NHS Health Scotland

Social prescribing for mental health: guidance paper

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1. Introduction

Mental health continues to be a significant public health issue in Scotland. Mental health problems affect one in four people each year (SPICe, Scottish Parliament, 2014), with anxiety and depression being the most common. Both mental health problems and mental wellbeing are associated with deprivation, with more deprived communities experiencing higher levels of mental health problems and lower levels of mental wellbeing (Catto *et al*, 2012).

Self-management is important to improving mental health and has been identified in *The Mental Health Strategy for Scotland: 2012-2015* as an important approach to reducing common mental health problems and supporting recovery for those experiencing mental illness. Social prescribing is one means of supporting self-management.

This guidance on the use of social prescribing for mental health has been developed by NHS Health Scotland in partnership with the Self-Management and Social Prescribing National Advisory Group (see Appendix 1 on page 20), set up by the Scottish Government Mental Health Directorate in response to commitment 15 of the *Mental Health Strategy*. It builds on an earlier report published by the Scottish Development Centre for Mental Health in 2007 *Developing Social Prescribing and Community Referrals for Mental Health in Scotland*.

The paper draws on published research, local practice and evaluations, and learning from champions who are leading locally based approaches to social prescribing in Scotland. It:

- explains the rationale for investing time and resources in social prescribing for mental health improvement
- describes different models of social prescribing in places across Scotland
- proposes a set of principles underpinning the development of social prescribing projects to support mental health
- provides guidance on the best available knowledge of what works to support people's mental health when setting up a social prescribing service.

2. Who is the paper for?

The paper will be of particular interest to policy makers, planners and commissioners of services which aim to improve mental wellbeing and prevent and treat mental health problems and work to address mental health inequality. It will also be of relevance to managers and practitioners, who are seeking to develop, implement and evaluate different ways of connecting individuals to alternative and appropriate sources of support.

3. Key messages

Social prescribing is an important approach to self-management of mental health. It is based on a clear rationale that supporting people to access and use non-medical sources of support can help address poor mental health and contribute to improved mental health. There are a wide range of approaches to social prescribing for mental health, these use different models, target different populations and have different intended outcomes.

There is a good theoretical basis for social prescribing and promising evidence that social prescribing contributes to improved access to resources and sources of support that are important for improved mental health. The evidence of effectiveness is still developing in part due to the range of different models being used and limited number of good quality evaluations. Further monitoring of social prescribing programmes, well designed processes and outcomes, and evaluations and tests of change will build the evidence base further and help establish which social prescribing interventions are effective for which participants and in which context.

Leadership is vital in securing coordinated action, galvanizing support and building strong partnerships across services and settings to make best use of the contribution of a range of partners, agencies and community assets.

There is a need to look at social prescribing through an inequalities lens. It is plausible that approaches that target disadvantaged groups, providing accessible, intensive and tailored services may help reduce and mitigate mental health inequalities. In contrast those that are only information based and rely on people opting in are less likely to reduce inequalities.

4. The role of the RCGP in Scotland in social prescribing

The Royal College of General Practitioners (RCGP) (Scotland) is committed to supporting primary care to access and use resources effectively to improve health and wellbeing in communities.

Increasingly, demographic trends, changes in health service approaches and social issues impact on primary care with physical, mental health and life issues coming to primary care as the first port of call.

Patients should be able to draw upon their individual general practitioner’s and primary care team’s skills to value and look after their own health and to get the most effective support when problems arise.

Approaches to supporting the team include:

- Redefinition of the resource allocation supporting primary care.
- A new approach to quality that separates it from the Group Medical Services (GMS) contract and places it as the professional, peer based, values-driven responsibility of 'locality clusters' of practices.
- Resourced work with the Royal College of Psychiatry, supporting and augmenting the skills of general practitioners and primary care teams to improve mental health, including the design and training of psychological interventions suitable for primary care use. This will build on GPs' existing expertise in multi-morbidity and bio-psychosocial approaches, adding additional learning from specialist colleagues from mental health.
- Working with the Integration Agenda towards a range of supports for community health and wellbeing.
- Development of new approaches, in particular to supporting people in distress and those who attend frequently to primary and secondary care and partner services without resolution of their problems, for example the use of a '5 Areas' model to assess the distress from a bio-psycho-social and cognitive-behavioural perspective.

The House of Care, as highlighted in the RCGP Scotland document A blueprint for Scottish general practice provides an 'excellent example' of 'care and support planning – led by teams of professionals working with patients and their carers in the community – which is effective in helping people to take more control over their health and to stay well.'

The RGCP Scotland supports social prescribing, defined as a range of approaches to linking people to non-medical sources of support. This aims to identify the 30-40% of GP consultation time where the patient could benefit from involvement in services and community groups to complement their medical treatment. The signposting of the possibly wide range of opportunities and interventions to suit the person's needs would include, for example, debt or relationship counselling, alcohol and/or drug interventions, and social and self-help groups.

Particular benefits may include:

- Tailored, non-medical support, either from increasing GPs' awareness of services or from the expertise of 'links workers'.
- Improved resilience and community presence offering increased protection to patients in future stressful situations.
- 'Help seeking' and 'health seeking' behavioural change, as patients experience a range of non-medical supports.
- Improved partnerships built between the practice and services and supports in the community.
- Enabling primary care teams to collate information and provide intelligence on the gaps for their patients in services and community supports. This will give a strong evidence base with which to work with commissioners in planning

partnerships and integrated bodies, to resource supporting development in the community.
- Primary care influencing resource use towards targeted prevention, early intervention and effective complementary management of crisis, with recovery interventions, all in community settings. This is in contrast to the current pressures on practices through rationed and inconsistent access to reactive, uncontrollable, expensive crisis care within the NHS.

The Royal College of General Practitioners (Scotland) will, given suitable resources, explore the value of this approach over time and its contribution to supporting the effectiveness of primary care teams and shifting from a medical/clinical focus to 'normalised' support, accessed in the community.

The RCGP Scotland intends to collaborate positively building on current tests of change, for example: the Links Worker Programme in Deep End Practices in Glasgow; The RCGP (Scotland)/Alliance Improving Links in Primary Care Project; ALISS and Scotland's House of Care Programme.

The College will:

- Propose a coordinated programme of collective research and development in Scotland and a variety of adequate funding streams to continue to develop and evaluate approaches. This will include outcomes for patients, staff and general practitioners as well as those resources referred to in the community.
- Disseminate good practice throughout the Learning Network via our normal communications network.
- Encourage uptake of this approach, along with other approaches, such as the House of Care, and the 5 Step formulation, through support and training and so shift resource and funding to primary care and the community.
- Continue to recognise that the signposting and linking could be carried out by a range of people, for example a dedicated link worker based in the practice, link workers in partner agencies, the third sector, highly trained volunteers and community members.

(Dr Miles Mack, Chair Royal College of General Practitioners Scotland, 2015)

5. 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 which are likely to help with the health problems they are experiencing. Social prescribing has been used with a number of different client groups and draws on a wide range of different community based services. These include arts and cultural activities, green space, debt advice, physical activity and leisure, bibliotherapy, learning,

volunteering, housing advice, benefits, employment and legal advice (Friedli *et al*, 2007).

The term ‘social prescribing’ is used interchangeably with other terms, such as community referral and linking schemes. Some people prefer not to use the term ‘prescribing’ as it can be seen to place the person in the role of patient or passive recipient and underplay the importance of self-management, choice and control.

Social prescribing is often used in primary care and enables staff to draw on non-medical options to support their patients. It can also be used by professionals working in a wide range of other services providing ‘sources of support’, including staff working in physical healthcare pathways and by communities and community organisations.

Irrespective of where it is delivered, social prescribing is generally person-centred and tailored to the individual’s needs.

6. Models of social prescribing

A wide range of approaches to social prescribing for mental health are in place in different parts of Scotland. These approaches differ in the ways they connect clients to non-medical sources of support, the populations they target and the intended outcomes. These approaches include:

- sign-posting and connecting the general population to a broad range of community based services which address risk factors for mental health problems or poor mental health, including social activities, physical activity, volunteering, debt and welfare rights services
- primary care referrals connecting people with mild to moderate mental health problems to low intensity, non-medical early interventions for common mental health problems, such as structured and supervised exercise and self-help resources
- referrals connecting those with poor mental health to resources and support that have been identified as contributing to their poor mental health, including to practice or community based specialist sources of support, for example welfare rights advice and learning on prescription programmes
- primary care referrals connecting those with poor mental health to generic workers who act as a case worker or life coach, who are able to support people to identify factors that are associated with their mental health and help them access relevant non-medical sources of support

- referrals by healthcare professionals connecting clients progressing through physical healthcare pathways who are experiencing poor mental health, to non-medical sources of support and resources.

Although social prescribing is often understood as a role for primary care staff, for example ‘exercise on prescription’, other statutory and voluntary agencies can ‘prescribe’ social activities to address mental health issues.

While in many approaches, health or social care staff refer individuals to appropriate services, in other models individuals are encouraged to self-refer to community sources of support.

Social prescribing can support self-management helping people to take control of their own healthcare plans. A range of self-referral therapeutic opportunities are available across Scotland, including stress control groups, mindfulness groups, Living Life to the Full groups and web-based resources for anxiety and depression (for example computerised cognitive behavioural therapy).

7. Why invest in social prescribing?

Social prescribing encourages people to develop greater ownership of their mental health and take responsibility for improving the factors that influence it (*General Practitioners at the Deep End*). This is seen to have greatest impact where it is person centered and where there is also a focus on improving the wider contextual factors. There are reported benefits to the individuals involved in social prescribing including improved social networks, friendship, acceptance and opportunities to participate in and enjoy the same range of everyday activities.

Within the context of mental health there is a strong theoretical basis for social prescribing. Evidence tells us that a range of social and personal factors contribute to the development and maintenance of poor mental health. These factors include financial insecurity and poverty, unemployment and work stress as well as social isolation. If we can help people address these factors through, for example, gaining better social support, addressing problems of debt and poor finances and improving employment prospects, then it is plausible that this will help improve their mental health. Social prescribing provides an approach to support people to access these services as part of a package of care to support those with mental health problems.

The demand on primary care, mental health and wider services to support people with mental health problems is increasing. In some cases a low intensity intervention is useful, but for other situations more complex treatment is appropriate. It is common, however, for people to present to primary care and other services with a

range of social issues affecting their mental health (*General Practitioners at the Deep End*). The negative impacts on mental health can arise from one particular issue (such as debt) or complex and multiple life experiences (poor housing, unemployment and social isolation) and addressing these issues can also improve their mental health and promote self-management.

The potential range of factors influencing mental health means that a single organisation cannot address all these issues and a partnership response is often needed.

At the same time there is increasing financial pressure within all sectors to respond efficiently and effectively. Services across the whole public service system will be increasingly working to reduce duplication through the sharing of services in line with the integration agenda. Social prescribing provides opportunities to deliver services and support in different ways consistent with a range of current and emerging policy directives, such as the *Commission on the Future Delivery of Public Services* (Christie, 2011), the *Quality Strategy* and community empowerment legislation. Social prescribing can make an important contribution to this agenda and integrated joint boards should explore this approach.

Many practices and services are already developing alternative responses to mental health problems by improving access to social, cultural and environmental resources and assets which support mental wellbeing and seek to prevent mental health problems from occurring. They are expanding local 'treatment' options which can be low cost, low complexity interventions, which help people to identify issues impacting on their mental health, take appropriate action and stay well.

8. Knowledge of impact

There is a strong theoretical basis for social prescribing. Connecting people with appropriate local sources of support can potentially lead to improvements in levels of mental wellbeing, greater sense of control, heightened ability to cope with life, increased confidence, improved wellbeing, increased purpose in life, heightened personal aspirations, increased personal drive, etc. Being involved in social prescribing programmes has at times led to individuals moving on from 'client' status, to volunteering and becoming board members of the social prescribing programme.

There is promising evidence that social prescribing can be effective in increasing access to services such as self-help resources and financial advice; reducing social isolation and improving mental health outcomes (see box on page 6). While a large number of social prescribing schemes have been developed, the range of different approaches and limited good quality evaluations makes it difficult to draw firmer conclusion at present. This is not unusual for social interventions of this type and the

methodological challenge of evaluating social prescribing schemes has been acknowledged. A number of programme evaluations are building on the current evidence base and are showing promising results for particular types of interventions. Well-designed monitoring and evaluation programmes, such as the Links Worker Programme, will help us to understand which social prescribing services are effective for which populations and in what circumstances.

Routine monitoring of social prescribing programmes, tests of change, theory-driven outcomes 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.

> Planners and those delivering social prescribing approaches are encouraged to build evaluation processes into any new (or existing) initiatives in order to describe the extent to which they achieved the desired outcomes and further build the evidence base**.**

Exercise referral schemes (ERSs) are a way to enable 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.

While there have been limited large-scale evaluations and reviews of ‘books on prescription’ schemes, a recent evaluation of Reading Well on Prescription suggests that there is good uptake of the recommended titles.

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 (Mossabir).

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.

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.

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 only information based and rely on people opting in to services. Further research is needed to test out this hypothesis.

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
- having staff with appropriate skills and characteristics and a knowledge of the resources currently available in the community.

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
- having the resources to access services.

In addition, good support and supervision and specialised programmes characterised by choice and variety were also valued**.**

9. Making it happen

Knowledge about implementing social prescribing interventions has continued to grow over recent years through both research and local practice. Planners should develop local approaches based on their local learning, current practice examples and the evidence of these effective approaches.

The following guidance has been developed, based on the best available research, evidence and learning from developing, implementing and evaluating social prescribing programmes in Scotland.

7.1 Key facilitative factors for effective social prescribing

A number of key principles which underpin social prescribing for mental health have been identified, these include:

- engaging the individual in identifying the support required, based on their needs
- building relationships and trust within the local partnership to support planning, delivery and evaluation of the approach
- engaging local partners and stakeholders in the design of a social prescribing approach maximising the particular contribution or offer the various partners can make – including the NHS, local authority and community and voluntary sector agencies, and communities themselves
- embedding the social prescribing approach within wider pathways and routes of referral
- complementing direct and tailored support for individuals with a focus on prevention, working to challenge the contextual factors that often give rise to the mental health issue
- supporting capacity building within all sectors, so that staff and volunteers feel able to support social prescribing approaches
- equality proofing local approaches to ensure that they do not widen the health inequalities gap further
- monitoring and evaluating local approaches in order to incrementally build the evidence base regarding what works.

7.2 Planning, delivering and evaluating local social prescribing programmes

Local approaches to social prescribing are often influenced by the strategic and delivery context, willingness and availability of partners, 'lead' services, levels of investment, the needs of the local area, evidence and inequalities. The **leadership**, **infrastructure and support** required for each model varies, it is important to define the:

- target population group or groups
- desired outcomes
- required social prescribing opportunities.

7.3 Leadership

It is important to appreciate the contribution that a wide range of partners can bring in developing a social prescribing approach, which can be harnessed through local leadership and coordination by a local champion (e.g. Head of Service or lead GP). It is vital to ensure that there is shared commitment, coordinated actions, and priority given to developing a social prescribing programme, which links to and supports the achievement of local objectives, such as the Single Outcome Agreement, and supports its monitoring and reporting approaches. Some local areas have established a social prescribing leadership or steering group which has helped them to take a more strategic and collaborative approach, through this they can:

- strengthen partnership working and appreciation of individual assets that can contribute to collective action (e.g. existing knowledge, skills and expertise)
- create a shared ownership and accountability for delivery of the social prescribing approach
- strengthen communication enabling clarity of the local approach(es) and processes
- identify joint priorities and gaps in current provision
- extend the reach and scope of social prescribing interventions
- coordinate approaches to build capacity within and across services and sectors, e.g. mental health awareness guidance and pathways
- combine funding to reprioritise or disinvest in some services and parts of the system to reinvest elsewhere towards improved outcomes – for example, seed funding, leading to sustainable funding
- consider other resources in kind, such as staff time, and how potential barriers for participants can be overcome, e.g. cost to participate.

7.4 Infrastructure

The social prescribing service you develop will depend on your target population, reach, the desired purpose of the social prescribing project and the sources of support that are available to draw on. Defining the target population and purpose is an important first step.

For example, do you want to develop a service for the general population to promote their mental wellbeing? Are you targeting those with mild to moderate depression with a view to helping reduce levels of depression or are you targeting those with complex psychosocial issues and helping them to access sources of support to

address these issues as part of a package on support for mental health problems in primary care?

Once this has been agreed, partners should design the social prescribing approach around them, using, for example:

- sign-posting and connecting the general population to a broad range of community based services
- primary care referrals to low intensity, non-medical early interventions for common mental health problems
- primary care referrals to generic workers (link workers) who act as a case worker or life coach to support people to interact with, often complex and bureaucratic, non-medical sources of support
- referrals to practice or community based specialist sources of support
- referrals by healthcare professionals, for clients progressing through physical healthcare pathways.

Defining the desired outcomes is best considered as early as possible within the local partnership arrangement. To help you do this, refer to the Mental Health Improvement Outcomes Framework. Outcomes can be considered at various levels, including population, partnership, service/practice, and individual (person-centred). It may be helpful to refer to the House of Care model as an illustration of how planning, securing and monitoring investment on behalf of an individual or a population can secure best possible outcomes.

Defining the required social prescribing opportunities is important, considering whether people should have increased or improved access to them (or reduced inequality in access). For example, you might wish to decide if it is a single scheme, such as exercise referral or books on prescription, or access to multiple opportunities. Mapping out what opportunities already exist is helpful. This allows for identification of any gaps and increases the use of what services are already out there. It is recognised that sometimes this develops incrementally – one social prescribing approach is prioritised and then others are added when possible, contributing to the wider determinants of health and addressing other risk factors.

Defining referral or sign-posting criteria – there are several options in defining referral pathways: self, single route (such as GP), open (e.g. family, friends or other statutory or voluntary organisations) or a mixture of these. It is important that time is taken to build trust between GPs and intermediary organisations as GPs often prefer to refer directly to organisations that have become a trusted intermediary. During the

planning stage, it is important to build in time to hold good, constructive dialogues with GPs, in order to develop supportive working relationships and co-designed referral processes (see Healthy Active Minds).

Defining the pathway, routes, access points and what people can expect to receive. For this to work well, staff from all levels should be engaged in the planning process, in order for relationships to be built and to better understand how each other works, the terminology used, the barriers faced and the opportunities available to them. A recent evaluation of the Bridge Project found that the likely 'active ingredients' of a general practice-based system included:

- identification of a practice-based link worker
- active identification of people in need
- building relationships with community service providers
- providing older people with up-to-date information about services
- supporting people to engage with services
- feedback and follow up.

Briefings and training – it is important to consider how to build capacity for the social prescribing programme from the planning stage. Specific resources should be considered, such as briefings and training for all those involved, including sign-posters, referral agents and link workers depending on the service provided. The Links Worker Programme suggests that Primary Care teams need to support:

- active engagement with resource distribution, so that those with the most need are the most likely to receive the support they need and time is built in to consider equality issues such as health literacy
- protected time for shared learning (within practices and between practices) and continuous practice development and improvement
- awareness raising of clinicians and their administrative staff to identify people who would benefit from information for support, or to have a wider understanding of the social and personal context of illness, of personal belief systems or anxieties and of how support might enable better self-management
- sharing of quality assured information, efficient and accessible processes for patients to receive information at the point when it is needed and likely to be responded to
- people who are experiencing barriers to accessing resources, and develop skills in supporting people practically to find solutions. (Signposting alone is not sufficient in helping people who need support the most; without additional input,

signposting alone is likely to widen inequalities as it will only benefit those who already have sufficient capacity to make use of information and overcome barriers.)

Networks of support for the non-mental health workforce delivering social prescribing – building support at a local level is important, for example identifying a local mental health champion to offer advice to the social prescribing approaches to build confidence and strengthen local relationships, along with enhancing opportunities and partnership working and improving efficiency.

Communications and information – this involves staff providing information about a range of community resources, such as voluntary agencies, self-help groups, leisure, volunteering, training and educational opportunities in the community. This information can be given through discussion with clients, supporting this with information leaflets, booklets, etc. A range of web-based resources have been developed in many areas (developed by Health Board, local authority or voluntary agencies), e.g. Well Connected in Lanarkshire, and My Wellbeing in Dundee.

It is important that internet directories of community resources for use by practitioners are kept up to date, locally relevant and user-friendly. This is important when considering how best to embed the social prescribing programme. A Local Information System for Scotland (ALISS) is a national information engine, sharing details of local social prescribing opportunities. A key challenge in this is sharing and coordinating what is already in place or has been done locally.

In order for people to access information, it is important to consider if people have good levels of health literacy skills, and the ability to manage their time or personal resources, such as money. These competencies can often be taken for granted by professional staff; however, the ability to read, process information or attend appointments can be problematic for some individuals. It is important to note that those who would have the most to gain from healthy life choices or from health interventions are often least able to take advantage of them because they lack the basic capability to do so.

Evaluation and monitoring – building evaluation and monitoring into social prescribing programmes is vital to ensure there are systems in place to measure whether the approach is having the desired impact on mental health and wellbeing of the chosen population. It is important that a monitoring and evaluation plan is developed at the same time as developing the social prescribing service. This plan will help you determine the reach, and appropriate outcomes and indicators of success, both in the short and longer term and help clarify reasonable time frames for these outcomes. Short-term outcomes might include, for example, uptake and where there is appropriate maintained contact with support services. Medium-term impacts would be associated with the social issues contributing to poor mental health

and long-term outcomes would be measures of mental health and wellbeing. Continuous improvement should be built into the development process with evaluation and monitoring informing the next stages of planning and action.

A range of tools are available to help guidance the development of evaluations.

7.5 Levels of support

The level of support required varies depending on the target population:

- **Self-referral** – if people self-refer into a social prescribing programme, it can often be the first step on a person's recovery or improvement journey. People need to feel valued and in control. Approachable, friendly staff with good listening skills are vital in supporting someone who has self-referred.

- **Supported intervention** – this helps people to find the right information and to be sign-posted to a mutually agreed source of support. It is important to reduce any barriers around access. Support can be delivered either face to face or via the telephone. This can include either a specific social prescribing service where people are referred to a bespoke service or it could be about embedding social prescribing in health and wellbeing programmes. If a person is already at high risk and receiving additional support for a mental health, physical health or social or economic issue, then the services being referred to could work to help address issues of inequality.

- **Supported welcome or introduction** – this can be provided by someone within the mainstream social prescribing domain by facilitating an initial meeting, interview, planning and induction to help the person stay connected. Local briefing sessions, peer support and single telephone numbers could also be considered.

- **Supported access** – There is a variance in levels of support required based on need and preference. This might involve someone to support the person to connect with the social prescribing domain, e.g. peer supporter, support worker, community link worker. Some people require practical support, liaison and buddying to appointments. In doing so, there is a need to ensure that the social prescribing programmes are reaching those in greatest need and to take into consideration the reasons why some people drop out from referral appointments. Evidence suggests that people don't follow up when they are sign-posted to other services. There are various reasons for this. If people are supported via a link worker model, individuals are supported to make changes in their lives which help improve their health and wellbeing (Community

Compass). People sometimes need to be referred to support organisations, rather than just being given an information leaflet or information on local groups. This can be for many reasons, including:

  - they don't have the confidence
  - they don't know where a group is held
  - they don't know people there – fear of the 'unknown'
  - they can't physically get there – e.g. no money, no car, unable to navigate public transport systems
  - mental health problems – e.g. panic attacks when they go out
  - they are frightened or agoraphobic.

- **Peer support groups** – sessions can support increased understanding of mental wellbeing, self-resilience, healthy coping skills, understanding emotional responses to distress, capacity to withstand distress, and awareness or sense of wellbeing. This approach provides flexibility, more time, resources and complements other services. The benefit of this support is that people can share their experiences with others who have travelled a similar road before them. It allows members to build trust and help them to find a way through their own challenges. It gives individuals hope for a fulfilling, meaningful life (in extension, it is possible for them if they know someone else has achieved it). Many community and voluntary sector organisations value a person-centred approach, enabling more time being spent with individuals within community-based groups or one-to-one sessions.

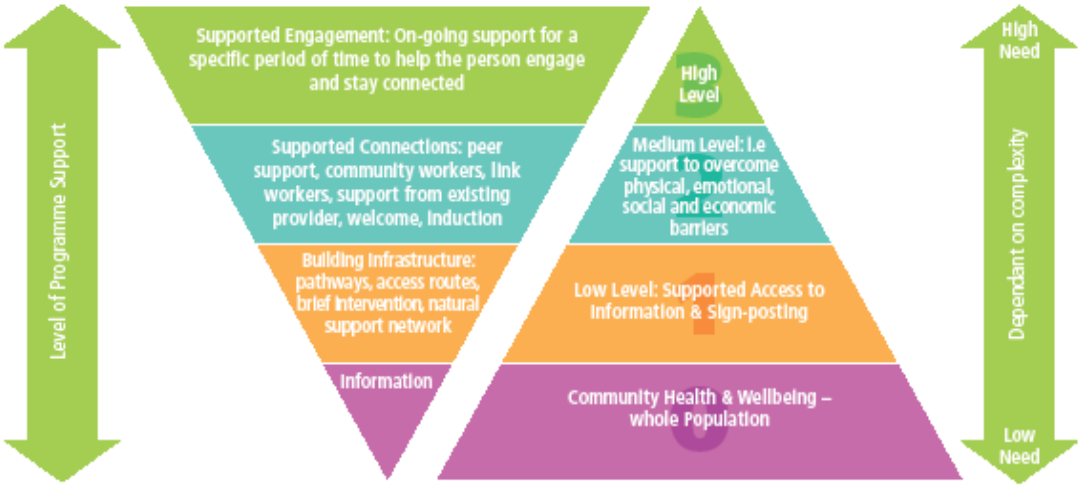
7.6 A case study example

Here is an example of how one area (Lanarkshire) has identified and agreed different levels of intervention for different client groups.

A stepped model of social prescribing

The model of the delivery needs to consider infrastructure required, the range of interventions and support required across tiers (see figure 1). The tiers interact and relate, i.e. improving general information and access at tier 0, which is less resource intensive, will provide the foundations upon which supportive structures and programmes can be built, promoting access across all tiers. Individuals and groups will move between the tiers, i.e. individuals may need support at tiers 2 or 3 to engage with social prescribing opportunities initially to achieve short-term outcomes. However, to achieve longer-term outcomes their connection, interest and wellbeing will be sustained at tiers 0 and 1 through linkages with lower intensive mainstream opportunities through natural networks of support.

Figure 1: Model of delivery for social prescribing



Source: NHS Lanarkshire, 2015

10. Mental health inequalities and social prescribing

Social prescribing can potentially play a role in tacking mental health inequalities. Evidence about effective interventions for reducing health inequalities indicates policies and practices that improve accessibility, prioritise disadvantaged groups and provide intensive support are more likely to be effective. Consequently, local partnerships should take this into consideration when planning new or reviewing existing social prescribing programmes.

In contrast, services that are only information based, reliant on people taking the initiative to 'opt in' and which involve significant price or other barriers, are less likely to reduce health inequalities. In the context of social prescribing, it is possible that models which rely on sign posting 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 disadvantaged are less likely to take up services and those more socially advantaged due to facing greater challenges and having the capacity to take up the opportunities on offer without additional support services (see Macintyre).

In planning your approach, it is important to be aware of the characteristics of policies and interventions which impact on reducing inequalities. A range of tools have been developed to support equality proofing of local approaches to ensure that they do not widen the health inequalities gap further.

11. Overcoming the barriers

The empirical evidence for social prescribing has provided us with increased understanding of its effectiveness, but efforts are needed to build this evidence base further. Experiential knowledge is abundant but not as well documented as it could be. Routine monitoring of social prescribing programmes, tests of change and theory driven outcomes and process evaluations will build this evidence base further and help establish which social prescribing interventions are effective for which participants and in which context (see Teuton). We would encourage partners to gather the evidence base on social prescribing, in order to strengthen its standing. Data management systems and processes to quality assure and record demand, access and capacity to monitor throughout should be developed.

From the perspective of referral agents time, information overload, unfamiliar resources and services, lack of up-to-date information, expectations about providing medical support and a tendency to respond to the consequences of social problems rather than the social problems themselves emerge as some potential barriers to using social prescribing services (*General Practitioners at the Deep End*). Experiential knowledge suggests that the link worker model may go some way in addressing these challenges (see Community Health Connections).

Engaging general practitioners and other agencies in referring clients to community resources can be challenging. GPs involved in the Deep End Practices have recommended the following key actions to support more effective social prescribing in primary care:

- More medical and nursing time is required during consultations to respond to challenging needs and circumstances facing some patients, thereby allowing clear explanation and referral to sources of support.
- Guidance is needed for patients needing advocacy support.
- Primary care teams would benefit from the addition of a practice-attached social worker, employability adviser and mental health worker.

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Other online resources

Community Compass Case Study
www.youtube.com/watch?v=3IxNstRk9CM&list=PLdtTilZi8S795eYpNQXJsn5C0KKritEzM&index=1

Scotland's House of Care
www.alliance-scotland.org.uk/what-we-do/projects/scotlands-house-of-care/

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

Element
www.element.org.uk/self-help-resources/well-connected-programme.aspx

My Wellbeing, Dundee City Council
www.dundeecity.gov.uk/mywellbeing

Mental Health Outcomes Frameworks, NHS Health Scotland
www.healthscotland.com/OFHI/MentalHealth/content/MHtools.html

Appendix 1: Members of the Self-Management and Social Prescribing National Advisory Group

Karen Adam (NHS Tayside, and chair of group)
Naureen Ahmad (Scottish Government)
Sheila Allan (Dundee City)
Jane Ankori (Health and Social Care Alliance)
Martin Bird (Midlothian)
Chris Bruce (Joint Improvement Team Scotland)
Allan Clifford (Department for Work and Pensions)
Lisa Curtis (Scottish Government)
Martin Docherty (Volunteer Scotland)
Alan Douglas (Bipolar Scotland)
Frances Elliot (Scottish Government, but currently NHS Fife)
Bridget Finton (Scottish Natural Heritage)
Andy Fox (East Renfrewshire Council)
Elspeth Gracey (CHEX community health exchange)
Wendy Halliday (NHS Health Scotland)
Justine Hampton (NHS Health Scotland)
Tommy Harrison (Mental Health Lead, NHS Greater Glasgow & Clyde)
Nigel Henderson (Health and Social Care Alliance)
Paul Henderson (Perth and Kinross Council)
Jacqui Heron (Recovery Across Mental Health)
Christine Hoy (Health and Social Care Alliance)
Gemma Jackson (Volunteer Scotland)
Ruth Jepson (Scottish Collaboration for Public Health Research and Policy)
Maxine Jones (International Futures Forum)
Mark Kelvin (Health and Social Care Alliance)
Susan Kerr (Department for Work and Pensions)
Dr Graham Kramer (General Practitioner and Scottish Government)
Kevin Lafferty (Forestry Commission)
Jenny Lim (General Practitioner)
Sheena Lowrie (NHS Lothian)
Miles Mack (RCGP Scotland)
Marion Macleod (NHS, National Education Scotland)
Grace Martin (Volunteer Scotland)
Allyson McCollam (NHS Borders)
Mark McGeachie (Scottish Government)
Shona McIntosh (Scottish Government)
Joanne McLean (Mental Health Foundation)
Steven McLellan (Recovery Across Mental Health)
Stewart Mercer (Professor, University of Glasgow)
Karen Nicoll (General Practitioner)
Diana Noel-Paton (The Thistle Foundation)
Kevin O'Neill (NHS Lanarkshire)
Chris O'Sullivan (Mental Health Foundation)
Gerry Power (East/Mid Lothian)

Helena Richards (Carr Gom)
Tony Robertson (University of Edinburgh)
Arma Sayed-Rafiq (NHS Health Scotland)
Frances Simpson (Support in Mind)
Kathryn Skivington (University of Glasgow)
Craig Stewart (East Ayrshire)
Joanna Teuton (NHS Health Scotland)
Clare Thirlwall (Dumfries and Galloway Council)
Graham Watt (Professor, University of Glasgow)
Frank Weber (General Practitioner)
Heather Williams (NHS Health Scotland)
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