NHS Health Scotland

Social prescribing for mental health: background paper

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This report is based on a rapid review of literature published between 2002 and 2014 and was produced in conjunction with the Self-Management and Social Prescribing National Advisory Group.

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Introduction

Mental health continues to be a significant public health issue. In 2012 approximately 14% of the Scottish adult population had a possible psychiatric diagnosis. Both mental health problems and mental wellbeing are associated with deprivation, with poor mental wellbeing and mental health problems being commonest in the most deprived quintiles.[1]

Self-management is an important approach to improving mental health. It has been identified in the *Mental Health Strategy for Scotland: 2012–2015*[2] in terms of both early interventions for common mental health problems and supporting recovery for those with more enduring mental health problems.

Social prescribing is one means of supporting self-management. It is an approach (or range of approaches) for connecting people to non-medical sources of support or resources in the community which are likely to help with the health problems they are experiencing. Social prescribing has been used with a range of client groups and provides opportunities to access a wide range of different community-based services.[3]

Social prescribing is commonly, though not exclusively, used in primary care and provides non-medical options for primary care staff to draw on to support their patients. It can also be used by professionals working in other services.

This paper provides an overview of the review-level published research evidence on social prescribing in the context of mental health problems.

The paper has been developed by NHS Health Scotland in partnership with the Scottish Government Mental Health and Protection of Rights Division Self-Management and Social Prescribing Advisory Group. It forms part of a series of resources produced in partnership with this group to help inform the development of social prescribing approaches to self-management of mental health in Scotland.

Key messages

1. Social prescribing is an approach (or range of approaches) for connecting people to non-medical sources of support or resources in the community to promote good mental health and manage mental health problems and is an important approach to self-manage mental health.

2. Based on the evidence that social factors contribute to the development and maintenance of mental health problems there is a strong theoretical basis for social prescribing.

3. There are a wide range of approaches to social prescribing for mental health. These use different models, target different populations and have differing intended outcomes.

4. Exercise referral schemes (ERSs) help people with poor mental wellbeing or mental health problems to access structured, supervised exercise (a low-intensity treatment for common mental health problems). The National Institute for Health and Care Excellence (NICE) recommend ERSs for sedentary or inactive people with a heath condition or other health risk factors. They suggest that local monitoring and evaluation data is collected in order to inform future practice.

5. There is promising evidence that holistic social prescribing models, using 'linking systems' may offer a useful framework for enabling people to access multiple sources of support for social issues related to their mental health and contribute to improved psychological and social wellbeing.

6. There is good evidence that referral to welfare rights advice can result in short-term financial and psychological gains. However, further research is needed to examine the longer-term impacts.

7. There is promising evidence from small-scale studies that arts on prescription and learning on prescription may be helpful in increasing self-reported social support, personal skills and psychological factors such as self-esteem.

8. There is a need to look at social prescribing through an inequalities lens. It is plausible that approaches which target disadvantaged groups and provide accessible, intensive and tailored services are more likely to reduce inequalities than those that are information based and rely on people opting in to services. Research is needed to test out this hypothesis.

9. Some of the key components of successful social prescribing projects are: investing in relationships with key partners and potential referrers; having clear referral pathways; having 'champions' of social prescribing within the referring services; and having staff with appropriate skills and characteristics and a knowledge of the resources currently available in the community.

10. Factors associated with good uptake of services include short waiting times; relevant, trustworthy and good-quality accessible services; motivated clients;

good support from friends and family; and having the resources to access services. In addition, good support and supervision and specialised programmes characterised by choice and variety were also valued.

11. A large number of social prescribing schemes have been implemented and evaluated; however, the published research in relation to some models is limited and of mixed quality. This is not unusual for social interventions of this type. Programme evaluations are building on current evidence base and are showing promising results for particular types of intervention. Routine monitoring of social prescribing programmes, tests of change and theory-driven outcome and process evaluations will build the evidence base further and help establish which social prescribing interventions are effective for which participants and in which context.

Background

Why social prescribing?

Social prescribing has been identified as an important means of supporting the self-management of a range of mental health problems, and the Scottish Government has made a commitment to working in partnership to increase local knowledge of social prescribing opportunities and benefits.

> We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.
> **Mental Health Strategy for Scotland: 2012–2015: Commitment 15**[2]

The Self-Management and Social Prescribing National Advisory Group was established through the Mental Health and Protection of Rights Division of the Scottish Government in 2014 to look at implementation of this commitment. One aspect of this work is to share the current knowledge base about social prescribing in relation to mental health, drawing on national and international research and theory as well as local evaluations and learning from current practice in Scotland and beyond. This paper primarily provides a summary of published review-level research. It is based on a rapid review of reviews of social prescribing approaches relevant to mental health and summarises findings about effectiveness as well as factors that facilitate or hinder service implementation and/or uptake. The review also considers how social prescribing may contribute to reducing mental health inequalities.

Other associated resources include a series of case studies illustrating key implementation issues and a guidance paper on social prescribing for mental health, *Social prescribing for mental health and wellbeing: implementation guidance paper,*[36] from the Self-Management and Social Prescribing National Advisory Group.

What is social prescribing?

Social prescribing describes an approach (or range of approaches) for connecting people to non-medical sources of support or resources in the community that are likely to help with the health problems they are experiencing. Social prescribing has been used with a range of client groups and draws on a wide range of different community-based services. These include opportunities for the arts, physical activity, learning, volunteering, social support, mutual aid, befriending and self-help, as well as support with benefits, debt, legal advice and parenting.[3]

Social prescribing is commonly, though not exclusively, used in primary care. It provides non-medical options for health and social care staff to draw on to support their patients. It can also be used by professionals working in other services; there are examples of social prescribing being used as part of physical healthcare pathways and by community organisations.

The term social prescribing has been criticised because of the medical connotations associated with 'prescribing', which potentially cast one person in the role of patient, or passive recipient, and underplay the importance of self-management, choice and control. An alternative term, 'community referral', is also used to describe a similar approach. This term, however, can result in confusion as it is also used to describe referrals to community-based health services.

How can social prescribing contribute to improved mental health?

Mental health is not only the absence of mental health problems or symptoms. It also includes mental wellbeing, described by Herman *et al* as:

'…a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and can contribute to his or her community.'[4]

Poor mental health (mental health problems and poor mental wellbeing) is influenced by a wide range of social, environmental and individual factors. These include social isolation and loneliness, neglect, violence, low income and poverty, educational difficulties, work stress and unemployment, poor access to good quality basic services and discrimination.[5] In light of this, there is a strong theoretical basis for social prescribing as a way of connecting people to, and supporting them to use,

appropriate non-medical sources of support to help address one or more of these social, environmental and individual determinants in order to promote good mental wellbeing and managing mental health problems.

Social prescribing can therefore potentially be a useful mechanism for the following:

1. Supporting individuals to access resources and support which will help to promote mental wellbeing

   A review of evidence-based actions to promote individual mental wellbeing by the New Economics Foundation (NEF)[6] identified five areas of activity which are important in developing individual mental wellbeing:

   - social relationships
   - physical activity
   - awareness
   - learning
   - giving.

   Social prescribing is one potential way of connecting people to sources of support and resources and encouraging engagement in these activities with a view to improving mental wellbeing.

2. Increasing access to early interventions for common mental health problems

   Clinical guidance from the Scottish Intercollegiate Guidelines Network (SIGN) and the National Institute for Health and Care Excellence (NICE) recommend guided self-help, computerised cognitive-behavioural therapy and a course of structure and supervised exercise as low-intensity interventions for common mental health problems.[7–9] Social prescribing, through the Exercise on Prescription (or Exercise Referral Schemes) and Books on Prescription schemes, is a method of connecting clients to these interventions.

3. Supporting those who have on-going mental health or psychosocial problems

   Social prescribing can potentially play a role in mitigating against some of the social and environmental risk factors that contribute to and maintain poor mental health and social exclusion. Approaches that connect people to services which can, for example, help them access social support and increase social capital, secure better incomes through financial and welfare advice and/or increase their sense of self-worth and self-efficacy can potentially contribute to improved mental health and social inclusion for those with psychosocial or mental health problems.

A wide range of approaches to social prescribing have been described. These approaches differ in the ways they connect clients to non-medical sources of support, the populations they target and the intended outcomes, and include:

Information based services

- Signposting and connecting the general population to a broad range of community-based services including social activities, physical activity, volunteering, debt and welfare rights services, using information-based services such as noticeboards and websites.

Early interventions for common mental health problems

- Primary care referrals to low-intensity, non-medical early interventions for common mental health problems such as structured and supervised exercise and self-help resources.

Social prescribing to address social issues

- Referrals to practice- and community-based specialist sources of support, for example welfare rights advice and learning on prescription programmes.
- Primary care referrals to generic ‘link’ workers who act as a case worker or life coach to support people to access and interact with a range of non-medical sources of support. These include debt advice, social groups and local housing associations.

Social prescribing is not only used in primary care. It is also used in other parts of the health system, for example by healthcare professionals supporting the mental health of clients progressing through physical healthcare pathways.

What did we do?

We carried out a rapid review of the published literature between 2002 and 2014 to identify systematic reviews and non-systematic reviews of social prescribing or community referral projects for adults, with a focus on mental health problems. This involved searching libraries of systematic reviews (e.g. Cochrane, EPPI, CRD); evidence reviews supporting key pieces of NICE public health guidance; and key databases. Evidence on ERSs was included, as this approach can be seen as a form of social prescribing and has been used to enable people with common mental health problems to access structured, supported exercise schemes. We did not undertake a systematic review of primary research studies.

Systematic reviews synthesise the best available research using a systematic and transparent process which reduces bias and provides reliable evidence about the

effectiveness of interventions.* The value of review-level evidence is, however, constrained by the availability of good-quality primary outcome studies for inclusion in these reviews. As a consequence, in some instances the evidence is limited. This should not be interpreted as proof that an intervention is ineffective, rather it may be that an insufficient amount of good quality research about a particular intervention has undertaken to warrant inclusion in a review. This is the case for some models of social prescribing, but there are increasing numbers of evaluations being undertaken which show promising results.

Some single studies are included here and contribute important evidence, particularly in relation to implementation issues. However, caution must be exercised in considering the findings about effectiveness of single studies owing to the potential for bias. Randomised controlled trials (RCTs) provide the most reliable source of effectiveness evidence, as they reduce the potential for bias.

What did we find?

Overview of the published research

The published review-level literature in this area is relatively limited and the evidence base is restricted by the availability of good-quality published primary studies. Most of the published reviews identified described evaluations of social prescribing projects where the intervention was a single, clearly defined activity, for example an exercise referral programme, rather than interpersonal or socially based activities. Although a wide range of social prescribing projects that go beyond primary care have been developed in Scotland, for example where social prescribing is delivered by services associated with physical healthcare pathways or community organisations, most of the papers retrieved focused on primary care. This may be a consequence of our search strategy and the terms used for social prescribing or may reflect a publication bias.

A number of systematic and non-systematic reviews examining effectiveness were identified; these included systematic reviews of exercise on prescription,[10,11] a review of arts on prescription[12] and a systematic review of welfare advice in health care.[13] In addition, a systematic review of barriers and facilitators to ERSs,[14] completed as part of the NICE guidance update on ERSs, was identified along with a scoping review of linking schemes for people with long-term conditions.[15] With the exception of exercise on prescription, these drew largely on the grey (unpublished) literature and small-scale evaluations.

* Non-systematic reviews provide an overview of the research in a particular area, but are not carried out using a systematic process.

A small number of primary studies and evaluations are also referred to. These studies used before and after designs with mixed quantitative and qualitative methods and low numbers, and measured relatively short-term outcomes. As a result, they are at risk of bias and conclusions about effectiveness should be considered in light of these limitations. These evaluations did, however, explore a range of implementation issues which provide valuable insights into some of the barriers and facilitators for social prescribing projects.

The reader should consider the evidence presented here alongside evidence of other models of social prescribing and other models of self-management, including brief intervention, health coaching, problem solving and goal setting, evaluations of local and national projects, the existing policy context, legislation and current practice in Scotland.

Information services for promoting mental wellbeing

Signposting using information-based services such as noticeboards, websites and other digital media is a potentially important way of promoting mental health and self-management. It can reach a large population and does not require significant professional input once the information has been developed. There are numerous examples of this approach being used in Scotland. Typically people are signposted to the activities identified in the NEF review (see page 5) or to other sources of information such as Steps for Stress (a national resource to support people to deal with stress, which can be found at: www.stepsforstress.org) or local-level resources about mental health and wellbeing. The review did not specifically look at the effectiveness of these types of interventions.

Early interventions for common mental health problems

Exercise referral schemes and mental health

Physical activity is associated with improved mental health and both SIGN and NICE[7,8] recommend structured, supervised exercise programmes as a low-intensity treatment option for depression. Physical activity is also identified as important in the prevention of mental health problems and the promotion of mental wellbeing.[16]

The delivery of ERSs in primary care is a form of social prescribing; it is a method of promoting physical activity to people. The prescription or referral often entitles the person to free gym membership for the duration of the intervention and offers a course of supervised and structured exercise. These schemes have been offered to a range of populations including those with poor mental wellbeing or mild to moderate depression.

There is a significant body of good-quality research about ERSs and a number of systematic reviews have been published. These reviews, on the whole, look at

effectiveness in increasing physical activity among sedentary populations and have found a small increase in physical activity at 6–12 months compared with standard care. This difference was of borderline significance at 12-month follow up.[10]

The range of programmes delivered and the reasons for referral is variable and the available evidence does not allow for the relative effectiveness or cost-effectiveness of schemes for different sub-groups to be assessed. In general, studies have not specifically looked at the effectiveness of ERSs for those with mental health problems. Some studies have compared outcomes for those referred for mental health and physical health problems, though the findings are unclear.

There is some evidence of reduced levels of depression and anxiety and/or improved psychological wellbeing for those referred for mental health issues and among general sedentary populations.[10] However, few studies have evaluated the impact of ERSs on other outcomes such as psychosocial outcomes (for example social capital, community engagement); access to affordable facilities; clinical outcomes; or adverse effects.

The cost effectiveness evidence suggests that ERSs were more expensive than other interventions for encouraging physical activity among sedentary populations and considered above NICE's usual threshold for cost-effectiveness. However, other benefits aside from increased physical activity were not taken into account in the economic model.[16]

Recent NICE guidance indicates that there is a need to evaluate the effectiveness and cost-effectiveness of ERSs for those with mental health problems in terms of both the effect on levels of physical activity and psychosocial outcomes.[16]

On the basis of the available evidence, NICE Public Health Guidance 54[16] recommends ERSs for people who are sedentary or inactive **and** have existing health conditions or other factors that put them at increased risk of ill health. This would include people with mental health and psychosocial problems. It also recommends that schemes incorporate key behavioural change approaches, collect specified monitoring and evaluation data and make that data available for analysis, monitoring and research to inform future practice.

Implementation, referral and uptake of services: emergent themes

A number of personal attributes and attitudes, characteristics of the ERS location, social support and cost emerge as important in the uptake and adherence to ERSs (see Table 1). Motivational counselling, ongoing professional support, the quality of the counselling and support, and the fidelity of the intervention were also identified as important factors. Schemes with tailored motivational structures as opposed to ones with lack of choice were seen as more likely to be taken up and adhered to.

Similarly, non-judgemental delivery and quick referral pathways were seen as important and congestion was seen as a barrier.

Table 1: Factors influencing uptake and adherence to ERSs[14]

Theme	Facilitative	Barrier
Personal attributes, attitudes and resources	Personal motivation and goals Enjoyment of exercise Progress in terms of personal goals Positive expectations and experience of exercise environment Getting into a routine	Negative expectations about and experience of exercise environment Low perceived self-efficacy Limited time and financial resources
Characteristics of ERS and location	Choice and variety of opportunities Professional support Accessible location Group activity	Absence of translators Inaccessible location Quality of facilities Absence of support Inconvenient timing of session
Social support	From friends and family Positive social engagement	Lack of support from family and ERS providers
Other		Cost

Socio-demographic factors may also play a role. There is some evidence that women are more likely to uptake ERSs and that increasing age is associated with both increased uptake and adherence to ERSs, although some studies do not show these associations. There is also some evidence to suggest that increasing deprivation is associated with reduced uptake and adherence and that living in a rural location is associated with low uptake. Conversely, car ownership is associated with increased uptake and adherence and those most active before referral to an ERS are more likely to take up the referral and adhere to the programmes. However, the extent to which those with mental health problems are more likely to uptake and adhere to ERSs than with those referred for physical health problems is unclear.[10]

Referral rates are often variable across services and lack of engagement by health professionals emerged as a key reason for lack of referral. This was due to uncertainty and/or disagreement about who was responsible for the referral (the client or the primary care practitioners) and the complex paperwork involved. A second theme was the low priority given to ERSs by GPs given the short time frame for consultations, multiple needs of clients and GP workloads. Lack of awareness of

the ERS, and the need for reminders about it, emerged as a third theme and lack of feedback about participants was also highlighted. Referrers also expressed concerns about their legal responsibility for any adverse health events and inappropriate referrals to the scheme. Others factors thought to reduce referrals included lack of enthusiasm for the project and the poor interpersonal skills of the health professional.[10,14]

Books on prescription

Guided self-help is an important first-line treatment for common mental health problems and current guidance from SIGN and NICE recommends this as a low-intensity treatment option for sub-threshold and mild to moderate depression. Books on Prescription (BoP) schemes represent an organised system of delivery of bibliotherapy for mental health within health care. There are currently a large number of BoP programmes across the UK, many based on the Cardiff Model.[17] The majority of schemes aim to provide an early intervention for common mental health problems. In the context of primary care clients presenting with mild to moderate depression are prescribed a suitable self-help book(s) by their GP (or other health professional) from a range of resources. Schemes are not limited to primary care and other services may also be involved. Books are generally accessed through local library services which have received resources and training to provide this service.

No systematic reviews were identified; however, a survey of BoP schemes across the UK suggests that monitoring and evaluation is core to most schemes. The number of prescriptions written by GPs and received by libraries, along with the number of books issued emerge as key indicators of success, but no data was reported in the survey.[18] An evaluation of Reading Well Books on Prescription in England found good reach and uptake of the core titles recommended in the scheme; however, the impact on service users is difficult to establish due to the low number of survey respondents. [19]

Implementation, referral and uptake of services: emergent themes

There is emerging evidence from a number of evaluations that such schemes are viewed positively by prescribers and recipients but further evaluations would build the evidence base further. These studies suggest that BoP can provide a pre-prepared reliable and flexible resource for GPs (and other prescribers) to draw on which involves limited financial and time resources[18, 19,20]. However, the findings from one pilot project suggest that in the early stages of a project prescribing rates may be low. Possible reasons for this include GPs forgetting about the services due to the high volume and diversity of patients presenting in primary care and having limited time to explain the scheme and write the prescription. In addition, healthcare professionals expressed concerns about prescribing unfamiliar materials to clients, though they recognised that as generalists they are unlikely to be familiar with all the available and recommended resources.[20]

A number of positive features of the BoP scheme emerged from the literature. In particular the usefulness of ‘prescription pads’ as an aid memoir, bringing a degree of formality to the intervention, enabling GPs to offer ‘something’ to their client and use BoP as an early intervention. In addition, there is some indication that BoP potentially enables GPs to determine whether clients might benefit from more intensive psychological help. From the perspective of clients, the prescription provides a useful means of identification for those with no library membership and was thought to be enabling, helping them feel more confident to access services.[18,19, 20]

Having a ‘champion’ for self-help materials within the practice emerged as an important facilitator and the community location was thought to promote greater accessibility and be less stigmatising. Barriers to accessing the service included literacy levels, the availability of materials for those with visual impairments, levels of motivation, cognitive skills and factors relating to the clients’ mental health problems.[18,19,20]

There is some evidence to suggest that clients may experience difficulties in understanding and acting on the content of the self-help material and this can result in them becoming disengaged.[19] This is consistent with evidence that self-help needs some form of support or supervision to be fully effective.[8] An alternative model of BoP includes brief support sessions offered by staff trained in skills to support self-help.[21]

Evidence also suggests that library staff valued BoP schemes. The schemes were seen as a potential source of external funding, brought new borrowers to the library and enabled new links to be developed with community partners, although there were some concerns about access to funding, waiting times for books and the challenges of partnership working.[18] Resources for borrowers were thought to be easily accessible and did not result in them feeling uncomfortable; few problems were experienced in terms of availability of popular books; and no problems were reported with returns. Although training in mental health issues is often provided for library staff involved in BoP schemes, the extent to which staff in libraries perceived a need for this training was mixed.[20]

Social prescribing to address social issues contributing to poor mental health

Social issues such as poverty, low income, unemployment and social isolation are risk factors for the development and maintenance of poor mental health.[5] A number of projects have used social prescribing as a means of connecting patients to non-medical resources and sources of support to address relevant social issues.[22–24] This approach has been used with patients with mental health problems, those with

poor mental wellbeing and low self-esteem, and ‘frequent attenders’ in primary care. It is often found in general practices in areas of high socio-economic deprivation where there are higher rates of psychosocial problems.[22] Two models emerged from the literature: single-issue models and holistic schemes sometimes referred to as ‘link worker’ or ‘linking’ schemes.

Single-issue referral programmes

In single-issue referral programmes, clients are typically referred by a GP (or other primary care professional) to a specific source of support, such as welfare rights advice, an arts programme or learning schemes, offered within primary care or a community-based setting.

Welfare rights advice

A systematic review of welfare rights advice in healthcare settings identified 55 studies, the majority of which provided welfare rights advice within the GP surgery or at the client’s home.[13] All but one of the studies were UK based. Much of the evidence is drawn from the grey literature and the quality of the research is variable, with less than 10% of studies using a control or comparison group. In around half of the studies advice was provided by staff or volunteers from the Citizens Advice Bureau, and in 40% of cases by welfare rights advisers. The majority of schemes received referrals through primary care staff, other agencies or self-referral.

Although full financial data was reported in only half of cases, the authors concluded that there was good evidence from these studies to suggest that welfare rights advice delivered in healthcare settings results in financial benefits. In the year following the advice, the mean financial gain per person was £1026. The authors noted that this was not a precise estimate; there was variation in the gains made and some indicated that the data were incomplete as claims were still pending. Further research exploring who is most likely to benefit financially would be useful in targeting advice.

The impact on social and health outcomes was less conclusive – sample sizes were small and follow-up short term, therefore the health and social effects of improved financial circumstances were less likely to have been identified. However, where significant impacts were identified these were in terms of psychological and social outcomes rather than physical health. Further evaluations over a suitably long period of time are needed to fully understand the social and mental health impacts.[13]

Implementation, referral and uptake of services: emergent themes

A mixed-methods evaluation of a welfare advice scheme across 30 general practices found variable levels of referral for advice. The findings suggest that, although the referral rate was associated with practice size, the level of enthusiasm for, and commitment to, the advice service from primary care teams was also important. The

location of the service within primary care was thought to ensure easy access to advice in comparison with more centrally located services. [25]

Learning on prescriptions schemes

Learning on prescriptions (LoP) schemes tend to be targeted at people with mental health problems, low self-esteem or chronic health problems. GPs refer clients to a learning adviser for a tailored learning experience in order to help improve confidence and to help them cope with their physical or mental health issue. Services tend to be flexible, with advisers meeting clients in accessible locations and gradually encouraging attendance at more central locations. Advisers adopt a client-centred approach, offer practical and emotional support and are able to advocate on behalf of the client.[26]

No reviews of LoP schemes were identified and few published evaluations were identified. A mixed-methods evaluation of a Healthy Learning Project in Leicester reported that half of the clients engaged in a learning activity and 10% entered employment within six months of accessing the project. Almost half the clients had either no or low qualifications when they first accessed the services. The study also reported a reduction in the number of clients receiving incapacity benefit and improved psychological outcomes, such as increased confidence and motivation.[26] However, the details of the evaluation were not available and therefore reliability of the findings cannot be verified.

Implementation, referral and uptake of services: emergent themes

Consistent with other findings, this study found that bringing the services to the attention of GPs and providing evidence of the benefits and effectiveness of the service were particular challenges. The authors suggested that this may not be as important for other professional groups, as when mental health services were made aware of the scheme they generated more referrals than GPs. However, mental health services by their nature will have a larger pool of clients who may benefit from the service. Providing continuous feedback to referral agents and engaging the referrer at all stages in the work was seen as particularly important in increasing the number of referrals.[26]

Arts on prescription schemes

There is a developing evidence base suggesting that engagement in the arts is associated with improved mental wellbeing, quality of life and social inclusion. Arts on prescription (AoP) schemes, often facilitated by artists and musicians, have been established as a means of enabling people to access community-based arts programmes. They have been used to support recovery for those with enduring mental health problems and help people who are socially isolated as well as those with mild to moderate mental health problems.[12]

There is limited published research on AoP schemes and a recent review drew largely on the grey literature.[12] Projects were typically small and evaluations tended to be qualitative, focusing on the experience of those attending schemes and implementation issues. The findings of qualitative studies suggest that referrals were primarily from mental health professionals in primary and secondary care. Little information was available about uptake of services or objective measures of the social or psychological impact, though some projects used measures of mental health, such as the Hospital Anxiety and Depression Scale (HADS) and the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS).The sample sizes and study design make it difficult to draw conclusions about impact. Qualitative research findings suggest that clients who attended services experienced benefits in terms of personal and social outcomes, including increased self-esteem, a sense of purpose, improved social skills, community integration, empowerment and social inclusion.[27,28]

Implementation, referral and uptake of services: emergent themes

Findings from qualitative research suggest that referral agents felt that AoP schemes potentially had therapeutic and social benefits as well as providing opportunities for peer support for those with mental health problems.[29] The community-based and potentially non-stigmatising nature of AoP was regarded positively in light of increasing community-based and self-directed support for those with enduring mental health problems.

Overcoming institutional barriers and professional isolation were identified as challenges to service development. Important facilitators included good communication with referral agents, ‘champions’ of AoP within referral agencies and link workers with knowledge of the voluntary sector and community development principals. A flourishing voluntary and community sector and an awareness among practitioners of the potential role of non-medical sources of support and resources were also felt to be important factors. There was recognition, however, that services need to show evidence of outcomes in order to access continued funding and commissioning.[12, 28]

Link worker/referral facilitators

Link worker programmes are often based in primary care services and use a process of triage and referral. Clients, often with psychosocial and mental health problems, are referred by a GP, or other primary care staff, to a link worker or referral facilitator. The link worker helps the client to identify their psychosocial needs and, in conjunction with the client, develops a tailored programme of non-medical sources of support. Link workers generally advocate for, and support, clients to access what can be complex services. Although the term ‘link worker’ is common in Scotland, other terms, such as referral facilitator, are also used.[30]

Often people are exposed to multiple risk factors and are connected with more than one service. Needs commonly include social support; financial and welfare advice; skills development; and opportunities to increase self-esteem. Services might include voluntary work agencies, further education, clubs, arts and dance classes, and debt services.[30, 31] Link workers have a good understanding of and access to services in the community as well as strong listening and communications skills.[31] This model can be more intensive than other models of social prescribing as the link worker acts as a bridge between primary care and opportunities in the community.[23]

A scoping review of linking schemes, defined as social interventions including social prescribing schemes, identified seven evaluations from the published and grey literature.[15] The interventions were diverse but all involved referral of clients from health or social service to services which aimed to support patients to access community-based resources. The target population varied but included those with mental health problems, those suffering social isolation and frequent users of primary care. Most of the projects used a facilitator to help identify and support the use of appropriate resources in the community to meet the needs of clients. There is evidence from two studies of a positive impact on mental health or psychological outcomes and from two others of a reduction in psychotropic or antidepressant medication. However, one study reported an increase in prescriptions including medication for mental health problems. Aspects of social isolation or loneliness were measured in four studies and there was some evidence of a positive impact on these social outcomes. Although the evidence base is still relatively limited, owing to the small number of available studies and mixed quality of these, there is promising evidence that these schemes may have positive impacts on mental health and reduce social isolation.[15]

The cost effectiveness of linking schemes is unclear as only one economic evaluation was identified. An economic evaluation of the Amalthea project found the link worker arm of the study was more costly in the short term than ‘treatment as usual’. However, it is unclear if this was due to the increased level of prescribing in the link worker group. In addition, the follow-up period may have been too short (four months) to show any realistic economic benefits.[30]

The evidence of the impact of linking schemes on use of health services is mixed and it is difficult to draw firm conclusions. Some studies reported a decrease in the number of GP appointments, while others reported no impact. Similarly, the impact on referrals to other services varied. The impact of these schemes on health service use is complex and needs to be considered within the context of the service being provided, as reductions in GP and onward referrals are not necessarily positive outcomes.[15]

A number of evaluations of Scottish 'linking schemes' have been undertaken or are ongoing and will further contribute to the evidence base: The Bridge Project, Glasgow Links Project and Dundee project.[†]

Implementation, referral and uptake of services: emergent themes

Research suggests that, although social needs are complex and not easily resolved by one person or agency, patients are often persistent in seeking solutions despite services being fragmented and difficult to access. In this context GPs are often seen as trusted advocates for social needs and provide a holding and non-stigmatising environment.[32] Although many GPs recognise the importance of community resources in addressing social issues associated with poor health they can be slow to refer to social prescribing schemes.[22,23] Possible reasons for this include the following: a reluctance to probe about social issues and a tendency to respond to the psychological consequences of social issues (low mood, depression) rather than provide practical support; organisational expectations of GPs to provide medical solutions; busy consultations with a bias towards a medical model; continuing professional development which focuses on disease management; a limited range of referral options and limited knowledge about appropriate services and resources in the community; and a reluctance to refer to voluntary organisations.

Aspects of link worker schemes may go some way to addressing these issues and a number of factors emerged as important in establishing linking schemes. A centralised electronic database, with up-to-date information about local services, and generic link workers, with a wide and current knowledge of services, were seen as vital in improving referral pathways and potentially saving time for practitioners.[22,24,31] The nature of the relationship between the GP and the link worker also emerges as important: GPs actively involved in the selection of the community development worker felt more confident that they were referring to someone they knew rather than 'into a black hole'. Similarly, a link worker and their location in primary care was regarded positively as a single point of contact and was seen as important in improving access and confidentiality, as well as enabling primary care staff to have a tangible referral option. The relationship between the link worker and the voluntary sector was similarly seen as important and integral to the development of the social prescribing schemes.

The skills and role of the facilitator also emerged as important. In particular, their ability to develop a good relationship with the client, tailor activities to their clients'

[†] The Bridge Project – www.gla.ac.uk/media/media_282275_en.pdf

Dundee Sources of Support – www.dundeepartnership.co.uk/content/health-wellbeing

Glasgow Links Worker Programme – www.alliance-scotland.org.uk/resources/library/grid/1/type/all/topic/13/tag/all/condition/all/

needs and be flexible and skilled in encouraging and supporting attendance at activities. From the perspective of facilitators, however, this role can be challenging in terms of integrating into primary care while maintaining contacts and connections in the community.

Engagement and retention of clients in services is often mixed and there are a range of potential reasons for poor uptake. Qualitative research suggested that clients do not always perceive referrals to be appropriate, health issues or lack of motivation to change can prevent attendance and in some cases clients generate alternative solutions.[32] Clients also identified waiting time, transport, literacy, confidentiality, disclosure in voluntary groups, appropriateness, and the availability and accessibility of activities as barriers. However, having space to discuss issues with a link worker emerges as important for clients, as does support to attend community or voluntary sector organisations.[31] There is some evidence that screening by health or social care professionals and short waiting times for initial appointments may be associated with greater participation in linking schemes.[15]

Addressing mental health inequalities

Inequalities in mental health remains a public health challenge in Scotland and there is evidence of a social gradient for both mental health problems and mental wellbeing.[1] It is important, therefore, not just to improve population mental health outcomes but to also reduce inequalities in mental health in Scotland.

In her paper for the Ministerial Task Force on Health Inequalities, Macintyre[33] outlined the characteristics of actions which are most and least likely to be effective in reducing health inequalities. This work suggested that policies and practices that improve accessibility, prioritise disadvantaged groups and provide intensive support are more likely to be effective. Link worker models of social prescribing which provide more personalised and intensive support, or models which provide accessible and acceptable services, such as primary-care-based welfare advice or learning services, may therefore be more likely to contribute to reducing inequalities in mental health. Although social prescribing does not address the underlying problems in the community or broader society, it may go some way to mitigating the impact of the social causes of mental health inequalities on individual health and enable people with complex social needs to gain support to address some of the issues they face.[31] However, these possibilities need to be further evaluated.

In contrast, services that are information based, reliant on people taking the initiative to opt in and which involve significant price or other barriers, are less likely to reduce heath inequalities.[33] In the context of social prescribing it is possible that models which rely on signposting or simple referrals to services are less likely to reduce

health inequalities and may inadvertently increase inequalities. This is because those who are more socially advantaged are more likely to take up services and those facing greater challenges are less likely to have the capacity to take up the opportunities on offer without additional support services. The evidence cited previously (page 10), that increasing deprivation is associated with reduced uptake and adherence to ERSs, is consistent with this view.

A note on digital interventions

As digital participation increases in Scotland, there are a number of potential advantages to using effective digital interventions within the context of social prescribing. For example, digital interventions are flexible and can be accessed in the users' own time, are available at all times without appointment, are anonymous and flexible, thus allowing a greater sense of control for the individual and can be easily adapted by the provider. The use of digital media may, however, have unintended consequences for health inequalities. Digitally based interventions often rely on an opt-in and potentially have significant price and other barriers[34].

Data suggests that while home internet access has increased, approximately a fifth of the adult population do not have access. These trends are declining but still represent a sizeable minority. Home internet access increases with increasing net annual income. An analysis of internet access by the Scottish Index of Multiple Deprivation (SIMD) suggests that there are lower rates of home-based internet access in the 15% most deprived areas in Scotland (64%) than in the rest of Scotland (81%). There is also evidence that internet use decreases with age though there has been a large increase in the number of older people using the internet over the last 10 years.[35] In addition, approximately half of those with some form of long-term illness, health problem or disability did not use the internet. Differentials in access have reduced over time and some research suggests that the digital divide is shifting from a gap in access and connectivity to a knowledge divide. There have been calls for measures to be taken to provide low-income and disadvantaged persons with appropriate training and resources to prevent Information and Communication Technology (ICT)-mediated communications becoming a new barrier to heath service access.[34]

Conclusions

On the basis of the evidence that social factors contribute to poor mental health, there is a strong theoretical basis for using social prescribing as a means of promoting mental wellbeing and self-management of mental health problems. A wide range of social prescribing programmes have been implemented, focusing on different populations and prescribing a variety of services with a view to impacting on different outcomes. Although the review-level evidence in some areas is limited and of variable quality, the available evidence is promising and suggests that some models of social prescribing may be effective in supporting people with mental health problems to access non-medical sources of support and could have a positive impact on psychological and social outcomes. Programme evaluations are accumulating evidence about effectiveness of particular types of interventions and show promising results. However, it remains important to build the evidence base. The continued inclusion of monitoring systems, tests of change and theory-driven impact and process evaluations in social prescribing projects will help to achieve this. Issues for consideration might include: gathering standardised monitoring data (such as socio-demographic data, referral data, information about uptake of services and, where appropriate, adherence to programmes); using objective short- and longer-term outcomes measures; developing controlled trials to compare social prescribing models or evaluating models against standardised care; and economic evaluations. Process evaluations and tests of change provide further learning into implementation issues and effective components of the programme.

Consistent themes emerge about the implementation of social prescribing projects. These include the need for champions of social prescribing within services, investment in relationships with potential partners and referral agents, clear referral criteria and pathways, up-to-date and accessible information about community-based services and sufficient numbers of appropriately trained staff to provide timely and relevant support. Similarly, factors that are likely to facilitate uptake of and adherence to community support by clients include the availability of accessible community-based services and resources with minimal financial implications, social support and the motivation and ability of clients to access resources.

Social prescribing services and programmes should be considered through an inequalities lens. Those which improve accessibility, prioritise disadvantaged groups and provide intensive support are more likely to be effective in reducing inequalities. However, it is important that further research is undertaken to test out this hypothesis.

References

1. Catto S, Tod E, McCartney G. *Scotland's mental health: adults 2012*. Edinburgh: NHS Health Scotland; 2012. www.scotpho.org.uk/publications/reports-and-papers/887-scotlands-mental-health-adults-2012 (accessed 28 September 2015).

2. Scottish Government. *Mental Health Strategy for Scotland: 2012–2015.* Edinburgh: Scottish Government; 2012. www.gov.scot/Publications/2012/08/9714 (accessed 28 September 2015).

3. Friedli L, with support from Vincent A, Woodhouse A, McCollam A. *Developing Social Prescribing and Community Referrals for Mental Health in Scotland.* Edinburgh: Scottish Development Centre for Mental Health; 2007. www.scotland.gov.uk/Resource/Doc/924/0054752.pdf (accessed 28 September 2015).

4. Herman H, Saxena S, Moodie R. *Promoting mental health: concepts, emerging evidence, practice.* Geneva: WHO; 2005. www.who.int/mental_health/evidence/en/promoting_mhh.pdf (accessed 28 September 2015).

5. World Health Organisation. *Risks to mental health: An overview of vulnerabilities and risk factors – Background paper by WHO secretariat for the development of a comprehensive mental health action plan*. Geneva: WHO; 2012. www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf (accessed 28 September 2015).

6. Aked J, Marks N, Cordon C, Thompson S. *Five ways to wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being*. London: Nef; 2008. www.neweconomics.org/publications/entry/five-ways-to-well-being-the-evidence (accessed 28 September 2015).

7. SIGN. *Non-Pharmaceutical management of depression in adults: A national clinical guideline. 114*. Edinburgh: SIGN; 2010. www.sign.ac.uk/guidelines/fulltext/114/index.html (accessed 28 September 2015).

8. National Collaborating Centre for Mental Health. *Depression: The treatment and management of depression in adults (updated edition). National Clinical Practice Guideline 90*. Leicester: British Psychological Society; 2010.

9. National Institute for Health and Care Excellence. *Common mental health disorders: Identification and pathways to care. NICE Clinical Guideline 123.* London: NICE; 2011. www.nice.org.uk/guidance/cg123/resources/guidance-common-mental-health-disorders-pdf (accessed 28 September 2015).

10. Campbell F et al. *A systematic review and economic evaluation of exercise referral schemes in primary care: A short report.* London: NICE; 2013. This report was commissioned by the NHIR HTA Programme as project number 13/45/01. www.nice.org.uk/guidance/ph54/evidence/ph54-exercise-referral-schemes-supporting-evidence (accessed 28 September 2015).

11. Pavey TG, Taylor AH, Fox KR, Hillsdon M, Anokye N, Campbell JL, Foster C, Green C, Moxham T, Mutrie N, Searle J, Trueman P, Taylor RS. Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. *British Medical Journal* 2011;343:d6462. www.bmj.com/content/343/bmj.d6462.full.pdf+html (accessed 28 September 2015).

12. Bungay H, Clift S. Arts on prescription: A review of practice in the UK. *Perspectives in Public Health* 2010;130(6):277–81.

13. Adams J, White M, Moffatt S, Howel D, Mackintosh J. A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. *BMC Public Health* 2006;8:81.

14. Morgan F, Turley R, Morgan H, Searchfield L, Weightman A. *The factors that influence referral to, attendance at and successful completion of exercise schemes and longer term participation in physical activity*. Cardiff: Support Unit for Research Evidence; 2013. www.nice.org.uk/guidance/ph54/documents/review-2-review-of-factors-that-influence-referral-attendance-and-completion-of-exercise-referral-schemes.-appendices2 (accessed 28 September 2015).

15. Mossabir R, Morris R, Kennedy A, Blickem, C, Rogers A. A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. *Health and Social Care in the community.* December 2014.

16. National Institute for Heath and Care Excellence. *Exercise referral schemes to promote physical activity. NICE Public Health Guidance 54*. London: NICE; 2014. www.nice.org.uk/Guidance/PH54 (accessed 28 September 2015).

17. *Self-help book prescription schemes*. www.fiveareas.com/bookprescriptionschemes/ (accessed 28 September 2015).

18. Chamberlain D, Heaps D, Roberts I. Bibliotherapy and information prescriptions: a summary of the published evidence-base and recommendations from past and on-going Books on Prescription projects. *Journal of Psychiatric and Mental Health Nursing* 2008;15:24–36.

19. The Reading Agency. *Reading Well Books on Prescription Evaluation Report 2013/14.* London: The Reading Agency; 2014. http://readingagency.org.uk/adults/impact/research/reading-well-books-on-prescription.html (accessed 28 September 2015).

20. Robertson R, Wray SJ, Maxwell M, Pratt R. The introduction of a healthy reading scheme for people with mental health problems: usage and experiences of health professionals and library staff. *Mental Health in Family Medicine* 2008;5:219–28.

21. Farrand, P. Development of a supported self-help book prescription scheme in primary care. *Primary Care Mental Health* 2005;3:61–6.

22. Popay J. et al. Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part 1: the GP perspective. *Journal of Epidemiology and Community Health* 2007;61(11):966–71.

23. Bradling J, House W. Social prescribing in general practice: adding meaning to medicine. *British Journal of General Practice* 2009;59(563):454–6.

24. Cawston P. Social prescribing in very deprived areas. *British Journal of General Practice* 2011;61(586):350.

25. Greasley P, Small N. Providing welfare advice in general practice: referrals, issues and outcomes. *Health and Social Care in the Community* 2005;13(3):249–58.

26. South P. Working collaboratively: prescriptions for healthy learning – an example of success. *International Journal of Mental Health Promotion* 2006;8(3):25–9.

27. Stickley T, Hui A. Social prescribing through arts on prescription in a UK city: participants' perspective (part 1). *Public Health* 2012;126(7):574–9.

28. Stickley T, Eades M. Arts on prescription: a qualitative outcomes study. *Public Health* 2013;127(8):727–34.

29. Stickely T, Hui A. Social prescribing through arts on prescription in a UK city: referrers' perspectives (part 2). *Public Health* 2012;126(7):580–6.

30. Grant C, Goodenough T, Harvey I, Hine C. A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *British Medical Journal* 2000; 320:419–23.

31. South J, Higgins TJ, Woodall J, White SM. Can social prescribing provide the missing link? *Primary Health Care Research and Development* 2008;9(4):310–18.

32. Popay J, Kowarzik U, Mallinson S, Mackian S, Barker J. Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part II: lay perspectives. *Journal of Epidemiology and Community Health* 2007;61:972–7.

33. Macintyre S. *Inequalities in health in Scotland: What are they and what can we do about them? Occasional paper No. 17*. Glasgow: MRC Social and Public Health Sciences Unit; 2007.

34. McAuley A. Digital health interventions: widening access or widening inequalities? *Public Health* 2014; 128 (12) 1118-1120.

35. Scottish Government. *Scotland's People Annual report: Results from 2013 Scottish Household Survey*. Edinburgh: Scottish Government; 2013.

36. NHS Health Scotland. *Social prescribing for mental health and wellbeing: implementation guidance paper.* Edinburgh: NHS Health Scotland; 2015.

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