme and reduction in BMI; those aged 70-79 were three times more likely to complete.</td>
</tr>
<tr>
<td></td>
<td>Nottingham 'Arts on Prescription'</td>
<td>Stickley &amp; Hui (2012a)</td>
<td>• In-depth interviews with 16 mental health patients using narrative enquiry showed that scheme provided a creative and therapeutic environment with social, psychological and occupational benefits, participants were able to determine a new future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stickley &amp; Hui (2012b)</td>
<td>• Semi-structured interviews with 10 out of 148 health professional referrers over 4 years. Scheme gave GPs greater range of options for patients’ complex social problems but concerns about whether resources would be maintained in future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stickley &amp; Eades (2013)</td>
<td>• Follow-up one-to-one interviews with 10 mental health service-users previously interviewed still involved with scheme.</td>
</tr>
<tr>
<td></td>
<td>Nottingham 'Prescription for Learning'</td>
<td>Aylward &amp; James (2002)</td>
<td>• Assessed impact on 196 patients with anxiety, low self-esteem and chronic pain, found enhanced confidence and self-esteem, lifted mood, improved sleep, increased activity and healthier behaviour, widened social networks and gave sense of control.</td>
</tr>
<tr>
<td>West Midlands</td>
<td>North Staffordshire ‘Signposting Project’</td>
<td>Biastock, Brannelly, Davis &amp; Howes (2005)</td>
<td>• Made recommendations of local services for patients experiencing mental distresses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Analysis of 12 service-users from wellbeing postal or phone questionnaires; and phone interviews with practice staff indicated offer was valued but it increased staff workload.</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>Bradford ‘CHAT’ social prescribing scheme pilot</td>
<td>Woodall &amp; South (2005)</td>
<td>• 18 semi-structured interviews over 10 weeks examined scheme from perspectives of 10 patients with non-clinical needs and 8 health professionals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 82% patients visited health care professional less in 6 months after scheme than in 6 months before it; staff saw intervention as access to expert knowledge and as part of holistic practice.</td>
</tr>
</tbody>
</table>
### Yorkshire and the Humber

<table>
<thead>
<tr>
<th>Location</th>
<th>Program</th>
<th>Authors/Institution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doncaster</td>
<td>‘Patient Support Service’ and ‘Social Prescribing’ pilot</td>
<td>Faulkner (2004)</td>
<td>Case study design used semi-structured interviews with 11 patients and 9 staff. GP selected patients with additional problems to those treated medically and provided prescription for referral; voluntary sector employed advisors to link patients to community support groups.</td>
</tr>
<tr>
<td>Rotherham</td>
<td>‘Social Prescribing’ pilot</td>
<td>Dayson, Bashir &amp; Pearson (2013) CRESR Sheffield Hallam University</td>
<td>Examined social outcomes and hospital episodes with ‘outcomes star’ style tool developed for scheme with 8 measures, on referral and after six months. Of those referred 87% were adults over 60. Found that patients had around half the number of outpatient appointments, Accident &amp; Emergency attendances and hospital admissions in 6 months after scheme than in 6 months before.</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>‘Social Prescribing’ pilot</td>
<td>AgeUK (2011)</td>
<td>Assessment of older adult social, emotional and practical support needs led to 62 referrals to AgeUK services and 34 referrals to other organisations. Small number of older people completed WEMWBS before (mean 24.5 out of 70) and after scheme (mean 36 out of 70) indicating that wellbeing improved though no statistical analysis carried out.</td>
</tr>
</tbody>
</table>

### North East

<table>
<thead>
<tr>
<th>Location</th>
<th>Program</th>
<th>Authors/Institution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durham</td>
<td>‘Arts for Wellbeing’</td>
<td>White &amp; Salamon (2010)</td>
<td>Primary prevention service not therapy, aim to increase service-user confidence, resilience and self-esteem. Interim evaluation of 18-month pilot: analysis of WEMWS (14-item and later 7-item) participant comments, focus group narratives and interviews with facilitators and carers.</td>
</tr>
<tr>
<td>Newcastle</td>
<td>‘People Powered Health’ social prescribing programme</td>
<td>ERS Research &amp; Consultancy and Beacon North Ltd (2013)</td>
<td>Evaluation of project governance and allocation of budgetary resources. Did not report service-user outcomes as unable to access patient-level data including SWEMWBS scores and confidence ratings used by link workers.</td>
</tr>
<tr>
<td>North West</td>
<td>Manchester ‘Referral Facilitation Service’</td>
<td>Clarke, Sarre, Gledinning &amp; Datta (2001)</td>
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<tr>
<td>-----------</td>
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</tr>
<tr>
<td></td>
<td>• Evaluation of referral facilitation service in primary care employing coordinators to provide generic advice, support and counselling for individuals and families.</td>
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</tr>
<tr>
<td></td>
<td>• Over 1200 referrals in 2.5 years showed reasons for uptake: emotional and minor mental health and material problems such as welfare and housing. Service anonymous therefore less stigmatising than social services.</td>
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</tr>
<tr>
<td>Salford ‘Refresh’ social prescribing</td>
<td>Brandling &amp; House (2007)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Aimed to tackle health concerns through community activities as complement to medical care.</td>
<td></td>
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<tr>
<td></td>
<td>• Evaluation of initial scheme found 66% of patients had fewer GP visits with 34% reduced by 3 or more, and 46% reduced medical prescription.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adults with mild to moderate mental health issues offered creative activities instead or as well as medication. Evaluation at start, 3 x 2 month intervals, and 2 x 3 month follow-ups for anxiety and depression (HADS) and life skills (CO-OP).</td>
<td></td>
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<tr>
<td></td>
<td>• Analysis not reported as insufficient data; diary entries of facilitator commenting on individual progress showed confidence and self-esteem.</td>
<td></td>
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<tr>
<td></td>
<td>• GHQ-28 before and after the initial 15 week scheme with 33 participants found reduction in mental health issues.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continued use of GHQ-28 showed moderate impact on self-esteem and social functioning with statistically significant involvement in participatory activities and evidence of reduced use of GPs, social workers and other services.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Case study of referral to arts activities by health and social services. Participants used less in-patient and other hospital services, and showed reduced risk of relapse.</td>
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</tr>
</tbody>
</table>
4.3 Summary of evaluation methods

Out of 86 published UK social prescribing schemes, 35 (40.7%) have been evaluated and 12 of these employed quantitative methods using one or more validated and reliable indicator scales (Table 3) to assess a variety of individual and/or population, and mental and/or physical health outcomes with three of these using RCTs and one scheme comparing physiological measures. The other 23 schemes employed qualitative analysis of questionnaires, interviews, surveys and focus groups.
### Table 3. Quantitative evaluation of social prescribing schemes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator scale</th>
<th>Authors</th>
<th>Frequency of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>General Anxiety Disorder 7-items (GAD-7)</td>
<td>Spitzer, Kroenke, Williams &amp; Lowe (2006)</td>
<td>2</td>
</tr>
<tr>
<td>Cost</td>
<td>Cost per Quality Adjusted Life Years (QALY)</td>
<td>Phillips (2009)</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>Patient Health Questionnaire 9-items (PHQ-9)</td>
<td>Spitzer, Williams &amp; Kroenke (2001)</td>
<td>2</td>
</tr>
<tr>
<td>Exercise level</td>
<td>International Physical Activity Questionnaire (IPAQ)</td>
<td>Craig, Marshall, Sjöström, Bauman, Booth, Ainsworth, et al. (2003)</td>
<td>1</td>
</tr>
<tr>
<td>Functional status (health and wellbeing)</td>
<td>Short Form Health Survey 12-items (SF-12)</td>
<td>Ware, Kosinski &amp; Keller (1996)</td>
<td>1</td>
</tr>
<tr>
<td>Mental health</td>
<td>General Health Questionnaire 28-items (GHQ-28)</td>
<td>Sterling (2011)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Short Warwick-Edinburgh Mental Wellbeing Scale 7-items (SWEMWBS)</td>
<td>Stewart-Brown, Platt, Tennant, Maheswaran, Parkinson, Weich, et al. (2011)</td>
<td>1</td>
</tr>
<tr>
<td>Psychological wellbeing</td>
<td>Hospital Anxiety and Depression Scale (HADS)</td>
<td>Zigmond &amp; Snaith (1983)</td>
<td>4</td>
</tr>
<tr>
<td>Quality of life</td>
<td>Delighted-Terrible Faces Scale (DTFS)</td>
<td>Andrews &amp; Withey (1976)</td>
<td>1</td>
</tr>
<tr>
<td>Social support</td>
<td>Duke-UNC Functional Social Support Questionnaire</td>
<td>Broadhead, Gehlbach, Van de Gruy &amp; Kaplan (1988)</td>
<td>1</td>
</tr>
</tbody>
</table>
5 Pathways to implementation

5.1 Ways in which social prescribing schemes have been set up

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

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

Figure 1. Social prescribing by GP

- Patient presents in primary care with non-medical / psycho-social symptoms
- GP refers patient to suitable scheme from those available that they are aware of
- Patient telephones scheme contact person for initial interview and assessment
- Patient attends scheme, and reassessment after a number of sessions (free or subsidised)
- Reassessment is fed back to GP, patient is signposted to similar activities (often incurring cost)

Figure 2. Social prescribing by primary care staff

- Patient presents in primary care with non-medical / psycho-social symptoms
- Primary care staff refer patient to suitable scheme from printed or online directory
- Patient telephones scheme contact person for initial interview and assessment
- Patient attends scheme, and reassessment after a number of sessions (free or subsidised)
- Reassessment is fed back to primary care, patient is signposted to similar activities (often incurring cost)

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

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

NESTA (2013: 13)
Although at the inception of social prescribing, exercise referral was generally reserved for patients with physical health issues (e.g. obesity and Type 2 Diabetes), and self-help reading for those with mental health issues (e.g. mild to moderate anxiety and depression), recent research has shown that prescribed physical interventions (e.g. exercise and walks) are of benefit for mental health conditions and dementia, providing a positive experience to combat negative symptoms and side effects of medication, opportunities for social support and a means of boosting confidence and self-esteem. It is surprising that book referral does not generally occur for physical health conditions where patients might benefit from an increased understanding of their medical condition and treatment options available. Furthermore, some referral schemes (e.g. self-help books and online CBT books, art and exercise) have been incorporated into Step 1 of IAPT stepped recovery, after IAPT referral by GPs for patients with mental health conditions as an alternative to drug treatments, and have been used in conjunction with therapies such as psychological counselling, or while waiting to receive it (up to 6 months). Additionally, schemes have been incorporated into Step 2 as an adjunct to therapy (Figure 4).

5.2 Scaling up pilot studies

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

Figure 3. Social prescribing through link worker

Figure 4. Social prescribing as part of IAPT provision
In addition to grant-funding, NESTA (2013: 24) advocated two other funding pathways:

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

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

5.3 Choice of referral options and pathways to implementation

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

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

6.1 Best practice guidance for sector workers

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

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

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

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

6.2 Frameworks for setting up social prescribing schemes

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

The NHS ‘Five Year Forward View’ took a strong focus upon preventative treatments in public health, stating ‘That’s why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing’ (NHS, 2014: 10). Whilst most local authorities have responsibility for a range of broad-based public health programmes, the NHS has a distinct role in secondary prevention. This review demonstrates that social prescribing is able to encompass new approaches to secondary prevention by which people become engaged with responsibility for their own health and wellbeing, and pursue a healthier lifestyle.
To reduce future health costs a stronger focus on collaborative commissioning of services and interventions is needed which will involve the strategic promotion of mental wellbeing, mental capital, creativity and resilience as outcomes. It is important to make connections with a far wider range of stakeholders than previous traditional health models have encompassed, and where partners might include community services, such as business, culture, education and leisure sectors, in addition to local third sector and voluntary agencies.

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

6.3 Methods for evaluating social prescribing schemes

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

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

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

Outcomes currently measured and assessed include subjective wellbeing, quality of life, behaviour changes, physiological changes, and health service uptake and medication usage. Whereas quantitative research measures pre-post differences using validated and reliable scales (see Section 4), qualitative research delves deeper into the nature of change, and begins to suggest mechanisms by which any effects are mediated. Rather than use a single method to assess outcomes, it is preferable to gather converging evidence using mixed methods (a mix of quantitative and qualitative approached) for data evaluation.
An exemplary health and wellbeing programme that used mixed methods was Well London Phase 1 (2007-11) which combined a cluster RCT with a qualitative approach (Phillips, Bottomley, Schmidt, Tobi, Lais, Yu, et al., 2014). Funded by the Big Lottery Fund, Well London was hosted by the Greater London Authority, led by the London Health Commission and delivered by the Well London Alliance. The programme compared populations from 20 geographic target sites with 20 matched control sites from London’s poorest areas (census-defined ‘lower super output areas’). Fourteen projects, focused on physical activity, healthy eating, mental wellbeing, local environments, and arts and culture, aimed to build community capacity and cohesion. Approximately 100 randomly selected adults were surveyed before and after the Well London intervention across all sites giving a sample of around 4000. This quantitative approach was complemented by qualitative interviews with a sample of participants comprising both intervention and control group residents. Primary outcomes were effects on healthy eating (five portions of fruit/vegetables a day), physical activity (five 30-minute moderate-level physical activities a week) and mental wellbeing (GHQ-12 and WEMWBS). Secondary outcomes were a range of other healthy eating, physical activity, mental wellbeing and social cohesion measures. Although no statistically significant difference was found for primary outcomes, two secondary outcomes were significant; the intervention group ate more healthily and thought that people pulled together more to improve the local area, compared with controls.

It is important to take into account lessons learnt through evaluation of programme outcomes. Well London Phase 2 (2012-15) evolved from learning acquired in Phase 1; target sites are now places within natural neighbourhoods rather than those defined by census information, and communities have opportunities to shape local project delivery. Phase 2 has also started to explore how the intervention can be scaled-up to reach larger audiences. Scaling up service provision to a system-wide healthcare intervention is another important aspect of social prescribing, particularly for initiatives which are successful at a modest level and

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

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


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Further information: [www.ucl.ac.uk/culture/projects/museums-on-prescription](http://www.ucl.ac.uk/culture/projects/museums-on-prescription)
A Review of Community Referral Schemes

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