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Research Report

Care Options for Primary Care:

The development of best practice information and guidance on Social Prescribing for Primary Care Teams

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Foreword by Professor Bill Shannon, Vice-President of the Irish College of General Practitioners

The term “Social Prescribing” was certainly a new one for me and I expect will be for many of my GP colleagues, and possibly other professionals in Primary Care. Essentially it covers a whole raft of possible non-medical interventions aimed at supporting people with mental health needs. That covers all of us, because it includes a major emphasis on health promoting activities, as well as those proven to help people struggling with common mental illnesses, such as anxiety and depression.

Having spent a professional lifetime as a GP I was, like so many of my colleagues, often left with little choice but to prescribe medication for my patients with symptoms of anxiety and depression, despite knowing their underlying problem often had a psycho-social rather than a purely medical basis. Of course for many years the community resources were simply not there to be mobilised but now, in more enlightened times, we can take more appropriate action for such patients with the advent of social prescribing. Indeed the key report produced by The Expert Group on Mental Health Policy in 2006, “A Vision for Change” stressed the importance of a comprehensive community-level response for people with mental health difficulties, including non-medical interventions at Primary Care level.

General Practitioners have repeatedly stated that, ***given adequate support***, most mental health problems could be treated at primary care level. Such adequate support must surely mean the provision of extra resources in the community along the lines indicated in this comprehensive evidence-informed report. It is heartening to read of the many proven non-medical interventions available to members of Primary Care Teams in the UK.

Although this report describes a number of such initiatives recently developed at several sites in Ireland, we still have a long way to go before we see the implementation of many of the recommendations in “A Vision for Change”, despite it being Government policy for the past five years. I commend this report for its clarity and evidence base concerning the central importance of social prescribing for the Mental Health of the Irish population.

Professor Bill Shannon

Executive Summary

The aim of this report is to offer information and best practice guidance on social prescribing for Primary Care Teams. Social prescribing is emerging as an area of practice in the context of a number of key developments in mental health promotion and prevention and primary care provision. This report includes evidence from national and international research. It adopts an evidence informed approach integrating best research evidence with practitioner and user expertise.

“Social prescribing creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services (Brandling and House, 2007).

The social importance of mental health (and therefore the importance of a society-wide response to mental health) is widely recognised. The WHO has found that mental disorders rank second in the global burden of disease, following infectious diseases (World Health Organisation, 2003). The economic costs of mental health problems are considerable. Among HSE priorities for 2012 are the promotion of positive mental health and suicide prevention, the development of the capacity to effectively manage mental health needs appropriate to a primary care setting and the development of effective partnerships with voluntary and statutory agencies to deliver integrated care for service users. This report examines the practice of social prescribing as one method of delivering on these priorities.

Social prescribing in primary care is a relatively recent concept describing the use of non-medical support to address the needs of people whose mental health is affected by depression or anxiety. It is one means of providing psychosocial and/or practical support for people with mild to moderate mental health problems, and research suggests a range of positive outcomes, including emotional, cognitive and social benefits.

Social prescribing may also be a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Gask et al., 2000, Bates, 2002, Friedli et al., 2009, Evans et al., 2011). Common activities included in social prescribing, among reports reviewed, include self-help, exercise, arts and creativity, green activity, community involvement and supports including volunteering, debt advice etc.

Social prescribing practice takes a range of forms but a number of core elements can be identified from models reviewed. The primary care team is a central component of the social prescribing model acting as referrers and sometimes as coordinators of the social prescribing service. Sometimes co-ordination of social prescribing is contracted out to voluntary or community services. Activities to which people are referred are located within the community, generally provided by voluntary and community groups and organisations. An information resource such as a directory or a service that keeps up to date information on what supports are available in the community is another key element. A range of mechanisms is involved relating to referral pathways (including feedback), quality and review processes. The primary care team is the main source of referral. They need to know what to look for in patients who might be suitable for social prescribing and be clear about what is

achievable from this approach, and so training and support is an important consideration. Service users for whom social prescription has been found to be particularly suitable include those with vague or unexplained symptoms or inconclusive diagnoses, those with many symptoms affecting multiple systems, frequent attenders for GP appointments, those with poor social support mechanisms and those experiencing psychological difficulties. The research highlights the need for social prescribing schemes to be user-led with service users involved as key stakeholders from the outset.

The role of facilitator/coordinator who acts as a link between health professionals and the community services has been identified time and again as key to successful social prescribing. The relationship between the primary care team and the services delivering activities in the community has emerged as a pivotal aspect of social prescribing models (Edmonds, 2003, Constantine, 2007, Friedli et al., 2009, White and Salamon, 2010). Most of these services are provided by the voluntary sector and it is vital that the relationship between the primary care team and the local voluntary sector is nurtured and supported.

Social prescribing practice expands the range of service options for those with mental health needs, offering greater service user choice as well as greater opportunities to improve health and social outcomes that are connected to mental wellbeing. Projects reviewed vary in scope and definition but have a number of common threads. The relationship between PCT and community sector is pivotal to successful working. A shared language and a common understanding of goals and expected outcomes is vital. Measurement is challenging but a number of innovative approaches are emerging to address these challenges. Quality assurance is important and should be developed within a framework of existing quality initiatives within the primary care and community sectors.

Recommendations for the definition and implementation of social prescribing practice in Ireland include:

- A collaborative approach to the development of social prescribing practice at national and local level.
- Social prescribing should be considered as part of the on-going development of primary care teams and mental health services. Identification of where co-ordination of the scheme is best located should be one of the first steps in initiating a local social prescribing scheme.
- Planning needs to take into account that social prescribing practice can increase demand on voluntary sector services.
- Resource allocation is a key consideration in the development of social prescribing practice. Project costs and model of delivery will be determined by the nature and range of activities selected and the nature of the referral.
- A database of all users of a social prescribing service should be initiated and maintained by the facilitator/co-ordinator to enable a longitudinal study to be carried out to monitor the effectiveness and the cost-effectiveness of the individual projects to all stakeholders.
- A national research framework for social prescribing projects bringing together expertise in mental health promotion and primary care would ensure best use of resources locally in terms of building an evidence base and generating effective evaluations. Measurement of effectiveness should occur at individual, population and service level.

Overview of Social Prescribing Activities

Activity	Observation on evidence-base	Examples in Ireland
Social Prescribing /General	NICE guidelines on the management of anxiety and depression include activities which fall within the recommendations for evidence-based treatment options, approaches that often fall under the 'social prescribing umbrella', for example, exercise-referral, self-help, CBT based approaches, bibliotherapy, social support and, more recently, computer-assisted CBT. However, the guidelines do not include referral guidelines (NICE 2004a; 2004b; 2006b).	The HOPE- Erris Primary Care Project Partnership is a partnership between Erris PCT and the Family Centre in Castlebar funded by The National Office for Suicide Prevention. Thelma.Birrane@hse.ie Mary.OSullivan@hse.ie
Self Help: Computerised therapy Books on prescription/ bibliotherapy	NICE found good evidence for the effectiveness of some CCBT for depression and anxiety. NICE recommends the use of bibliotherapy in the management of patients with mild to moderate anxiety and depression(NICE 2011).	In February 2009, the Library Council of Ireland, the HSE and the ICGP introduced the 'Power of Words' a national bibliotherapy scheme made available to all GPs registered in the country.
Exercise on prescription	NICE guidance recommends that patients of all ages with mild depression should be advised of the benefits of following a structured and supervised exercise programme of typically up to 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks (NICE 2007).	National GP Exercise Referral Programme led by the HSE in partnership with the ICGP and ILAM. There are 500 GPs registered on the programme and each GP can refer 5 patients who fit the inclusion criteria per week. www.gpexercisereferral.ie
Green activity/ ecotherapy	A report commissioned from the University of Essex by Mind (Mind 2007)and a national evaluation from 2003-2007 of 52 Green Gym projects by Yerrell (BTCV 2008) suggests that ecotherapy is an accessible, cost-effective complement to existing treatment options for mild to moderate mental health problems.	The Green Prescription Programme is being piloted in Cloghan, Co. Donegal AnnMarie.Crosse@hse.ie Healthyfoodforall.com provides information and guidance on community food initiatives in Ireland and Northern Ireland.
Arts on Prescription	While there is a body of available work about the benefit and value of 'arts in health' and 'arts for health', extensive searches found little published empirical research that focuses specifically on AoP.Guidelines for Good Practice for Participatory Practice in Healthcare Contexts are available at: www.waterfordhealingarts.com	There are a range of arts and health related activities developing in Ireland. A directory of these activities is available at www.artsandhealth.ie
Community Learning and Supports	Opportunities for learning may impact positively on health (National Institute of Adult Continuing Education (NIACE), 2009) by improving an individual's: socioeconomic position; access to health services and information; resilience and problem-solving; and self-esteem and self-efficacy.	Information on a wide range of community supports and education can be found at: www.aontas.com; www.volunteeringireland.ie; www.citizensinformation.ie.

Introduction: Aims, Objectives and Methodology

The aim of this report is to offer best practice information and guidance on social prescribing for Primary Care Teams in Ireland. The specific objectives are:

- a) To report on both national and international evidence for the effectiveness of social prescribing in primary care for people suffering from mental distress, in particular mild to moderate depression and anxiety.
- b) To identify examples of good social prescribing practice both in Ireland and internationally.
- c) To provide guidance and recommendations for primary care teams relating to the establishment of a social prescribing practice at a local community level including examples of quality assurance models.
- d) To take into account the diversity of community settings including urban / rural and the challenges and opportunities for social prescribing that these represent.

The report includes evidence from national and international research. It adopts an evidence-informed approach integrating best research evidence with practitioner and user expertise. Two strategies were adopted:

1. A systematic review of the literature on the effectiveness of social prescribing in primary care for people suffering from depression and anxiety. The following criteria were applied:

- Irish and international literature published in the last 5 years (i.e. literature from 2006, 2007, 2008, 2009, 2010, and 2011). Where key literature prior to 2006 emerged this was also reviewed.
- Multi-disciplinary. Subject areas – primary care, mental health, health care, general practice, psychology, psychiatry and social science.
- Peer reviewed journal articles, books, policy and practice reports (including governmental and non-governmental reports).
- A combination of the following keywords was included in the search terms: Social prescribing/social prescription/community referral; anxiety, depression, prescribing for learning/ arts/ exercise; community/local/voluntary supports. Search engines used included Medline, Web of Science, Swetswise, Google Scholar and Psychlit. Databases/Repositories searched included: NUIG and TCD Library Catalogues; thehealthwell.info; nice.org.uk; who.int; impha.net; hselibrary.ie/Lenus.ie; drugnet.

2. Data gathering examples of good practice:

Examples of best and promising practice were gathered through the literature review. In addition to this two other approaches were taken:

- (i) Call for information through professional networks.
- (ii) Fact finding interviews with key informants through contact with relevant statutory and voluntary and community services. Over thirty individuals provided information either by phone, face to face interview and/or by email (see Appendix 1.1 for details).

The focus of this exercise included the exploration of:

- What works in social prescribing, why and how.
- Challenges and barriers.
- Local variations, resource implications, support structures and processes, quality assurance, training implications, measures of success/effectiveness.

1. Policy and Practice Context for Social Prescribing in Ireland

Social prescribing is emerging as an area of practice in the context of a number of key developments in mental health promotion and prevention and primary care provision.

1.1 Mental health and society

The social importance of mental health (and therefore the importance of a society-wide response to mental health issues) is widely recognised. The WHO has found that mental disorders rank second in the global burden of disease, following infectious diseases (World Health Organisation, 2003). In fact, mental disorders exact a greater toll on the health of the world's population than AIDS, TB and malaria combined. Five of the ten leading causes of disability worldwide are mental health conditions such as depression and schizophrenia, and the impact of mental health problems at a population level continues to grow.

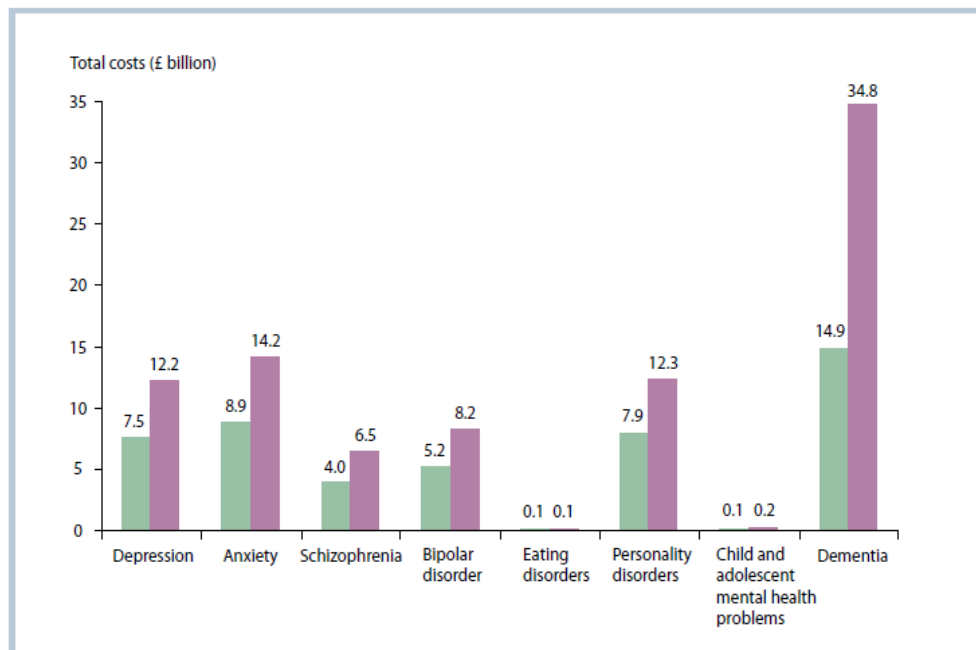
The economic costs of mental health problems are considerable. These were estimated to be at least 3–4% of GNP across the member states of the EU (Gabriel and Liimatainen, 2000). The total financial cost of mental ill health in Northern Ireland has been estimated at £2.8 billion (approximately €3.7 billion) (The Sainsbury Centre for Mental Health, 2003). The largest proportion of the cost occurs outside the health sector, for example through lost employment and absenteeism. Typically these social costs account for 60–80% of the total economic impact of major mental health problems. A report published by O'Shea and Kennelly in 2008 on behalf of the Mental Health Commission estimated that the total cost of mental health problems in Ireland in 2006 was in the region of €3 billion (O'Shea and Kennelly, 2008). Similar to the Sainsbury report it was identified that the majority of these costs were associated with lost employment, absenteeism and early retirement.

A recent report by MHC (The Mental Health Commission, 2011) in particular focuses on the negative impact of the recession on mental health stating that financial strain and indebtedness is strongly associated with both the onset and maintenance of common mental health problems. The more common mental health problems are treated at primary care level which means it is likely that in times of economic distress there will be an increase in the number of GP visits for mental health problems. With reference to *A Vision for Change* it states that our mental health system should also include a community-level response to mental health difficulties, such as through support groups and other voluntary groups; mental health interventions at primary care level – usually in the form of contact with a GP or other primary care professional. The recommendations made in the report largely focus on assisting people in dealing with their financial problems through communication with the banks and provision of useful information sources.

The cost of mental health problems poses the question of the use of available resources in prevention and promotion. Figure 1 is adapted from a report (McCrone et al., 2008) that looked at how the costs of mental health problems might change over a 20-year period in the UK. For each of eight mental disorders (depression, anxiety, schizophrenia, bipolar disorder, eating disorders, personality disorders, child and adolescent mental health problems, and dementia), Figure 1 shows the costs of mental health problems in the UK in 2007 and the expected costs in 2026 if treatment and support arrangements remain unchanged, and if impacts on, for example, employment patterns also remain unchanged. The projections also assume that the proportion of mental health needs that are recognized and treated remains the same. The projections clearly show a substantial increase in the

impact of mental health problems on the economy under current treatment and care arrangements.

Figure 1: Current and projected future costs by mental health disorder, England 2007, 2026



Source: McCrone, Dhanasiri, Patel, Knapp, Lawton-Smith. *Paying The Price*. London: King's Fund, 2008.

A report (Knapp et al., 2011) commissioned by the Department of Health England to identify and analyse the costs and economic pay-offs of a range of interventions in the area of mental health promotion, prevention and early intervention, found that over and above gains in health and quality of life, the interventions also generate very significant economic benefits including savings in public expenditure.

There has been little or no attention paid to economic aspects of mental health in Ireland up to now and no tradition of economic analysis of mental health data and no dedicated health economists working in the field. An overview of some of the key issues in this area is outlined in Appendix 1.2.

1.2 Mental Health Promotion

Promoting positive mental health, not just among individuals experiencing mental health difficulties, but also across entire populations is an integral part of improving health and wellbeing (World Health Organisation, 1986, World Health Organisation, 2001, World Health Organisation, 2002, Jane-Llopis and Anderson, 2004, Barry et al., 2009). The Marmot Report (2010: 560) sets out evidence of the inextricable relationships between physical health, mental well-being and social interaction. It shows that mental health and well-being has a significant influence in the contexts of human life – ‘achievement, life style, physical health, resilience and recovery, employment, relationships, and civic participation and engagement’.

A Vision for Change (Department of Health and Children, 2006) proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the

biological, psychological and social factors that contribute to mental health problems. It calls for formalised links between specialised mental health services and primary care and mainstream community agencies to support the care and integration of individuals within their local communities. It recommends that service users be viewed as active participants in their own recovery rather than as passive recipients of 'expert' care. It states that sufficient benefit has been shown from mental health promotion programmes for them to be incorporated into all levels of mental health and health services as appropriate and recommends that programmes should particularly focus on those interventions known to enhance protective factors and decrease risk factors for developing mental health problems. It recommends that designated health promotion officers should have special responsibility for mental health promotion working in cooperation with local voluntary and community groups and with formal links to mental health services.

Chief among the concerns expressed during the consultation process for A Vision for Change was the perceived 'over-reliance on medication' in dealing with mental health problems. This was seen to be the case for not just secondary level mental health services but also for GP provided care. Access for all individuals to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services is recommended. Supporting the development of mental health care within primary care services is also a key objective of Reach Out, the Irish National Strategy on Suicide Prevention (NOSP, 2005).

1.3 Mental Health and Primary Care

National figures on the treatment of mental health problems in general practice in Ireland are not available. In a study (Coptly, 2006) carried out by The Irish College of General Practitioners (ICGP) and the then South Western Area Health Board (SWAHB) (64% response rate) GPs reported that 25% of their caseload had 'psychological or mental health issues'. Most GPs (85%) referred less than 5% of these patients to mental health specialists. A series of studies by the Department of Community Health and General Practice in Trinity College looked at the general health and service use of people living in different parts of Dublin (Deady et al., 2003, O'Keefe et al., 2002). The proportion of people consulting their GP because of 'stress' varied from 26% in the Docklands area to 35% in Tallaght and 41% in Finglas. The GPs in the SWAHB study reported the most common mental health conditions in the individuals they see as anxiety (49%), depression (24%) emotional difficulties (20%) and other disorders such as psychosis and eating disorders (7%). GPs felt that most of the individuals with anxiety disorders, depression and emotional difficulties could be treated in primary care with adequate support. The type of support GPs wanted was access to counsellors or psychologists, i.e. professionals with the skills needed to deal with the majority of mental health problems encountered in primary care.

Another trend in Ireland is the significant increase by 42% between 2005 - 2009 in the number of prescriptions for antidepressants and the associated expenditure increased by 62% (HSE, 2010) despite the Benzodiazepine Report (Department of Health and Children, 2002) calling for a 'considerable reduction' in use of such drugs. The HRB Trends Series 9 report found that the annual number of cases treated for problem benzodiazepine use in Ireland increased by 63% between 2003 and 2008.

Frequent attendance has been highlighted as another issue to be addressed within primary care, with emotional and social problems being a significant factor in frequent attendance to primary care services (Heywood et al., 1998, Dowrick et al., 2000, Faulkner, 2002, Brandling

and House, 2008). It is estimated that a third of all GP consultations are the result of psychosocial problems, although they may not always be recognised as such (The Sainsbury Centre for Mental Health, 2006).

A key objective of Reach Out (NOSP, 2005) is to develop formal and structured partnerships between voluntary and community organizations and the statutory sector in order to support and strengthen community based suicide prevention, mental health promotion and bereavement support initiatives. The Health Service Executive in conjunction with the Irish College of General Practitioners (Coptly, 2006) emphasise in their management guidelines that patients presenting with mild to moderate depression or anxiety should be referred to services including those within the voluntary/community sector. Guidelines (NICE, 2011) on Anxiety Disorder (GAD) have added a requirement (section 1.1.4) that primary care staff inform people with GAD about local and national self-help organisations and support groups, in particular where they can talk to others with similar experiences.

While there has been and continues to be developments in the implementation of mental health policy in Ireland (Health Service Executive, 2012) progress by Government departments, independent bodies and the HSE has been criticised. The key barriers to full implementation have been identified as lack of resources available to mental health, the imposition of the public service moratorium and a lack of dedicated corporate leadership (Independent Monitoring Group, 2011). It is the view of the Independent Monitoring Group for Vision for Change that full implementation will only be possible when there is additional resource allocation, a redistribution of existing resources, significant change in how services are delivered and most importantly a cultural shift of attitude and practice by service providers and mental health professionals.

The national primary care strategy *Primary Care: A New Direction* (Department of Health and Children, 2001) lays the foundation for the development of primary care teams, which include GPs, public health nurses, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. Wider primary care networks include psychologists, speech and language therapists, community pharmacists, dieticians, podiatrists and dentists. This model of primary care marks a change in the delivery of health care, away from a hospital based system and with a greater emphasis on person centred care and also on a multidisciplinary way of working. Involvement of the service user in primary care is further supported in the HSE Framework Document on Service User Involvement and Primary Care 2011 (HSE, 2011a).

As of the end of October 2011, there are 401 (83% of 2011 target) Primary Care Teams in place. There are also a number of additional Teams in development with 46 of these Teams having held initial team meetings. The 401 PCTs provide services for over 3.2 million of a population with 2,970 staff members and over 1,521 GPs participating (HSE, 2011b). The HSE has processes in place to develop community participation in PCTs (see Appendix 1.3 for details).

Among HSE priorities for 2012 (Health Service Executive, 2012) are the promotion of positive mental health and suicide prevention, the development of the capacity to effectively manage mental health needs appropriate to a primary care setting and the development of effective partnerships with voluntary and statutory agencies to deliver integrated care for service users. This report examines the practice of social prescribing as one method of delivering on these priorities.

2. Social Prescribing – Definition and Practice

2.1 What is Social Prescribing?

Social prescribing in primary care is a relatively recent concept describing the use of non-medical support to address the needs of people whose mental health is affected by depression or anxiety. Social prescribing creates a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a variety of holistic, local non-clinical services (Brandling and House, 2008). Common activities included in social prescribing, among reports reviewed, include self-help, facilitated skill-development, exercise, arts and creativity, green activity, volunteering and community supports for employment, debt advice etc.

Social prescribing is one means of providing psychosocial and/or practical support for people with mild to moderate mental health problems, and research suggests a range of positive outcomes, including emotional, cognitive and social benefits. Social prescribing may also be a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general, and for people with enduring mental health problems (Gask et al., 2000, Bates, 2002, Friedli et al., 2009, Evans et al., 2011). Participation in the range of activities that social prescribing involves is consistent with wider goals relating to improving health, wellbeing and quality of life; reducing inequalities; and regenerating deprived communities. It has been found to have a role in increasing participation among those most deprived and marginalised; reducing social exclusion; helping people to actively manage their own health; and promoting employability (Friedli et al., 2009).

Social prescribing practice takes a range of forms but a number of core elements can be identified from models reviewed (see Appendix 2.1 for examples of social prescribing pathways). The primary care team is a central component of social prescribing model acting as referrers and sometimes as coordinators of the social prescribing service. Sometimes co-ordination of social prescribing is contracted out to voluntary or community services. Activities to which people are referred are located within the community, generally provided by voluntary and community groups and organisations. An information resource such as a directory or a service who keeps up to date information on what supports are available in the community is another key element. A range of mechanisms is involved relating to referral pathways (including feedback), quality and review processes.

Core Elements of Social Prescribing

PRIMARY CARE TEAM	SERVICE USER	MECHANISMS FOR: Referral, Feedback, Quality and Review
COMMUNITY VOLUNTARY SECTOR SERVICES		
INFORMATION RESOURCE		

2.2 Who is involved?

2.2.1 The Service User¹

Service users for whom a social prescription has been found to be particularly suitable include those with vague or unexplained symptoms or inconclusive diagnoses, those with many symptoms affecting multiple systems, frequent attenders for GP appointments, those with poor social support mechanisms and those experiencing psychological difficulties. A social prescription has been found to be beneficial in people with somatic preoccupation; who express dissatisfaction with results, who have been referred or discharged from secondary care; or who have had poor results with mainstream treatments and recurrent re-evaluation and revision of prescriptions due to lack of effect or side effects (Brandling and House, 2008).

The service user needs to have a clear understanding of the model of care that they are being offered. They may be used to operating within a medical model of care and may not accept the need for social support in addressing their health issues. Evans et al. (2011) highlight the importance of ensuring that clients know what to expect and are supported to feel empowered and open to other options during and after participation in the social prescribing service. They highlighted the importance of acknowledging and mitigating a fear of failure in service users. The research highlights the need for social prescribing schemes to be user-led with service users involved as key stakeholders from the outset.

2.2.2 The Primary Care Team

The primary care team (PCT) is the main source of referral. Social prescribing is a means of linking service users with supports in their community. The PCT need to know what to look for in patients who might be suitable for social prescribing and be clear about what is achievable from this approach and so training and support is an important consideration. They also need to have access to reliable information on supports available and have a referral pathway in place.

2.2.3 Social Prescribing Facilitator/Co-Ordinator

The role of facilitator/coordinator who acts as a link between health professionals and the community services has been identified time and again as key to successful social prescribing. *'Someone with highly developed interpersonal, communication and networking skills, with a motivating and inspiring manner to encourage clients to make brave decisions or take up new opportunities'* pg. 15 (Brandling and House, 2008).

2.2.4 The Community and Voluntary Sector

The relationship between the primary care team and the local community and voluntary sector in their locality has emerged as a pivotal aspect of social prescribing models (Edmonds, 2003, Constantine, 2007, Friedli et al., 2009, White and Salamon, 2010). It is vital that the relationship is nurtured and supported. Issues arising include the need for understanding of each other's area of work and expertise, clarity on what is being provided and what the expected outcomes are, clarity on referral and feedback pathways. Demand on

¹ Service user is the term used in the document to describe, patient/user/potential user of primary care services

this sector can be increased by social prescribing and capacity to meet that demand is an important implementation issue.

2.3 What is involved?: Models and Approaches

Social prescribing has been defined as a delivery mechanism for addressing the determinants of mental health in order to improve community wellbeing with models of social prescribing offering an infrastructure in which to embed the principles of health policy (Abernethy, 2011). A wide range of approaches to social prescribing have been adopted e.g. self-referral and signposting through the provision of information, indirect referral via an advisor or link worker or formal direct referral from a member of the primary care team. Other social prescribing or referral schemes have a worker based in primary care to facilitate referrals and joint working.

2.3.1 Signposting

Many primary care settings currently collate information on local self-help groups, in addition to providing a wider range of data on community-based supports and services within education, leisure and welfare, for example. This might take the form of a local directory, patient information leaflets, notice-boards, websites etc., in addition to more proactive provision of space and facilities for community groups within primary care practices. However, a social prescribing model generally involves a central point to which people are referred and a holistic assessment of the individual's life circumstances with subsequent setting and reviewing of goals.

2.3.2 Hub Model

One approach that appears to address many issues of best practice is the social prescribing hub. This approach involves promotion, administration, delivery and accountability of a social prescribing scheme to be undertaken by single organisations directly contracted by the PCT. It can address issues of ownership, flexible referral pathways, local responsiveness within a wider strategic approach, efficient management of venues and service providers and clear protocols between all parties. Hubs also address the key issue of the need for referral processes to be continuous with formal and informal feedback to referrers. White and Salamon (2010) emphasise that it is the route and 'distance travelled' by the service user that are as important as the activity. One method used to plan the establishment of a Social Prescribing Hub is through the use of the Mental Wellbeing Impact Assessment (Evans et al., 2011). This assessment identified that a social prescribing hub is for:

North Tyneside Social Prescribing Hub:

- Adults 18+
- People who find it difficult to engage/experience barriers to accessing activity (internal and external barriers)
- People with mild to moderate problems such as anxiety/stress/depression.

These groups may experience barriers because of how they feel, or real barriers to access because of how things are set up.

NOT for people with good networks and activities already. Not for children and young people as referral will be to activities for adults.

Source: (Evans et al., 2011)

2.3.3 Collaboration

Collaboration between a range of agencies interested in ensuring that their services are accessible and supportive of mental wellbeing is a key aspect of successful social prescribing approaches (White and Salamon, 2010, Abernethy, 2011, Evans et al., 2011). Early management of this collaboration appears to be a vital ingredient in successful social prescribing activities. Many commentators highlight the challenge of getting the balance between organic development of social prescribing schemes and the need for bureaucratic monitoring to ensure good practice and demonstration of effect. The involvement of all stakeholders in the planning and subsequent stages can pre-empt implementation difficulties and ensure clarity and commonality of aims and expectations. Agreeing meaningful and achievable outcomes at the outset will determine how the impact of social prescribing is measured.

2.4 How is Effectiveness Measured?

2.4.1 How do you measure success?

Evidence-based practice is a standard approach used to determine the value of interventions and inform choices relating to service provision. Evidence-based practice is rooted in healthcare and hierarchies tend to go from systematic reviews and randomized controlled trials at the 'upper' end to anecdotal evidence at the 'bottom'. There has been increasing debate on the suitability of this understanding of evidence to non-clinical interventions. Measuring the effectiveness of social prescribing, which intersects the medical and social worlds, brings to the fore the challenges of a meaningful evidence base.

2.4.2 Range of Outcome Measures

While acknowledging that social prescribing is a complex area with multiple stakeholders, variables and forms of evaluation, commentators have warned that over-focusing on instrumental clinical outcomes renders social prescribing evaluations less useful. Social prescribing practice to date suggests that a solely clinical approach to measurement will not yield meaningful results. Rather, the effectiveness of social prescribing can be holistically measured over three key levels: Service User, Service Provider and Community. These key levels are divided into outcome areas which include:

Outcome Measurement Levels	Outcome Areas
Service User	symptoms; wellbeing; social determinants
Service Provider	economic; waiting times; attendance frequency
Community	prescription behaviours; increased social capital; community inclusion

A broad range of instruments are used to capture outcomes in these areas. These range from evidence based, validated tools, to the use of existing service level data for example in

relation to waiting times, attendance frequency, prescription behaviours. Social capital can be captured using such tools as the Social Capital Assessment Tool (SOCAT).

The Nordoff-Robbins Research Department (Pavlicevic et al., 2009 Appendix 3) have developed an approach in the field of music therapy which addresses some of the challenges faced by a social prescribing approach. It suggests the building of evidence platforms over time, starting out with foundational information about service goals and objectives and moving to service level, population and clinical level evidence at key times in the process and as resources allow.

For the service user, social prescribing focuses on building empowerment, self-efficacy and social inclusion as a way of promoting mental wellbeing as well as reducing symptoms (e.g., depression, anxiety, sleep disturbances etc). Due to this range of desired outcomes, several mental wellbeing assessment tools are used. Not only do they capture social prescribing outcomes over time for the individual, but they can be used to establish areas of difficulty and to define user goals.

2.4.3 Measurement Tools

One common evidence-based model of assessing areas of mental wellbeing is that of the 'Five Ways to Wellbeing' (Aked et al., 2008). This examines areas in life where individuals can take action in to promote mental wellbeing: Connecting, Being Active, Taking Notice, Learning and Giving. These are all key aspects of social prescribing. Friedli et al. (2009 Appendix 4) also provides a comprehensive overview of evidence-based measures for social prescribing activities. A further tool being used recently in the social prescribing field is the Measure Your Concerns and Wellbeing (MYCAW) (Paterson et al., 2007). This individualised questionnaire has been designed to evaluate a range of complementary therapies used in patient care.

In addition, the following three tools have emerged to address the particular measurement needs of social prescribing projects:

The Recovery Star tool (MacKeith and Burns, 2008) was recommended by the UK's Cross-Government Strategy Mental Health Division (2009) New Horizons programme as an assessment, planning and outcomes tool in relation to mental health. It is designed to support individuals in understanding where they are in terms of recovery and the progress they are making. A version of *The Recovery Star* has been adapted for use by arts and health practitioners and participants (Appendix 2.2).

Mental Wellbeing Impact Assessment (MWIA) (Cooke et al., 2011) evaluates the impacts of policy and stakeholder practice on mental wellbeing overtime. Increased wellbeing awareness across all partners involved has been identified as a secondary benefit of implementing the MWIA. Not only does it incorporate social determinants of mental health, but it provides a common data-set for evaluation which aids comparisons over time and across contexts. Abernethy (2011:26) outlines that this MWIA "uses four key evidence based factors which promote mental wellbeing;

- enhancing control
- increasing resilience and community assets,
- facilitating participation
- promoting inclusion"

Life Domains is a model of assessment used by the Lancashire 'Help Direct' social prescribing project and is a holistic assessment which uses a 'life domain' format. The advantage of this measure is that like the MWIA tool, it identifies social, economic and psychological challenges and progress can be measured against this (Abernethy, 2011).

2.5 Quality Assurance

Social prescribing is a complex area which involves establishing good working relationships between referrers, services and service users. In order to build trust between these stakeholders, the issue of quality assurance is a key factor. Several mechanisms contribute to quality of services in particular, Standards of Practice, Training/ Accreditation and a Code of Governance. Quality assurance of social prescribing practice in Ireland should be informed by existing developments in these areas within community settings.

2.5.1 Standards of Practice

Winters et al. (2010) developed a set of Standards (Appendix 2.3) which can be applied to all Wellness Services within community settings. These standards address issues in relation to:

- A. Improving Outcomes
- B. Improving Quality
- C. Service Integration
- D. Stakeholder Engagement and Whole System Fit
- E. Efficiency Improvements
- F. Sustainability

Volunteer Centres Ireland – Quality Mark

While no framework for accreditation of voluntary organisations exists in Ireland currently, there is a framework in the UK; 'Investing in Volunteers'. This is quite a formal assessment approach. A less formal approach is being pursued in Ireland in two ways. Firstly through the accreditation of Volunteer Centres who work to create an enabling environment for volunteering in Ireland and provide support to individuals and organisations involved in volunteering. Through a peer review process which consists of core principles and indicators, Volunteer Centres are assessed for a Quality Award. Four of the twenty two Volunteer Centres in Ireland have achieved this to date. It is awarded by the centre demonstrating its effectiveness in key areas including its volunteer placement service, its support to voluntary organisations, and its efforts to promote volunteering to the public. Secondly, an initial Quality Standards Framework (Volunteer Centres Ireland, 2011) has been published with a final version due Spring 2012 and presently provides standards, indicators and practice examples in 19 different areas relevant to volunteering. These include issues in volunteering infrastructure development such as training, collaboration, management, promotion, acting as signatory to Garda Vetting, database maintenance. It also address principles such as accessibility and non-discriminatory. Organisations which involve volunteers may apply for assessment and compliance within this Framework.

ICS – Support Group Guidelines

Although not recommending a minimum standard of training for service providers, the Irish Cancer Society (Surrett-Thomas and Ryan, 2011) has outlined a set of guidelines for support groups. These guidelines cover aspects such as group affiliation, establishing groups, training (staff & volunteers), confidentiality, data protection, facilitation, advocacy, responsibilities etc. The ICS propose a voluntary affiliation process which aims to create standardised good

practice at local, regional and national level. The guidelines operate under a Declaration of Good Practice incorporating four key principles; Equity, Governance, Service and Confidentiality. While specific to the issue of cancer, these guidelines could be revised into generic support group standards of practice. This would give a recognisable, easily transferrable and trustworthy framework for community based support groups.

Participatory Arts in Healthcare – Good Practice Guidelines

Waterford Healing Arts Trust (WHAT) is housed in a dedicated Centre for Arts and Health in the grounds of Waterford Regional Hospital. In partnership with the Health Service Executive South (Cork) Arts and Health Programme and with financial support from Arts Council Ireland, WHAT commissioned the development of *Participatory Arts Practice in Healthcare Contexts - Guidelines for Good Practice* (White and Robson, 2009). These are evidenced based guidelines, which promote quality assurance for arts practitioners in the area of health.

2.5.2 Training/Accreditation

Exercise Referral Coordinator Certification

The Irish GP Exercise Referral Programme is a physical activity initiative to help adults get active. Patients are directly referred from the GP to a local leisure facility. To ensure patient safety and the effectiveness of the programme, gym instructors are required to obtain the 'Local Coordinator Certificate' awarded through successful completion of the GP Exercise Referral National Training Course. This course is the only qualification for this activity which is recognised by the HSE, the ICGP (Irish College of General Practitioners) and ILAM (the Irish Leisure Industry Body) and is compulsory for delivering the programme.

Facilitator Accreditation: WRAP@

The Wellness Recovery Action Plan programme (WRAP) is an evidence based recovery programme used around the world. Here in Ireland it is implemented by various bodies, both statutory and voluntary for example, the National Learning Network, St. Patrick's University Hospital, Primary Care Teams, and Mental Health Ireland. This Recovery-focused approach is one of the standards recommended in the Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007). Facilitators are trained and must be accredited.

Bereavement Support Group Accreditation Model

The Irish Association of Suicidology, with funding from the National Office for Suicide Prevention, commissioned a researcher to carry out a scoping exercise around the development and implementation of an accreditation model for non governmental organisations working in the area of suicide intervention, prevention and postvention. The standards will be designed to encourage and foster cooperation and continued development of best practise within the sector.

The final report, due in October 2012, will form the basis of finalising the standards and outline a prospective model of implementation. Further consideration will then be required around how organisations can be supported to adapt to the standards framework and finally the formal implementation of the standards.

2.5.3 Code of Governance for Community and Voluntary Organisations

Volunteer Ireland in conjunction with a consortium of stakeholders, has developed a Code of Governance for the Community and Voluntary sector (www.governancecode.ie) and a working group is progressing implementation. The code aims to support organisations to

- Avoid and minimise risk.
- Reduce inefficiencies and costs across the specific organisation.
- Chose a governance level appropriate to organisation type.
- Appeal to current and potential funders.

2.6 Overview of Social Prescribing

Social prescribing is a relatively recent area of practice to emerge in primary care and the community sector and primarily in the UK. Projects reviewed vary in scope and definition but have a number of common threads. The relationship between PCT and community sector is pivotal to successful working. A shared language and a common understanding of goals and expected outcomes are vital. Measurement is challenging but a number of innovative approaches are emerging to address these challenges. Quality assurance is important and should be developed within a framework of existing quality initiatives within the primary care and community sectors.

2.6.1 Common issues that arise in social prescribing practice

Common issues that arise in social prescribing practice include the need for:

- Clear referral and eligibility criteria which include arrangements for accountability and liability for referred patients.
- Feasible systems for the recording, storage and evaluation of information.
- Maintenance of up-to-date information on sources of voluntary and community support.
- A common language to ensure clear and understanding of aims and expected outcomes between partners coming from different disciplinary backgrounds
- Selection early on, of a measurement framework that is suited to the stakeholders involved in the process.

2.6.2 Issues in Measuring Effectiveness

Mental wellbeing outcomes include skills and healthy behaviours development, pro-social behaviours and contact, changes in prescription behaviours, reduction in frequency of attendance, improved quality of life and mental health and reduced symptoms (depression, anxiety, hopelessness etc). Using the range of measures described above, outcomes in relation to social prescribing projects which have been attributed to social prescribing practice include:

- Mental health promotion in individuals – holistic and flexible.
- Symptom reduction.
- More efficient use of statutory services.
- Changes in prescription and attendance behaviours.
- Long-term cost effectiveness.
- Reduction in stigma due to mainstreaming thereby facilitating early intervention.
- Increased uptake of interventions due to GP referral.
- Increased public knowledge of mental health.
- Increased social capital in communities.

2.6.3 Quality Assurance Issues

Such developments of good practice guidelines, standards, instructor certification, Code of Governance and the Volunteer Quality Mark promote quality assurance within the community and voluntary sector, thus further bridging the gap between the social and medical models.

It is of significant importance that the Quality Standards Framework being developed by Volunteer Ireland is progressed and implemented nationally. At present this framework is not a formal requirement of affiliated Volunteer Centres, but it is however beginning to establish the practice and recognition of quality assurance within voluntary/community organisations. While not all social prescribing activities will require the same level of standards of training, instructor certification etc., the issue of quality assurance remains an important one.

The progression of the National Code of Governance as described above would undoubtedly assist in bringing together many of the outstanding developments in the area of quality assurance.

3. Activities commonly used in social prescribing

There is no single definition of social prescribing, however, a number of activities are commonly found within definitions of social prescribing practice. This section presents definitions and examines the evidence available for these activities. A directory with greater detail on a range of specific projects is provided in Appendix 3.1.

3.1: Self Help

3.1.1: Computerised therapy

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

What the evidence says: NICE found good evidence for the effectiveness of computerised cognitive behaviour therapy (CCBT) for depression and anxiety. *Beating the Blues™* is a treatment option for people with mild or moderate depression (NICE, 2008). The programme consists of an eight session self-help treatment intended for use by patients with and without previous computer experience. Beating the Blues™ uses interactive modules, animations and voiceovers to motivate and engage the patient. An integral addition is a series of filmed case studies of fictional patients who replicate the symptoms of anxiety and depression and help demonstrate the treatment by CBT. It is only available on licence, and can only be accessed through a healthcare professional in the UK. It is currently available in over 300 NHS PCTs, community mental health trusts and specialist CBT services. It has also been introduced into The Netherlands, the US, Canada and Malta (Ultrasix, 2012)

FearFighter™ is a self-help computer program for treating phobias, panic and anxiety and is recommended by NICE as a treatment for anxiety and phobias (NICE, 2008). It is an 8 to 12 week course of therapy delivered online – either at home or at any other venue with internet access. It ‘interviews’ the individual to assess their anxieties and fears, helps plan a self-treatment schedule, monitors progress and gives feedback. The makers, CCBT Limited (ST Solutions) have entered into a framework agreement with the NHS to deliver the internet-based programme, and *FearFighter™* is purchased on a cost per capita basis (CCBT Limited, 2012).

Free CBT websites

There are several free-to-access CBT sites available on the internet. Powell and Clarke (Powell and Clarke, 2006) found that the internet had been used as a source of mental health information by over 10% of the population, and by over 20% of those with a history of mental health problems. The majority (90%) of these users were 18- to 29-year-olds, both people in employment and students. One of the challenges in recommending such a site within a social prescribing model is how to ensure the effectiveness, validity and appropriateness of the site. The British Association for Behavioural and Cognitive Psychotherapies has published a review of such sites (Gournay, 2006). The review identified free-to-access websites: MoodGym (<http://moodgym.anu.edu.au>) and Living Life to the Full (www.livinglifetothefull.com).

The review also makes recommendations to PCTs that CCBT, including free-to-access programmes, can benefit patients and the benefits may increase if the patient uses the

service in collaboration with a professional. The review also recommended that Information about all three of these websites should be made freely available to patients and also to mental health professionals who may have contact with people suffering from depression or anxiety. The websites may be used in addition to any of the steps within a stepped care program and health professionals should be educated in the advantages of providing access to the websites in combination with conventional evidence-based approaches. Potential users should be advised that the benefits of these websites generally come with repeated use. PCTs should continue to monitor the development of such internet-based programmes.

3.1.2: Books on prescription/bibliotherapy

Definition: Bibliotherapy usually takes the form of: a 'prescription' for a particular book to be borrowed from a public library, or from a GP or mental health worker; or recommendation by a GP or mental health worker of a list of books or other self-help materials that the patient can obtain from their local library. Over half of the library authorities in England are currently operating some form of bibliotherapy (Hicks, 2006). Other opportunities for developing bibliotherapy within a social prescribing model include referral to reading groups using self-help materials, or literature with a personal development theme.

What the evidence says: A review of research evidence for self-help interventions for people with mental health problems (Lewis and Anderson, 2003) found that most studies reported a significant benefit from use of self-help materials based on CBT approaches for treatment of depression, anxiety, bulimia and binge eating disorder. It suggested that the use of self-help materials was 'probably safer' if supported by a healthcare professional and suggested that self-help interventions could be a very useful first step in a stepped care approach. Frude (2004) found that bibliotherapy had high patient acceptability, a tendency to continued improvement over time and low relapse rates (Frude, 2004). Bibliotherapy is also cost-effective (Hicks, 2006) although the level of effectiveness depends on the quality of the book and the motivation, application and literacy levels of the patient. NICE recommends the use of bibliotherapy in the management of patients with mild to moderate anxiety and depression (National Collaborating Centre for Mental Health and the National Collaborating Centre for Primary Care, 2011, Reading Agency, 2003).

Bibliotherapy in Ireland : The Power of Words

In March 2007, the North Inner City Partnership in Primary Care (Dublin), in collaboration with Dublin City Public Libraries, piloted the first book prescription scheme in Ireland. The objective of the scheme was to give GPs, mental health professionals and their patients choice in the treatment approach to some mild and moderate mental health difficulties. In February 2009, the Library Council of Ireland, the HSE and the Irish College of General Practitioners introduced the 'Power of Words' a national bibliotherapy scheme to support and aid people with mild to moderate anxiety and depression. This information was made available to all GPs registered in the country.

3.2: Exercise on prescription

Definition: Exercise on prescription involves referring clients to supported exercise programmes that can include: gym-based activity, guided/health walks; cycling; swimming

and aquatherapy; team sports; and exercise and dance classes. In 2008 there were 136 exercise referral programmes available in England.

What the evidence says: Exercise is an effective adjunct intervention for some of the negative symptoms of mental illness such as depression and anxiety (Faulkner and Biddle, 1999). A number of trials have suggested that patients respond positively to GP advice to take more exercise (Killoran et al., 1994). National consensus statements on physical activity and mental health in the UK (Grant et al., 2000) show that exercise prevents clinical depression and is as effective as psychotherapeutic interventions. Exercise also reduces anxiety, enhances mood and improves self-esteem (Fox, 2000, Mutrie, 2000).

An evaluation of GP exercise prescription schemes has found that a ten-week programme of exercise prescribed by a GP significantly reduces depression and anxiety and increases quality of life and self-efficacy (Darbishire and Glenister, 1998). In the study, 68% of clinically depressed patients achieved non-clinical depression scores within three months. NICE published a review of four common methods used to increase the population's physical activity levels (brief interventions in primary care, exercise referral schemes, pedometers and community-based walking and cycling programmes), and it concluded that there was insufficient evidence to support the effectiveness of any of them, with the exception of brief interventions (advice and written information) in primary care (NICE, 2006).

A systematic review of 22 studies by Sorensen et al. (2006) found that most studies reported moderate improvements in physical activity or physical fitness for up to 6-12 months. For patients receiving the intervention, 10% had improved their physical activity levels compared with controls and mean aerobic fitness was improved by 5-10%. There is little evidence to support the view that more intensive programmes are more effective.

Exercise on Prescription in Ireland

The National GP Exercise Referral Programme (www.gpexercisereferral.ie), led by the HSE Health Promotion in partnership with the ICGP (Irish College of General Practitioners) and ILAM (Irish leisure industry body) evolved in 2008 after a series of three pilot studies were successfully carried out and evaluated in Cork, Kerry and Limerick. Evaluation of the project in Cork identified that the GP Exercise Programme was an effective means of increasing activity levels in patients who participated. There are 500 GPs registered on the programme and each GP can refer 5 patients who fit the inclusion criteria per week. An evaluation of the National GP exercise referral programme is due for completion in April/May 2012.

3.3: Arts and creativity

Definitions of creative activities and interests are broad and sometimes overlap with learning, but may include: arts and performance (including writing, painting, sculpture, photography, music, poetry, drama, dance and other performance arts, and film); libraries; museums; heritage; and cultural tourism. 'Arts on prescription' is distinct from art therapy, a professional discipline with a long tradition as a psychological therapy (Kalmanowitz and Lloyd, 1997). Evidence of effectiveness focuses on three main areas: the impact of participation in the arts on self-esteem, self-worth and identity; the role of creativity in reducing symptoms (e.g. anxiety, depression and feelings of hopelessness); and arts and creativity as resources for promoting social inclusion and strengthening communities.

Evidence: A number of studies have suggested that creative activity has positive effects on mental health such as the development of self-expression and self-esteem, opportunities for social contact and participation (Huxley P, 1997) and/or providing a sense of purpose and meaning and improved quality of life (Callard and Friedli, 2005, Oliver et al., 1996, Tyldesley and Rigby, 2003). Reviews by the Health Education Authority (Health Education Authority, 1999) and Matarasso (1997) demonstrated improvements in wellbeing as indicated by: enhanced motivation; greater connectedness to others; a more positive outlook; and a reduced sense of fear, isolation or anxiety. These benefits were brought about by the opportunities that engagement in art afforded for: self-expression; an enhanced sense of value and attainment; and pride in achievement.

Evaluation of the *Stockport Arts on Prescription Scheme* showed a moderate impact on self-esteem and social functioning. However, the increase in involvement in social activities was statistically significant, with some evidence that the use of GPs, social workers and other services was reduced (Health Education Authority, 1999, Huxley P, 1997, Tyldesley and Rigby, 2003). A further case study on people referred to arts activities by health and social services found that participants used in-patient and other hospital services less often and that the risk of relapse was reduced (Department for Culture Media and Sport, 1999). A qualitative study of the views and experiences of young African and Caribbean men in East London found very strong support for the mental health benefits of opportunities for arts and creativity (Friedli et al., 2002). A central theme was the importance of arts and creative expression as protective factors in the face of the racism and discrimination experienced by the young men interviewed, both within mental health services and in the wider community. In spite of encouraging findings, however, much existing evaluation is based on short-term or intermediate outcomes, and many studies are anecdotal and based on small-scale surveys, lack a longitudinal dimension and fail to identify arts-specific aspects of the programmes (Coulter, 2001).

Arts on Prescription in Ireland

Established in 1993, the Waterford Healing Arts Trust (WHAT) is one of Ireland's longest established arts and health programmes. Based in Waterford Regional Hospital, it seeks to improve the patient and staff experience through a multidisciplinary programme of arts experiences. In 2009 it opened the first arts and health Centre in the Republic of Ireland, enabling it to bridge its work between the acute hospital setting and the wider community. It hosts a weekly Open Studio art making facility for people isolated for reasons of health and / or disability. WHAT also supports the development of the arts and health sector in Ireland through professional development and www.artsandhealth.ie. In 2008 working in partnership with HSE South, WHAT commissioned the development of best practice guidelines for participatory arts projects in healthcare contexts. For further information, see www.waterfordhealingarts.com

A range of activities are emerging in relation to arts and health in Ireland and are outlined in Appendix 3.1.

3.4: Green activity/ecotherapy

Definition: 'Green activity' or 'ecotherapy' refers to schemes in which participants become both physically and mentally healthier through contact with nature. This can include: Gardening and horticulture; growing food; walking in parks or the countryside; involvement in nature conservation work (e.g. green gyms); and developing community green spaces.

What the evidence says: ‘Green exercise’ (physical exercise in a natural environment) is associated with increases in self-esteem, positive mood and self-efficacy (Pretty et al., 2005, Pretty et al., 2003). The Green Gym project is an example of an effective UK-wide initiative, set up as a result of a joint venture between a local health authority and the British Trust for Conservation Volunteers (BTCV)

An evaluation of green gyms (BTCV, 2002) demonstrated a range of physical and mental health benefits, including reductions in symptoms on HADS and improvements in quality of life. ‘Being out in the countryside’ emerged as a significant motivating factor, supporting other findings on the potential therapeutic value of the natural environment. (BTCV, 2002) found a significant improvement in mental health in the first three months of participation (as measured by the SF-12 health-related quality of life instrument). Factors motivating continued participation in green activity included the social aspect of working with a group, increased awareness of conservation and countryside issues, and doing something worthwhile. The green gym was viewed by participants as being beneficial to their mental health and wellbeing.

A report commissioned from the University of Essex by Mind (MIND, 2007) suggests that ecotherapy is an accessible, cost-effective complement to existing treatment options for mild to moderate mental health problems. For further information visit www.mind.org.uk/mindweek2007/report/. A national evaluation from 2003-2007 of 52 Green Gym projects involving 703 participants by Yerrell (2008) reports evidence of significant improvements on both mental and physical health scores on the SF-12 health-related quality of life scale, and increased levels of physical activity among participants, based on 67% follow up to 3-8 months. Further examples of ecotherapy projects in the UK and Ireland can be found in Appendix 3.1.

The Green Prescription Programme in Ireland

The Green Prescription Programme involves a health professional’s written advice to a client to become more active in the natural environment as part of the patient’s health and quality of life management. The programme seeks to prevent and tackle obesity and to promote health while reducing stress and increasing self esteem and social well being. The project is funded by the HSE’s National Obesity Taskforce and is currently being piloted in Co. Donegal. Evaluation of the Green Prescription Programme is being carried out by the Institute of Technology, Sligo.

3.5: Community Involvement and Support

3.5.1: Learning/education on prescription

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

What the evidence says: Opportunities for learning may impact positively on health (National Institute of Adult Continuing Education (NIACE), 2009) by improving an individual’s: socioeconomic position; access to health services and information; resilience and problem-

solving; and self-esteem and self-efficacy. A study looking at the health impact of participation in learning in a sample of 10,000 adults found that it plays an important role in contributing to the small shifts in attitudes and behaviours that take place during mid-adulthood (Feinstein et al., 2003). These include positive changes in: exercise taken; life satisfaction; race tolerance; authoritarian attitudes; political interest; number of memberships (of, for example, community groups); and voting behaviour.

Evaluation of prescription for learning in Nottingham, assessing the health impact on 196 participants, found the following benefits: improved confidence and self-esteem; lifted mood; improved sleeping; increased activity; wider social networks; greater sense of control; hope and optimism; and improved health behaviours. These findings are particularly significant as over two-thirds of referrals were for people with no qualifications, who had not accessed any form of learning since leaving school (Feinstein et al., 2003, James, 2001b).

Aontas is a national adult learning organisation in Ireland which promotes the provision of a comprehensive system of adult learning that is accessible and open to all (www.aontas.com). Research commissioned by Aontas in 2009 found that community education has wide ranging positive outcomes for learners (Aontas 2009). In particular, the following health outcomes were identified: decreased isolation/loneliness; decreased need for primary care service; personal development; increased self-confidence and improved personal relationships.

3.5.2: Supported Employment

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

Vocational advice

Definition: Vocational advice schemes typically employ advice workers as part of a mental health team, providing vocational advice and support (including job retention) to care coordinators, clients and, where appropriate, employers (see www.socialinclusion.org.uk/good_practice/index.php?subid=59). Social prescribing can support people in retaining or returning to employment, by enabling referral to any of the interventions described in this report. It is possible to target people who are, or are at risk of being, socially excluded as a result of experiencing emotional distress. This includes unemployment, risk of job loss and factors of social isolation. Social prescribing provides early intervention to keep people in work and maintain social contacts. Once a person has reached crisis point, it is much more difficult and costly to restore their employment and social status, with a subsequent exacerbation of economic and health inequalities.

Supported employment

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

Social enterprises/social firms

Definition: Social firms and other social enterprises offer a road to recovery and employment opportunities to people with mental health problems. A social firm is a type of social enterprise, the specific social purpose of which is to employ people disadvantaged in

the labour market. Other types of social enterprise include development trusts, co-operatives, credit unions and community businesses. Social firms subscribe to three core values (Social Enterprise Coalition 2005): enterprise – social firms are businesses that combine a market orientation and a social mission ('businesses that support' rather than 'projects that trade'); employment – social firms are supportive workplaces that provide all employees with support, opportunity and meaningful work; and empowerment – social firms are committed to the social and economic integration of disadvantaged people through employment. A key means to this end is economic empowerment through the payment of market wages to all employees. Social firms and social enterprises can provide employment opportunities within a social prescribing model. They can also be established to deliver mental health services – the Government is keen to see more public sector services delivered by social enterprise. For further information see www.socialenterprise.org.uk and www.socialfirms.co.uk.

3.5.3 Debt Advice

Debt advice has also been mentioned briefly in the literature as a possible component of social prescribing and could be particularly appropriate in the present economic downturn as financial distress is a common predisposing factor to stress related illness such as anxiety and depression for many people who may not in previous times have been predisposed to stress related difficulties. The national Money Advice and Budgeting Service (MABS) provides debt advice to families in Ireland and has a history of working with primary care. For example, the national Traveller MABS has provided training to primary health care workers (ntmabs.org) in Co. Wicklow to ensure access to financial services for Travellers.

3.5.4: Time banks

Definition: A time bank is a 'virtual' bank where people can deposit the time they spend helping each other and withdraw that time when they need help themselves. Everyone's time is of equal value and transactions are facilitated and recorded by a time broker. The time bank is essentially a mutual volunteering scheme, using time as a currency. Time banks have been widely used within broader regeneration and urban renewal programmes. There are also a number of examples of their use in primary care, in recognition that feelings of isolation may be a significant source of poor health status and that many presenting problems are social, rather than medical, in origin.

What the evidence says: Time banks have shown a positive impact on confidence and self-esteem, have provided opportunities for elderly and disabled people to contribute, and have strengthened community-based self-help and mutual aid. The main impact comes from sustained befriending and intensive or frequent volunteering. Other outcomes (Foundation, 2009, Seyfang, 2010, Transition Ireland, 2012) include: improved quality of life through social interaction and having practical needs met; support, confidence, friendship and new skills; an alternative for people reluctant or unable to use psychological therapies, although time banks also work well alongside talking treatments; helping to increase people's understanding and tolerance of depression and mental illness; supporting of primary care workers by creating a system of social support for more vulnerable patients; and referral providing access to a much wider range of services.

3.5.5: Volunteering

Definition: Volunteering has two potential benefits within a framework for social prescribing: encouraging people to volunteer because of the benefits to their own mental health; and use of volunteers to support people within a social prescribing intervention.

What the evidence says: Evidence of the mental health benefits of volunteering is interlinked with some evidence that older volunteers are more likely to gain psychological benefits from volunteering than younger people (Friedli et al., 2007). Friedli found limited evidence of a positive correlation between volunteering and happiness and benefits to volunteers from volunteering with indications that people with high levels of wellbeing tend to be more involved in voluntary work. She cites a review of 37 studies by Wheeler, Gore and Greenblatt (1998) that found that 70% of older volunteers scored higher on quality-of-life measures than their peers who did not volunteer. Additionally, the quality of life of 85% of the people the volunteers worked with also improved as a result of becoming less isolated and depressed. Friedli suggests that while the evidence is mixed, encouraging and facilitating access to volunteering activity may be empowering for some patients and a potential route to developing valued skills and opportunities for social contact.

Volunteer Ireland is the national volunteer development agency and a representative body for all local Volunteer Centres in Ireland. Volunteer Ireland work to inspire, promote, support and celebrate voluntary activity in Ireland (volunteeringireland.ie). Areas of work include advocacy; organizational development; research; promoting volunteering; inclusive volunteering and infrastructure development.

3.5.6: Peer Support

Evidence is building that peer support is an important and effective strategy for health care and behaviour change with its benefits extending into community, organizational and societal levels. With the growing recognition of the need for collaboration between primary care and the voluntary/community sector, this community-based approach offers a multi-level, evidence-based and cost effective intervention. In the UK, (Pfeiffer et al., 2011) found that results from 9 RCTs indicated that peer support interventions improved depression symptoms more than 'treatment as usual'. In America, a global systematic review carried out by the University of North Carolina and Peers for Progress, American Academy of Family Physicians Foundation in Kansas (Elstad et al., 2010) included papers evaluating peer support groups for health issues including; post-natal depression, depression and self-efficacy in cancer patients, smoking cessation, etc. Of the 47 studies reviewed, 83% reported significant change with 37 of the studies reviewed using randomised control trials. The Peers for Progress organisation in America aims to promote and evidence the case for peer support as a mechanism for health promotion:

“social support, a broader definition of peer support, decreases morbidity and mortality rates, reduces health care service use, increases life expectancy, self-efficacy, knowledge of a disease or conditions and self-reported health status and better self-care skills, including improved medication adherence. Additionally, providers of social support report less depression, heightened self-esteem and self-efficacy, and improved quality of life.”
(Peers for Progress 2012 - <http://www.peersforprogress.org/>).

Peer support therefore can be viewed as an effective and vital component of social prescribing. Common peer support mechanisms in Ireland are; Aware, Grow, AA, NA, Cancer Support Groups, Suicide Support groups etc.

3.8 Overview of Social Prescribing Activities

Review level evidence (Bunting et al., 2011) indicates that there is good evidence for the efficacy and effectiveness of a number of interventions for addressing depression and anxiety disorders at primary care level. Relevant interventions that have an established review level evidence base include guided self-help, CCBT and CBT and structured group physical activity programmes. The 2011 Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future (National Collaborating Centre for Mental Health and the National Collaborating Centre for Primary Care, 2011):

Recommendation 4.2: The clinical and cost effectiveness of two CBT-based low-intensity interventions (CCBT and guided bibliotherapy) compared with a waiting-list control for the treatment of GAD.

Recommendation 4.2: The effectiveness of physical activity compared with waiting-list control for the treatment of GAD.

Recommendation 4.5: The clinical and cost effectiveness of a primary care based collaborative care approach to improving the treatment of GAD compared with usual care. NICE recommended that the latter should be carried out using a cluster randomised controlled design in which the clusters are GP practices and people with GAD are recruited following screening of consecutive attenders at participating GP practices.

Other activities such as Arts on prescription, Green activity/ecotherapy, Community Learning Supports, have all been proven to have a positive effect on general wellbeing and mental health. Many of these studies have been carried out as pilot projects and would therefore require further large scale more sustainable studies, perhaps by means of randomised controlled trials to identify the true extent of their benefit to society and to social prescribing.

4. Conclusion and Guidance

4.1 Principles of Social Prescribing Practice

Social prescribing practice expands the range of service options for those with mental health needs, offering greater service user choice as well as greater opportunities to improve health and social outcomes that are connected to mental wellbeing. It responds to a wide range of wellbeing factors that are not addressed through traditional medical diagnostic protocols and has the potential to increase opportunities for early intervention. Social prescribing practice is consistent with and offers a means to enhance the implementation of current policy and practice guidance and recommendations in Ireland in relation to mental health and primary care.

Recommendations are made below for a number of actions that are necessary for the definition and implementation of social prescribing practice in Ireland. A number of core principles that should underpin social prescribing practice development include:

- Community development approach.
- Equality and inclusion.
- Evidence based practice.
- Family support.
- Mental health promotion and illness prevention.
- Partnership and collaboration.
- Person-centred care.
- Recovery as a conceptual framework and as a system of care.
- Service integration.
- Social capital including individual and community resilience.

4.2 National Implementation Guidance

4.2.1 A strategic approach to the development of social prescribing practice in Ireland is recommended. Key stakeholders in a collaborative approach to planning could include:

- HSE nationally (primary care, population health, health promotion, mental health).
- Family Resource Centre Network.
- Service user organisations.
- ICGP and other relevant professional bodies.
- National organisations involved in health initiatives related to arts, learning, exercise, employment support, debt advice etc.
- Research and education centres and networks.

A national workshop of interested parties with input from experts in Ireland and UK should be convened to develop an agreed framework for social prescribing practice in Ireland.

4.2.2 Social Prescribing should be considered as part of the on-going development of primary care teams and mental health services.

Established and developing PCTs should be identified to pilot and peer influence the adoption of social prescribing schemes. This is likely to be PCTs who have already established good partnership arrangements with the community/voluntary sector, in particular those that have established community health fora. Social prescribing practice should be developed locally within the context of existing HSE/community/voluntary sector relationships and in particular integrated with initiatives in community participation in

primary care. The Community Health Needs Assessments being carried out in 6 pilot PCTs offer a potentially significant information resource for the planning of social prescribing initiatives. PCTs adopting social prescribing schemes should also have well established links with Community Mental Health Teams.

4.2.3 Planning needs to take into account that social prescribing practice can increase demand on voluntary sector services. Involvement of the voluntary sector in the development of social prescribing practice is essential from the start to ensure that referral pathways are clear and feasible. Social prescribing should be developed within the context of existing developments in the voluntary sector.

4.2.4 Resource allocation is a key consideration in the development of social prescribing practice. Social prescribing may involve additional resource allocation, a redistribution of existing resources, and a cultural shift of attitude and practice by service providers. This needs to be a consideration in any workforce development planning.

4.2.5 A national research framework for social prescribing projects bringing together expertise in mental health promotion and primary care would ensure best use of resources locally in terms of building an evidence base and generating effective evaluations. The area of economic analysis of social prescribing as an area of mental health and primary care should be explored. This framework should include recommended evaluation instruments.

4.3 Local Implementation Guidance

In line with the principle of a community development approach it is important that the need for standardised evidence based practice is balanced with an organic approach that builds on the existing strengths and responds to the diverse needs of communities. Therefore a number of recommendations are made for local progression of social prescribing practice.

4.3.1 A collaborative approach to the development of a local social prescribing service is essential. Tasks that should be addressed collaboratively (with representatives from primary care, mental health services, community and voluntary sector, and service users) include:

1. Scope local activities and structures.
2. Define the parameters of the social prescribing scheme, this should include:
 - a. terminology to be used;
 - b. selection of a small number of clearly defined activities;
 - c. roles and responsibilities;
 - d. target groups of service users.
3. Agree aim and objectives and measurable outcomes at individual, service and population level.
4. Secure necessary resources.
5. Pilot test referral and feedback pathways with regular reviewing.
6. Share learning nationally.

Key stakeholders at local level could include:

- HSE locally (primary care, population health, health promotion, mental health)
- Family Resource Centres
- Local/Regional education and research networks

- Community Health Fora
- Relevant local community organisations health initiatives related to arts, learning, exercise, employment support, debt advice etc

Family support centres are an important hub in many communities and should be included in any planning of social prescribing initiatives nationally and locally. This is particularly important in terms of addressing issues of social inclusion. Other potential avenues for collaboration should be explored. For example, Citizens Information Centres and Library services, as collaborators on developing and maintaining an up to date information resource.

Local/area workshops should be facilitated to initiate a common approach to social prescribing practice at local level.

4.3.2 A strategic approach should be taken to local planning to ensure that at regional and national level economies and efficiencies of scale are achieved. In particular this applies to co-ordinating the supply of services to PCTs and in maintaining an up to date and accessible database of opportunities. A project management approach to local planning should be adopted with responsibility for the project resting with someone with sufficient seniority for decision-making and access to resources.

4.3.3 Identification of where co-ordination of the scheme is best located should be one of the first steps in initiating a local social prescribing scheme. Appointment of a **facilitator/link worker** is vital for the model to work. Their role should be to facilitate the necessary links between PCT and the community to ensure an inclusive approach to social prescribing developments. Additional personal support for service users to take up social opportunities can be provided through, for example, volunteer schemes. In areas experiencing high rates of exclusion or deprivation additional support is particularly important.

4.3.4 Social prescribing project costs and model of delivery will be determined by the nature and range of activities selected and the nature of the referral. For example, a service user may be referred on to an existing scheme such as bibliotherapy or a new service such as a ten week arts on prescription workshop may be what is needed. The onwards referral route to engage in related community based activities is important. A hub model, whereby a service is contracted by the PCT to organise and manage the service (sub-contracting providers where needed) appears to be a useful model to explore.

4.4.5 Measurement of effectiveness should occur at individual, population and service level. Locally measurement of effectiveness needs to be built in from the start of every project. Ideally this should happen within the context of a national research and outcomes framework. Monitoring referral and feedback pathways is central to measuring effectiveness. A database of all users of a social prescribing service should be initiated and maintained by the facilitator/co-ordinator to enable a longitudinal study to be carried out to monitor the effectiveness and the cost-effectiveness of the individual projects to all stakeholders.

Bibliography

- ABERNETHY, H. 2011. Promoting Emotional Wellbeing through Social Prescribing. In: CARTWRIGHT, S. & COOPER, C. (eds.) *Innovations in Stress and Health*. First ed. UK: Palgrave Macmillan.
- AKED, J., MARKS, N., CORDON, C. & THOMPSON, S. 2008. Five Ways to Wellbeing: A report presented to the Foresight Project on communicating the evidence base for improving people's well-being. London: New Economics Foundation.
- BARRY, M., CANAVAN, R., CLARKE, A., DEMPSEY, C. & O'SULLIVAN, M. 2009. Review of Evidence-based Mental Health Promotion and Primary/Secondary Prevention. London: Department of Health.
- BATES, P. (ed.) 2002. *Working for Inclusion: Making social inclusion a reality for people with severe mental health problems.*, London: Sainsbury Centre for Mental Health.
- BLASTOCK, D., BRANNELLY, T., DAVIS, A. & HOWES, D. 2005. Signposting Evaluation Report, National Institute of Mental Health, London.
- BRANDLING, J. & HOUSE, W. 2007. Investigation into the feasibility of a social prescribing service in primary care: a pilot project. University of Bath and Bath and NE Somerset NHS.
- BRANDLING, J. & HOUSE, W. 2008. Investigation into the feasibility of a social prescribing service in primary care: a pilot project. Bath: University of Bath.
- BTCV 2002. Green gym research summary. *Oxford: Oxford School for Healthcare Research and Development, Oxford Brookes University*.
- BUNGAY, H. & CLIFT, S. 2010. Arts on Prescription: A review of practice in the UK. *Perspectives in Public Health*, 130 277-283.
- BUNTING, B., BURTNEY, L., FERRY, F., FULLERTON, D., O'NEILL, S., MACAULEY, D., MCCORMACK, B., MCKENNA, H., MULHOLLAND, C. & RYAN, A. 2011. Rapid Review of Mental Health in Primary Care. HSC Research & Development Division Public Health Agency, Northern Ireland.
- CALLARD, F. & FRIEDLI, L. 2005. Imagine East Greenwich: Evaluating the impact of the arts on health and wellbeing. *Journal of Public Mental Health*, 4, 29-41.
- CCBT LIMITED 2012. Computer-aided Cognitive Behavioural Therapy.
- CONSTANTINE, R. 2007. *Social support through social prescribing: The attitude of leaders of voluntary organisations - a thematic analysis*. MSc Health Psychology dissertation, University of Bath.
- COOKE, A., FRIEDLI, L., COGGINS, T., EDMONDS, N., MICHAELSON, J., O'HARA, K., SNOWDEN, L., STANSFIELD, J., STEUER, N. & SCOTT-SAMUEL, A. 2011. Mental Wellbeing Impact Assessment: A Toolkit for Wellbeing. 3rd ed. London: National MWIA Collaborative.
- COPTY, M. 2006. Guidelines for the Management of Depression and Anxiety Disorders in Primary Care. Dublin: HSE, ICGP.
- COULTER, F. 2001. Realising the potential of cultural services: The case for the arts. London: Local Government Association.
- CROSS-GOVERNMENT STRATEGY MENTAL HEALTH DIVISION 2009. New Horizons: A Shared Vision for Mental Health. London: Department of Health.
- DARBISHIRE, L. & GLENISTER, D. 1998. The Balance for Life scheme: Mental health benefits of GP recommended exercise in relation to depression and anxiety. Essex.

- DEADY, J., LONG, J. & O'DOWD, T. 2003. People living in Finglas and their health. Northern Area Health Board and Department of Community Health and General Practice. Dublin: Trinity College Dublin.
- DEPARTMENT FOR CULTURE MEDIA AND SPORT 1999. Arts and Sport, Policy Action Team 10 - A report to the Social Exclusion Unit. London: Department of Culture, Media and Sport.
- DEPARTMENT OF HEALTH AND CHILDREN 2001. Primary Care: A New Direction - Quality and Fairness - A Health System for You - Health Strategy. Dublin: Stationery Office.
- DEPARTMENT OF HEALTH AND CHILDREN 2002. Benzodiazepines: Good Practice Guidelines for Clinicians.
- DEPARTMENT OF HEALTH AND CHILDREN 2006. A Vision for Change: Report of the Expert Group on Mental Health Policy. Dublin: Stationery Office.
- DOWRICK, C., BELLÓN, J. & GÓMEZ, M. 2000. GP frequent attendance in Liverpool and Granada: the impact of depressive symptoms. *British Journal of General Practice*, 50, 361-365.
- EDMONDS, N. 2003. Communities on Prescription? Primary care and the voluntary sector working together in practice. *Journal of Public Mental Health*, 2, 3.
- ELSTAD, E., BOOTHROYD, R., FISHER, E., HENES, A., MASLOW, G. & NELSON, K. 2010. Global Systematic Review of Peer Support for Complex Health Behavior.
- EVANS, R., HENDERSON, M., LUNNEY, M. & THOMPSON, J. 2011. North Tyneside Social Prescribing Hub: Mental Well-being Impact Assessment (MWIA).
- FAULKNER, G. & BIDDLE, S. 1999. Exercise as an adjunct treatment for schizophrenia: A review of the literature. *Journal of Mental Health* 8, 441-57.
- FAULKNER, M. 2002. Supporting the psycho-social needs of patients in general practice: the role of a voluntary referral service. *Patient Education & Counselling*, 52, 41-46.
- FEINSTEIN, L., HAMMOND, C., WOODS, L., PRESTON, J. & BYNNER J 2003. The contribution of adult learning to health and social capital. London: Centre for Research on the Wider Benefits of Learning.
- FOUNDATION, N. E. 2009. National Accounts of Wellbeing: Bringing Real Wealth onto the Balance Sheet. London: New Economics Foundation.
- FOX, K. R. 2000. Self-esteem, self-perceptions and exercise. *International Journal of Sport Psychology*, 31, 228-40.
- FRIEDLI, L., GRIFFITHS, S. & TIDYMAN, M. 2002. The mental health benefits of arts and creativity for African and Caribbean young men. *Journal of Mental Health Promotion* 1, 32-45.
- FRIEDLI, L., JACKSON, C., ABERNETHY, H. & STANSFIELD, J. 2009. Social Prescribing for Mental Health - a guide to delivery and commissioning. Stockport: Care Services Improvement Partnership, North West Development Centre.
- FRIEDLI, L., VINCENT, A. & WOODHOUSE, A. 2007. Developing Social Prescribing and Community Referrals for Mental Health in Scotland. The Scottish Development Centre for Mental Health.
- FRUDE, N. 2004. Bibliotherapy as means of delivering psychological therapy. *Clinical Psychology*, 39, 8-10.
- GABRIEL, P. & LIIMATAINEN, M. R. 2000. Mental Health in the workplace. Geneva: International Labour Organisation.

- GASK, L., ROGERS, A., ROLAND, M. & MORRIS, D. 2000. Improving quality in primary care: A practical guide to the national service framework for mental health. Manchester: National Primary Care Research and Development Centre.
- GOURNAY, K. 2006. Review of free to access computerised cognitive behaviour therapy websites. British Association for Behavioural and Cognitive Psychotherapies. (<http://www.babcp.org.uk>).
- GRANT, C., GOODENOUGH, T., HARVEY, I. & HINE, C. 2000. A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *British Medical Journal*, 320, 419–23.
- GRANT C. GOODENOUGH T. HARVEY I. HINE C 2000. A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *British Medical Journal*, 320, 419–23.
- HEALTH EDUCATION AUTHORITY 1999. Art for health: A review of good practice in community based arts projects and interventions which impact on health and wellbeing. *London: Health Education Authority*.
- HEALTH SERVICE EXECUTIVE 2012. National Service Plan 2012: Mental Health Services.
- HEALTH SERVICES EXECUTIVE. PRIMARY CARE REIMBURSEMENT SERVICES. 2007. Statistical Analysis of Claims and Payments.
- HEYWOOD, P., BLACKIE, G., CAMERON, I. & DOWELL, A. 1998. An assessment of the attributes of frequent attenders to general practice. *Family Practice*, 15, 198-204.
- HICKS, D. 2006. An audit of bibliotherapy/books on prescription activity in England. London: Arts Council England.
- HSE 2010. The Health Services Executive- Primary Care Reimbursement Services Scheme, Statistical Analysis of Claims and Payments
- HSE 2011a. HSE Framework Document on Service User Involvement and Primary Care
- HSE 2011b. Primary Care news. 08 Dec ed.
- HUXLEY P 1997. Arts on prescription: An evaluation Stockport. . *Stockport: Healthcare NHS Trust*.
- INDEPENDENT MONITORING GROUP 2011. A Vision for Change – the Report of the Expert Group on Mental Health Policy - Fifth Annual Report on implementation 2010. Dublin.
- JAMES, K. 2001b. Prescribing Learning, a guide to good practice in learning and health. Nottingham:NIACE.
- JANE-LLOPIS, E. & ANDERSON, P. 2004. European Policy and Action on Mental Health Promotion and Mental Disorder Prevention. IMPHA.
- KALMANOWITZ, D. & LLOYD, B. 1997. The portable studio: Art therapy and political conflict – initiatives in the former Yugoslavia and Kwa Zulu, Natal, South Africa. *London: Health Education Authority*.
- KILLORAN, A., FENTEM, P. & CASPERSEN, C. 1994. Moving on: International perspectives on promoting physical activity. *London: Health Education Authority*.
- KNAPP, M., MCDAID, D. & PARSONAGE, M. 2011. Mental health promotion and mental illness prevention: The economic case. Department of Health London: London School of Economics and Political Science.

- LEWIS, G. & ANDERSON, E. 2003. Self-help interventions for people with mental health problems. London: Department of Health.
- MACKEITH, J. & BURNS, S. 2008. Mental Health Recovery Star. London: Mental Health Providers Forum.
- MATARASSO, F. 1997. Use or ornament? The social impact of participation in the arts. *Stroud: Comedia*.
- MCCOLLAM, A., MAXWELL, M., HUBY, G., WOODHOUSE, A., MCLEAN, J., THEMESSEL-HUBER, M. & MORRISON, J. 2006. National Evaluation of the Doing Well By People With Depression Programme, Edinburgh: Scottish Executive.
- MCCRONE, P., DHANASIRI, S., PATEL, A., KNAPP, M. & LAWTON-SMITH, S. 2008. Paying the Price: the Cost of Mental Health Care in England to 2026. London: The King's Fund.
- MENTAL HEALTH COMMISSION 2007. Quality Framework: Mental Health Services in Ireland. Dublin: Mental Health Commission.
- MIND 2007. Ecotherapy: The Green Agenda for Mental Health. <http://www.mind.org.uk/mindweek>.
- MUTRIE, N. 2000. The relationship between physical activity and clinically defined depression. *Biddle SJH, Fox KR and Boutcher SH (eds) Physical activity and psychological wellbeing. London: Routledge*.
- NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH AND THE NATIONAL COLLABORATING CENTRE FOR PRIMARY CARE 2011. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults Management in primary, secondary and community care.
- NATIONAL INSTITUTE OF ADULT CONTINUING EDUCATION (NIACE) 2009. Well-being and Happiness. IFLL Thematic Paper 4. Inquiry into the Future of Lifelong Learning. Leicester. *National Institute of Adult Continuing Education*.
- NICE 2006. Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.
- NICE 2008. Computerised cognitive behaviour therapy for depression and anxiety. Review of Technology Appraisal 51.
- NICE 2011. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.
- NOSP 2005. Reach Out: National Strategy for Action on Suicide Prevention. Dublin: HSE & National Office Suicide Prevention.
- O'KEEFE, F., LONG, J. & O'DOWD, T. 2002. People living in the Dublin Docklands and their health. The Royal City of Dublin Hospital Trust and the Department of Community Health and General Practice, TCD.
- O'SHEA, E. & KENNELLY, B. 2008. The Economics of Mental Health Care in Ireland. <http://www.mhcirl.ie/Publications/>.
- OLIVER, J. P., HUXLEY, P. J., BRIDGES, K. & MOHAMMED, H. 1996. Quality of life and mental health services. *London: Routledge*.
- PATERSON, C., THOMAS, K., MANASSE, A., COOKE, H. & PEACE, G. 2007. Measure Yourself Concerns and Wellbeing (MYCAW): an individualised questionnaire for evaluating outcome in cancer support care that includes complementary therapies. *Complementary Therapies in Medicine* [Online], 15.

- PAVEY T. ANOKYE N. TAYLOR A. ET AL 2011 Dec. The clinical effectiveness and cost-effectiveness of exercise referral schemes: a systematic review and economic evaluation. Peninsula College of Medicine and Dentistry, University of Exeter, Exeter, UK. *Health Technol Assess.* , 15, 1-254.
- PAVLICEVIC, M., ANSDELL, G., PROCTER, S. & HICKEY, S. 2009. Presenting the Evidence: the Up to date Guide for Music Therapists responding to the demands for Clinical Effectiveness and Evidence-Based Practice. Nordoff-Robbins Music Therapy Research Dept.
- PFEIFFER, P., HEISLER, M., PIETTE, J., ROGERS, M. & VALENSTEIN, M. 2011. Efficacy of peer support interventions for depression: a meta-analysis. *General Hospital Psychiatry*, 33, 29-36.
- POWELL, J. & CLARKE, A. 2006. Internet information seeking in mental health: Population survey. . *British Journal of Psychiatry*, 189, 273-7.
- PRETTY, J., GRIFFIN, M., PEACOCK, J., HINE, R., SELLENS, M. & SOUTH, N. 2005. A countryside for health and wellbeing: The physical and mental health benefits of green exercise. *Countryside Recreation*, 13.
- PRETTY, J., GRIFFIN, M., SELLENS, M. & PRETTY, C. 2003. Green exercise: Complementary roles of nature, exercise, diet in physical and emotional wellbeing and implications for public health policy. *CES Occasional Paper Chelmsford: University of Essex*.
- READING AGENCY 2003. Reading and health mapping research project. St. Albans:Reading Agency.
- RUSSELL, J. 2006. Conversations in colour: Evaluation of an Arts for Health Partnership Programme 2005/6. Cork: Arts for Health Steering Group.
- SECKER, J., HACKING, S., SPANDLER, H., KENT, L. & SHENTON, J. 2007. Mental Health, Social Inclusion and the Arts: Developing the Evidence Base. Essex: The Anglia Ruskin University/UCLan Research Team.
- SEYFANG, G. 2010. Time banking: A new economics alternative. In: FULLER, D., JONAS, A. & LEE, R. (eds.) *Alternative Spaces Of Economy, Society and Politics: Interrogating Alterity*. Ashgate.
- SOBOCKI, P., JÖNSSON, B., ANGST, J. & REHNBERG, C. 2006. Cost of depression in Europe. Medical Management Centre, Department of Learning Informatics Management and Ethics, Karolinska Institutet, Stockholm, Sweden. *Journal of Mental Health Policy and Economics* 9, 87-98.
- SORENSEN, J., SKOVGAARD, T. & PUGGAARD, L. 2006. Exercise on prescription in general practice: A systematic review. *Scandinavian Journal of Primary Health Care.*, 24, 69-74.
- SOUTH, J., HIGGINS, T., WOODALL, J. & WHITE, S. M. 2008. Can social prescribing provide the missing link? *Primary Health Care Research & Development*, 9.
- SOWTER, T. & STONE, C. no date available,. Exploring Opportunities, Social Prescribing in Bromley, Bromley Primary Care Trust.
- SURRETT-THOMAS, D. & RYAN, O. 2011. Guidelines for Cancer Support Services in Ireland. Irish Cancer Society.
- THE LIBRARY COUNCIL OF IRELAND. THE HSE. ICGP 2009. Bibliotherapy: The Power of Words.
- THE MENTAL HEALTH COMMISSION 2011. THE HUMAN COST An overview of the evidence on economic adversity and mental health and recommendations for action. <http://www.mhcirl.ie/Publications/>.

- THE SAINSBURY CENTRE FOR MENTAL HEALTH 2003. The economic and social costs of mental illness in England. London: SCMHE.
- THE SAINSBURY CENTRE FOR MENTAL HEALTH 2006. Policy Paper: The Future of Mental Health: a Vision for 2015. London.
- TRANSITION IRELAND. 2012. *Transition Ireland and Northern Ireland: the network for communities building local resilience* [Online]. Available: <http://transitiontownsireland.ning.com/>.
- TYLDESLEY, R. & RIGBY, T. 2003. The Arts on Prescription Postnatal Depression Support Service: An evaluation of a twelve week pilot. *Stockport PCT*.
- ULTRASIS 2012. Beating the Blues.
- VOLUNTEER CENTRES IRELAND 2011. Quality Standards Document. Dublin: Volunteer Ireland.
- WHITE, C., GLOVER, A. & O'BRIEN, A. 2002. Summary Report on Lewisham Social Prescribing Pilot Project.
- WHITE, M. & ROBSON, M. 2009. Participatory Arts Practice in Healthcare Contexts: Guidelines for Good Practice. Cork: WHA Trust.
- WHITE, M. & SALAMON, E. 2010. An interim evaluation of the 'Arts for Well-being' social prescribing scheme in County Durham. Durham University: Centre for Medical Humanities.
- WINTERS, L., ARMITAGE, M., STANSFIELD, J., SCOTT-SAMUEL, A. & FARRAR, A. 2010. Wellness Services - Evidence-based review and examples of good practice - Final Report. Liverpool Public Health Observatory.
- WORLD HEALTH ORGANISATION 1986. Ottawa Charter on Health Promotion. Geneva, WHO.
- WORLD HEALTH ORGANISATION 2001. The World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva: WHO.
- WORLD HEALTH ORGANISATION 2002. The World Health Report 2002. Reducing Risks: Promoting Healthy life. Geneva, WHO.
- WORLD HEALTH ORGANISATION 2003. Mental Health Policy, Plans and Programmes. Policy Guidance Package. Geneva: WHO.
- YERRELL, P. 2008. National Evaluation of BCTV's Green Gym. School of Health & Social Care, Oxford Brookes University.

Appendix 1.1: Acknowledgements

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Appendix 1.2 Mental Health Costs and Evaluation

Economic impact of depression

Depression is one of the most disabling of all diseases, and causes a significant burden both to the individual and to society. WHO data suggests that depression causes 6% of the burden of all diseases in Europe in terms of disability adjusted life years (DALYs). Yet, there have been relatively few studies carried out on the economic impact of depression in Europe. A study carried out by Sobocki et al. (2006) estimated the total cost of depression in Europe based on published epidemiological and economic evidence. A model was developed to combine available epidemiological and economic data on depression in Europe to estimate the total cost of the disease. The cost data was calculated as annual cost per patient, and epidemiological data was reported as 12-month prevalence estimates. National and international statistics for the model were retrieved from the OECD and Eurostat databases. The aggregated annual cost estimates were presented in Euro for 2004.

In 28 countries with a population of 466 million, at least 21 million were affected by depression. The total annual cost of depression in Europe was estimated at €118 billion in 2004, which corresponds to a cost of €253 per inhabitant. Direct costs alone were in the region of €42 billion and consisted of outpatient care (€22 billion), drug cost (€ 9 billion) and hospitalization (€10 billion). Indirect costs due to morbidity and mortality were estimated at €76 billion. This makes depression the most costly brain disorder in Europe. The cost of depression corresponds to 1% of the total economy of Europe (GDP). These cost results are in agreement with previous research findings. Sobocki et al highlighted that their cost estimates were based on model simulations for countries where no data was available. The predictability of the model therefore is limited to the accuracy of the input data employed. As there is no earlier cost-of-illness study conducted on depression in Europe, they pointed out that it was difficult to evaluate the validity of the results for individual countries and thus further research was needed. The cost of depression poses a significant economic burden to European society. The simulation model employed by Sobocki et al shows good predictability of the cost of depression in Europe and is a novel approach to estimate the cost-of-illness in Europe.

Health and social care policy and commissioning must be evidence-based. The empirical results from this study confirm previous findings, that depression is a major concern to the economic welfare in Europe which has consequences for both healthcare providers and policy makers. One important way to address this growing problem is through increased research efforts in the field. Furthermore, early detection, prevention, treatment and patient management are imperatives to reduce the burden of depression and its associated costs. Improved mental healthcare policies and better access to healthcare for mentally ill people are continued challenges for Europe. This study identified several research gaps which are of interest for future research. In order to better understand the impact of depression to European society, long-term prospective epidemiology and cost-of-illness studies are needed which are presently lacking. On the basis of the findings, further economic evaluations of various treatments for depression are necessary in order to ensure a cost-effective use of European healthcare budgets.

Ireland

HRB Statistics Series 15 Activities of Irish Psychiatric Units and Hospitals 2010

Main Findings

There were 19,619 admissions to Irish psychiatric units and hospitals in 2010, a rate of 462.7 per 100,000 total population. This is a reduction of 576 admissions from 2009 (20,195). The rate of admissions also declined from 476.3 in 2009 to 462.7 per 100,000 population in 2010. There were 6,266 first admissions in 2010, an increase in the number of first admissions from 2009 (5,972). The rate of first admissions also increased from 140.9 per 100,000 in 2009 to 147.8 in 2010. There was a reduction in the number of re-admissions from 14,223 in 2009 to 13,353 in 2010. There was an equal proportion of male and female admissions and the admissions rates were similar for both; 464.6 per 100,000 for males and 460.9 for females. The 45–54 year age group had the highest rate of all admissions, at 727.7 followed by the 35–44 year age group, at 660.4 and the 55–64 year group, at 659.1 per 100,000 population. The 75 year and over age group had the lowest rate of all admissions, at 461.6 per 100,000 population. The 18–19 year age group had the highest rate of first admissions, at 291.6 per 100,000, followed by the 20–24 year age group, at 216.4 and the 25–34 year age group, at 193.4. The 55–64 year age group had the lowest rate of first admission, at 162.4 per 100,000. Single persons accounted for over half (54.5%) of all admissions in 2010, married persons accounted for 27%, widowed accounted for 4% and divorced accounted for 3%. The unskilled occupational group had the highest rate of all (749.2) and first admissions (175.1). Depressive disorders and schizophrenia together accounted for almost half (48%) of all admissions; depressive disorders accounted for 29% of all and 30% of first admissions while schizophrenia accounted for almost 20% (19.5%) of all and 12% of first admissions. Depressive disorders had the highest rate of all (132.8) and first admissions (44.7). Schizophrenia had the second-highest rate of all admissions, at 90.1 per 100,000. Neuroses had the second-highest rate of first admissions, at 18.2 per 100,000, followed by schizophrenia, at 17.7 and alcoholic disorders, at 15.0. Eight per cent of all and nine per cent of first admissions were involuntary, representing no change in all admissions from 2009 and a one percentage point increase in involuntary first admissions from 2009 (8%). The average length of stay for all discharges, excluding those of one year or more, was 26.0 days (median 14.0) days. Discharges with a diagnosis of organic mental disorder had the longest average length of stay, at 45.6 days (median 22.0 days), followed by schizophrenia, at 36.5 days (median 20.0 days). In the ten-year period from 2001–2010 admissions to general hospital psychiatric units have increased from 42% to 52%, admissions to psychiatric hospitals have decreased from 44% to 26% and admissions to private hospitals have increased from 14% to 22%.

Prescribing of psycholeptic drugs on the Health Services Executive Primary Care Reimbursement Services Scheme (HSE-PCRS)

The HSE-Primary Care Reimbursement Services (HSE-PCRS; formerly GMS medical services) scheme provides free healthcare to approximately 30.1% of the Irish population (1,276,178 million). Eligibility is means tested, and confined to persons who are unable without undue hardship to arrange general practitioner services for themselves and their dependants (Health Services Executive. Primary Care Reimbursement Services., 2007). All medicines are dispensed free of charge to patients registered under this scheme. While the HSE-PCRS population cannot be considered representative of the entire population, as the elderly, the young and the socially disadvantaged are over-represented, it is estimated to account for approximately 70% of all medicines dispensed in primary care. Data on prescribing and

utilisation of medical options for the management of anxiety and depression highlight the need for alternative responses: HSE Primary Care Reimbursement Scheme statistical analysis of claims and payments 2005-2009. **Psycholeptics which include (ATC code N05A Antipsychotics) (ATC N05B Anxiolytics) (N05C Hypnotics and sedatives) drugs prescribed for the treatment of anxiety and depression.** The total number of prescriptions for all psycholeptics on the HSE-PCRS scheme increased by 21% between 2005- 2009 and the associated expenditure of these drugs increased by 33%. The total number of prescriptions for antidepressants increased by 42% within the same time period and the associated expenditure increased by 62%.

Economic evaluation in mental health evaluations

Cost-effectiveness analysis (CEA) is a full form of economic evaluation where both the relative costs and outcomes (effects) of two or more courses of action are compared. In a cost-effectiveness analysis, information is gathered on the ways in which a health intervention changes the average health status of a group of people alongside costs. Therefore a CEA estimates what an improvement in health status will produce in terms of quality and quantity of life and how much it will cost to achieve these improvements. The cost-effectiveness of a preventive intervention is the ratio of the cost of the intervention to a relevant measure of its effect. The measurement of outcomes from programmes depends on the intervention being considered such as increased life expectancy and/or quality of life. The quality-adjusted life year, known as a QALY, is a year of life lived in perfect health. The average number of QALYs we can expect to live is our quality-adjusted life expectancy (QALE). CEA helps determine how to maximize the quality and quantity of life in a particular society that is constrained by a particular budget. Cost-effectiveness examines the optimal course of action when there is considerable uncertainty. For instance, this can arise when one intervention is slightly more effective but costs considerably more than the competing alternative. When a choice has to be made between alternative interventions or programmes for the same condition an incremental cost-effectiveness ratio (ICER) is used.

Two relevant studies of economic evaluation in this field have been identified:

The clinical effectiveness and cost-effectiveness of exercise referral schemes: a systematic review and economic evaluation.

Exercise referral schemes (ERS) aim to identify inactive adults in the primary-care setting. The GP or health-care professional then refers the patient to a third-party service, with this service taking responsibility for prescribing and monitoring an exercise programme tailored to the needs of the individual. A study carried out by Pavey et al (Pavey T. Anokye N. Taylor A. et al, 2011 Dec) on behalf of the National Institute for Health Research Health Technology UK assessed the clinical effectiveness and cost-effectiveness of ERS for people with a diagnosed medical condition known to benefit from physical activity (PA). The scope of the report was broadened to consider individuals without a diagnosed condition who are sedentary. MEDLINE; EMBASE; PsycINFO; The Cochrane Library, ISI Web of Science; SPORTDiscus and ongoing trial registries were searched (from 1990 to October 2009) and included study references were checked. Systematic reviews: the effectiveness of ERS, predictors of ERS uptake and adherence, and the cost-effectiveness of ERS; and the development of a decision-analytic economic model to assess cost-effectiveness of ERS. Seven randomised controlled trials (UK, n = 5; non-UK, n = 2) met the effectiveness inclusion criteria, five comparing ERS with usual care, two compared ERS with an alternative PA intervention, and one to an ERS plus a self-determination theory (SDT) intervention.

In intention-to-treat analysis, compared with usual care, there was weak evidence of an increase in the number of ERS participants who achieved a self-reported 90-150 minutes of at least moderate-intensity PA per week at 6-12 months' follow-up [pooled relative risk (RR) 1.11, 95% confidence interval 0.99 to 1.25]. There was no consistent evidence of a difference between ERS and usual care in the duration of moderate/vigorous intensity and total PA or other outcomes, for example physical fitness, serum lipids, health-related quality of life (HRQoL). There was no between-group difference in outcomes between ERS and alternative PA interventions or ERS plus a SDT intervention. None of the included trials separately reported outcomes in individuals with medical diagnoses. Fourteen observational studies and five randomised controlled trials provided a numerical assessment of ERS uptake and adherence (UK, n = 16; non-UK, n = 3). Women and older people were more likely to take up ERS but women, when compared with men, were less likely to adhere. The four previous economic evaluations identified suggest ERS to be a cost-effective intervention. Indicative incremental cost per quality-adjusted life-year (QALY) estimates for ERS for various scenarios were based on a de novo model-based economic evaluation. Compared with usual care, the mean incremental cost for ERS was £169 and the mean incremental QALY was 0.008, with the base-case incremental cost-effectiveness ratio at £20,876 per QALY in sedentary people without a medical condition and a cost per QALY of £14,618 in sedentary obese individuals, £12,834 in sedentary hypertensive patients, and £8414 for sedentary individuals with depression. Estimates of cost-effectiveness were highly sensitive to plausible variations in the RR for change in PA and cost of ERS.

The researchers found very limited evidence of the effectiveness of ERS. The estimates of the cost-effectiveness of ERS are based on a simple analytical framework. The economic evaluation reports small differences in costs and effects, and findings highlight the wide range of uncertainty associated with the estimates of effectiveness and the impact of effectiveness on HRQoL. No data were identified as part of the effectiveness review to allow for adjustment of the effect of ERS in different populations. The report concluded that there remains considerable uncertainty as to the effectiveness of ERS for increasing activity, fitness or health indicators or whether they are an efficient use of resources in sedentary people without a medical diagnosis. We failed to identify any trial-based evidence of the effectiveness of ERS in those with a medical diagnosis. Future work should include randomised controlled trials assessing the clinical effectiveness and cost-effectiveness of ERS in disease groups that may benefit from PA.

A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector

The objectives of the study carried out by Grant et al (Grant C, Goodenough T, Harvey I, Hine C, 2000) was to compare outcome and resource utilisation among patients referred to the Amalthea Project, a liaison organisation that facilitates contact between voluntary organisations and patients in primary care, with patients receiving routine general practitioner care in the form of a randomised controlled trial with follow up at one and four months using data from 26 practices in Avon. There were 161 patients identified by their general practitioner as having psychosocial problems. Primary outcomes were psychological wellbeing (assessed with the hospital anxiety and depression scale) and social support (assessed using the Duke-UNC functional social support questionnaire). Secondary outcomes were quality of life (QALY) measures (the Dartmouth COOP/WONCA functional health assessment charts and the delighted-terrible face scale), cost of contacts with the primary healthcare team and Amalthea Project, cost of prescribing in primary care, and cost of referrals to other agencies, over four months. The results of the study identified that the

Amalthea group showed significantly greater improvements in anxiety, other emotional feelings to carry out everyday activities, feelings about general health and quality of life. No difference was detected in depression or perceived social support. The mean cost was significantly greater in the Amalthea arm than the general practitioner care arm (£ 153 v £133, $p=0.025$). The researchers concluded that referral to the Amalthea project and subsequent contact with the voluntary sector results in clinically important benefits compared with usual general practitioner care in managing psychosocial problems, but at a higher cost.

There has been a major shift in mental health care expenditure in Ireland towards community based care. The evidence that community-based services are more likely to be effective in promoting quality of life among people with mental health problems, and not necessarily at greater cost, has mainly come from studies done in other countries. However costs need to be adapted to specific geographical and demographically similar populations as healthcare services and community services vary hugely in different cultural settings. There has been little or no attention paid to economic aspects of mental health in Ireland up to now and no tradition of economic analysis of mental health data and no dedicated health economists working in the field (O'Shea and Kennelly, 2008). Unit cost data is not systematically collected, making it difficult to examine the relative costs of various programmes. Similarly, there is very little data on the cost implications of the impact that mental health problems can have on many aspects of life including physical health, family relationships, social networks, employment status, earnings and broader economic status.

Summary

Overall, there is the need for a more enduring role for economic analysis within mental health care, particularly when it comes to exploring the economic and social returns from greater public investment in community based projects such as the issue of social prescribing. Policy makers are now investing more in mental health in the community; service providers and researchers in Ireland need much better data for any extra investment to yield the maximum returns in both health and the broader quality of life; advocacy groups and researchers need to increase their efforts to persuade the public that increased investment in mental health services represents a wise and just use of resources.

Appendix 1.3 HSE Recommended Process for Community Participation and Primary Care Teams

Source: <http://www.hse.ie/eng/services/ysys/SUI/Library/participation/>



Rather than presenting a prescriptive approach, the purpose of this reference guide for 'Community Participation and Primary Care Teams' is to provide HSE employees with an understanding of community participation within primary care and the basic stages that can be navigated through. The steps are not 'air tight' compartments and hence the line between the steps is arbitrarily drawn to allow people to move back and forth between the different stages.

This work will as always throw up challenges regarding expectations, methods of working and organisational constraints. However, this process of engagement allows all stakeholders to openly discuss such constraints and expectations and can reinforce learning from and between community and HSE participants.

Key structures and audit

- A list of Community Development Projects (CDPs) in your area is available from: www.changingireland.ie
- A list of Family Resource Centres (FRCs) in your area is available from: www.familyresource.ie/
- A list of local authorities can be accessed at: www.citizensinformation.ie

'Finding your way around the community and voluntary sector' by Hilary Curley is available at:

http://books.google.com/books?id=APEkN82rg_oC&printsec=frontcover&dq=findign+your+way+around+the+volunaty+and#v=onepage&q=&f=false

An audit of community research, needs assessment and consultations carried out to date might also be of benefit and a valuable resource.

Establishing and maintaining effective links

'Community Participation in Primary Care' Dr Philip Crowley, Combat Poverty Agency identifies some lessons from the Building Healthy Communities pilot programme in Combat Poverty. <http://books.google.com/books?id=BawZsjXQXlC&printsec=frontcover&dq=community+participation+in+primary+care&lr=#v=onepage&q=&f=false>

'A Model for Partnerships in Health'. Institute of Public Health. <http://www.publichealth.ie/publications/partnershipframeworkamodelforpartnershipshealth>

'Toolkit on engagement for commissioners'. Community Development and Health Network. <http://www.cdhn.org/toolkit/index.asp>

'Community development resource pack'. HSE

'Towards Standards for Quality Community Work: An All Ireland Statement of Values, Principles and Work Standards, Community Workers Co-operative'.

<http://cwc.ie/cwc/resources/publications-2.html>

Forming a small intermediary working group

This group will advise and support on community participation in the local area.

'Indicators for the working together standard'. Community Scotland. <http://www.scdc.org.uk/national-standards-community-engagement/>

'The Guide to Effective Participation' by David Wilcox available at www.partnerships.org.uk/guide

Community participation process

Methods for bringing together all local groups/persons with an interest in health and how the community can best engage with the PCT and vice versa can range from simple, yet successful, open evenings to more sophisticated community assessments that are carried out with a wide range of local groups and local people.

The meetings may be used to as a vehicle to:

- Present information on PCT and services, increasing awareness and understanding.
- Discuss with all present how health is effected in your community (e.g. SWOT analysis).
- Select community representatives and preferred structure for community participation.

It is important to include those whose voice are seldom heard. This will need to be supported and resourced, and can be built on over time.

Local community groups have a wide breath of knowledge and many community groups will be skilled in various consultation techniques as will many social inclusion, community workers and health promotion staff in the HSE. Organisations like the Community Action Network may also assist you at www.canaction.ie It may be useful to agree a time framework at this particular stage in the process.

Best practice guidelines for establishing and developing service user panels in a health setting: <http://www.hse.ie/eng/services/ysys/Documentation/involve/BestPractice.pdf>

Needs analysis

The HSE will conduct broader health services needs assessment at network level. Pilot work is underway in a few sites. The Institute of Public Health (IPH) has also developed an all Ireland health and well being dataset: http://www.publichealth.ie/files/file/AlHWDS_0.pdf It will be important to build on and avoid duplication of work already completed in this area.

Prioritising and action planning

The PCT will be unable to act on every wish expressed by the community. It is important to select a few actions that can be achieved easily and are early wins. Remember preparation and maximisation of clarity are essential:

'Participation in Anti Poverty and Regeneration Work and Research', Peter Beresford and Martin Hoban at: www.jrf.org.uk/knowledge/findings/socialpolicy

The Western Health and Social Services Guide to Public Involvement (Western Health and Social Services Board, Northern Ireland 2005) at: www.whssb.n-i.nhs.uk/index.html

Establishment of Participation Forum or similar representative structure

It is important to support a broad community forum that is as inclusive as possible and that can select representatives who will be involved in the PCT. Training and support for representatives is important and projects like those in Lifford/Castlefinn have a number of reps in place. If it is not possible to establish a community health forum, ascertain whether or not there is another representative structure in existence with a health remit that could be useful to feed into primary care and vice versa, as in West and South Offaly.

Guidelines, standards and training

- Community Action Network (CAN): www.canaction.ie/can_php/index.php
- Institute of Public Health: www.publichealth.ie
- Health Promotion: www.healthpromotion.ie
- Social Inclusion: www.hse.ie

Actions implemented and evaluation

- http://www.getinvolved.qld.gov.au/assets/pdfs/guide_evaluation.pdf
- <http://www.partnershiptool.ie/>
- http://www.combatpoverty.ie/publications/MB3_AGuideToSelfEvaluation_1996.pdf
- Community Participation Question Set: <http://www.partnerships.org.uk/guide/theory.htm>

Case study examples:

- Building healthy communities which included a range of communities of interest such as the Deaf community, ethnic minority groups, Travellers and women with mental health issues: <http://www.combatpoverty.ie/health/index.htm>
- Lifford and Castlefinn: <http://www.liffordcastlefinnhealth.com/publications.html>
- Combat Poverty Joint funding initiative: <http://www.hse.ie/eng/services/ysys/SUI/Library/>
- The West Offaly Way: http://www.westoffalypartnership.ie/West_Offaly_Way_Summary_Report.pdf

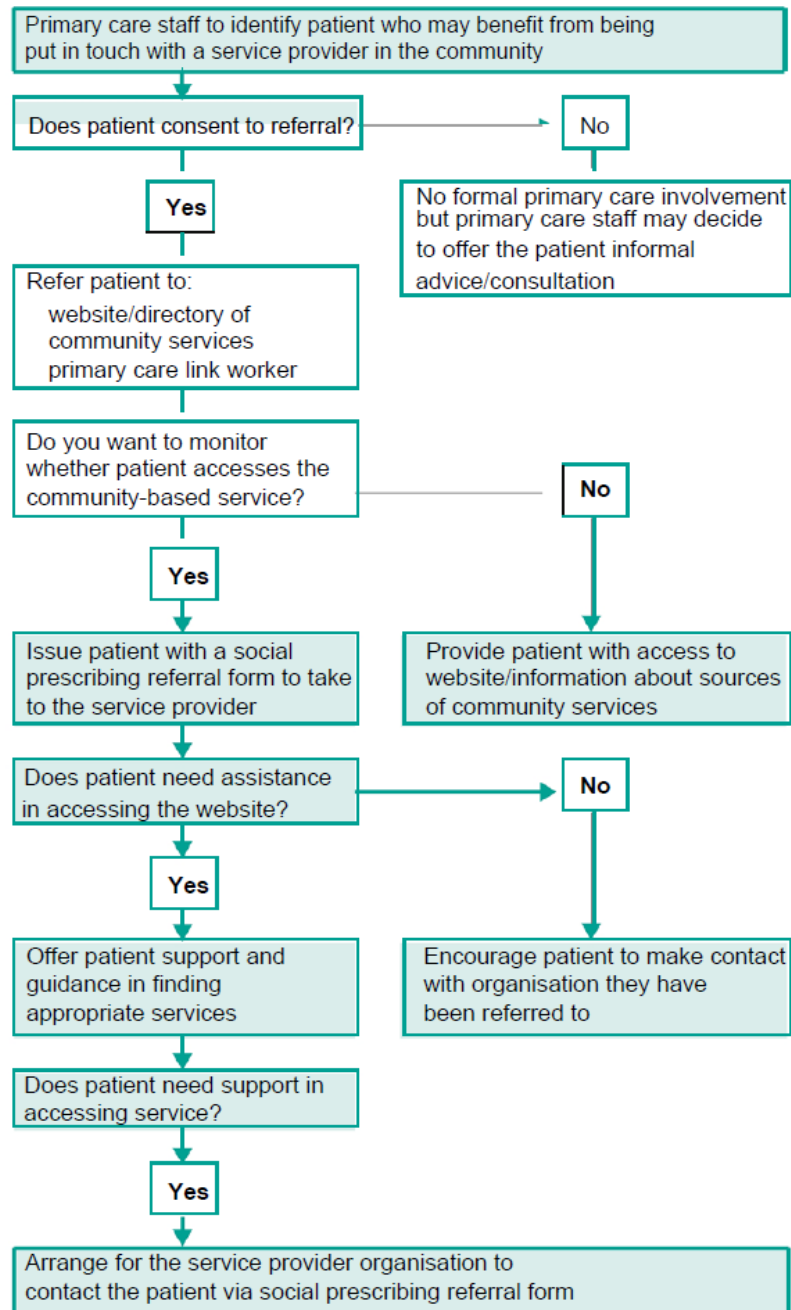
There are a number of useful resources available on the HSE website and in the www.lenus.ie repository.

The Combat Poverty Agency's publications catalogue is at <http://www.combatpoverty.ie/publications/index.htm> and all publications are available for download. A range of presentations and papers are also available at http://www.combatpoverty.ie/publications/conferencepapers/2007_CommunityParticipationInPrimaryCare.pdf

Appendix 2.1 Examples of Social Prescribing Pathways

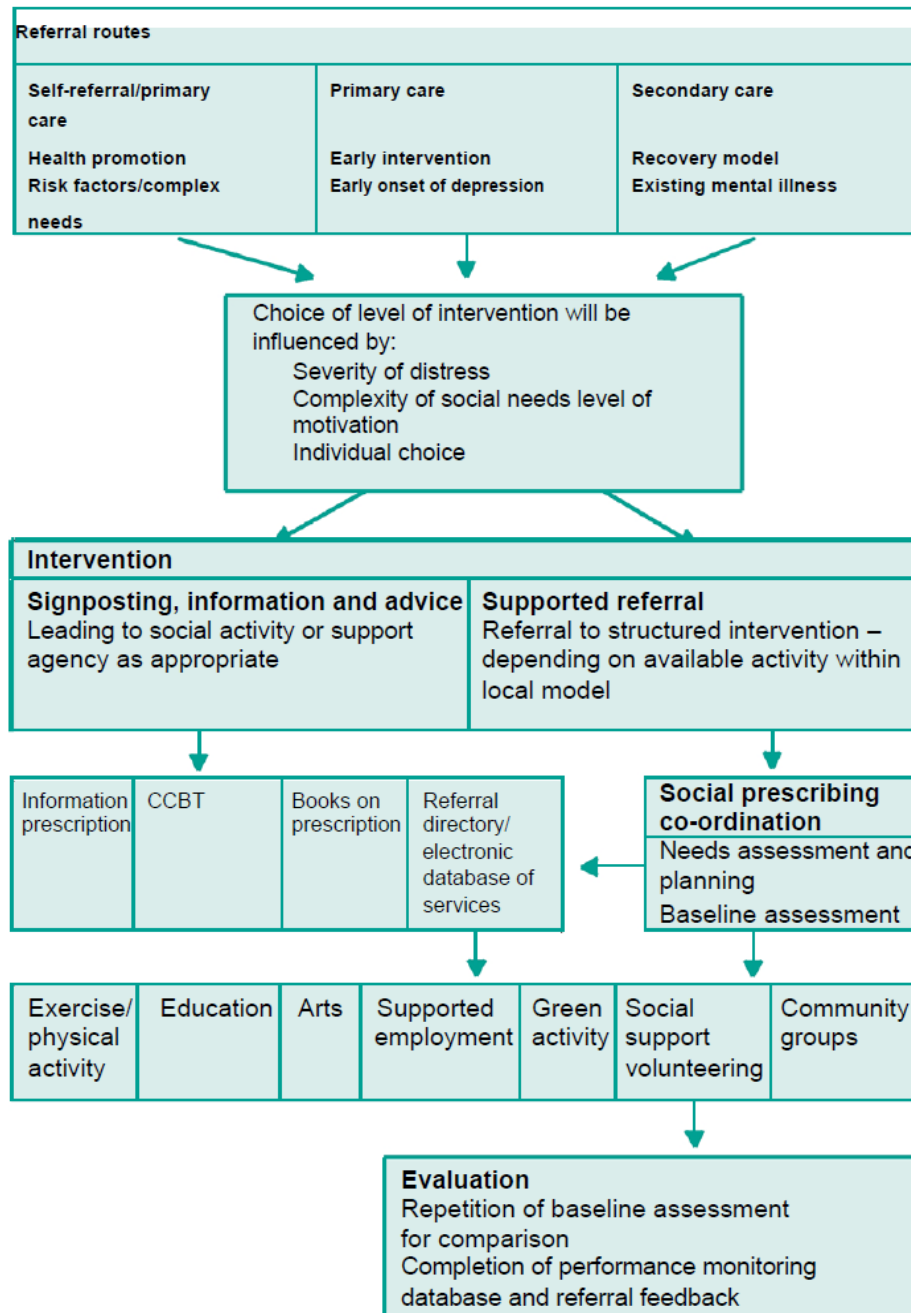
Appendix 2: Social Prescribing flowchart for primary care staff (Greenwich)

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



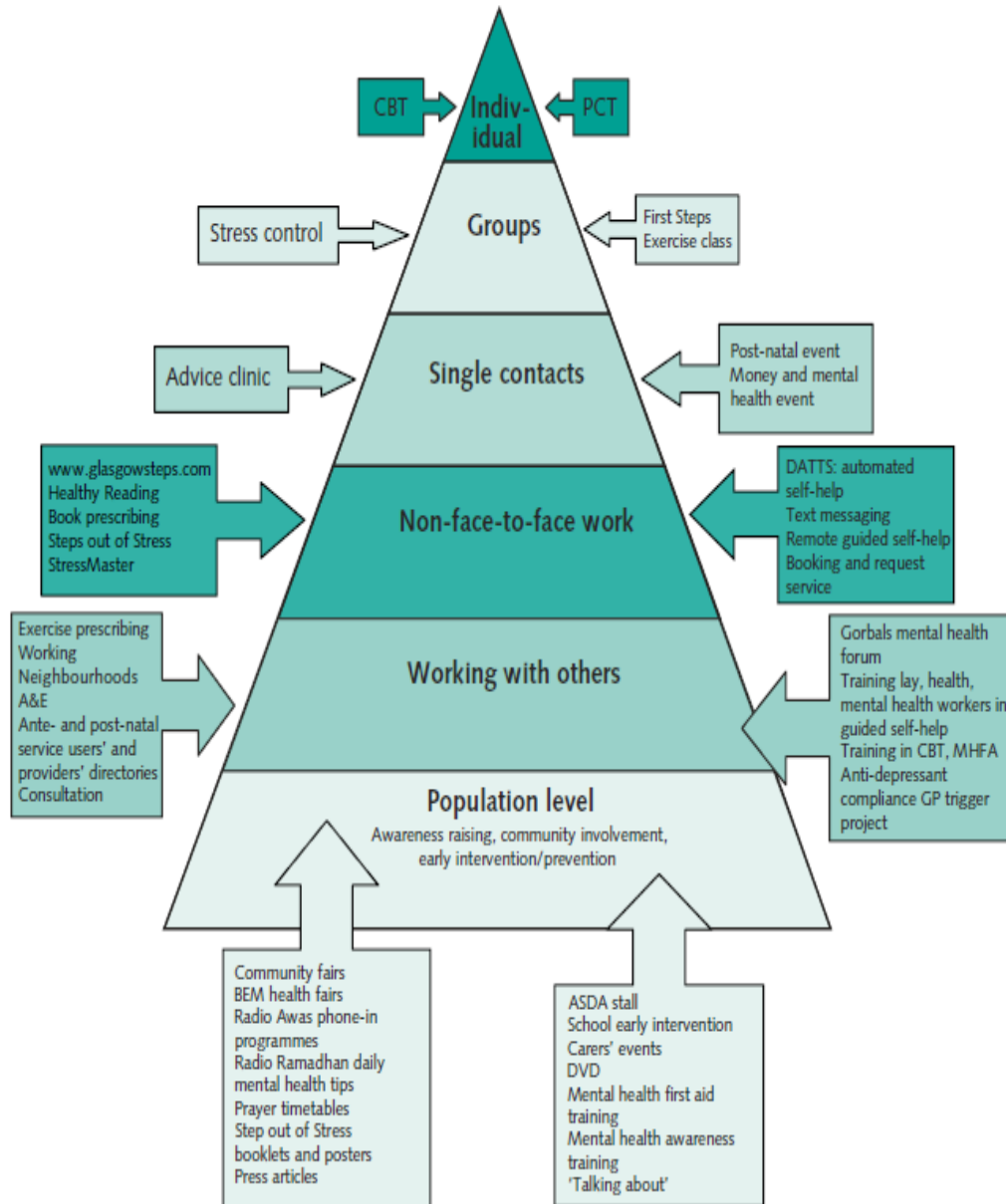
Source: Extract from: Friedli et al (2009)

Appendix 1: Social Prescribing Care Pathway – a model (North West)

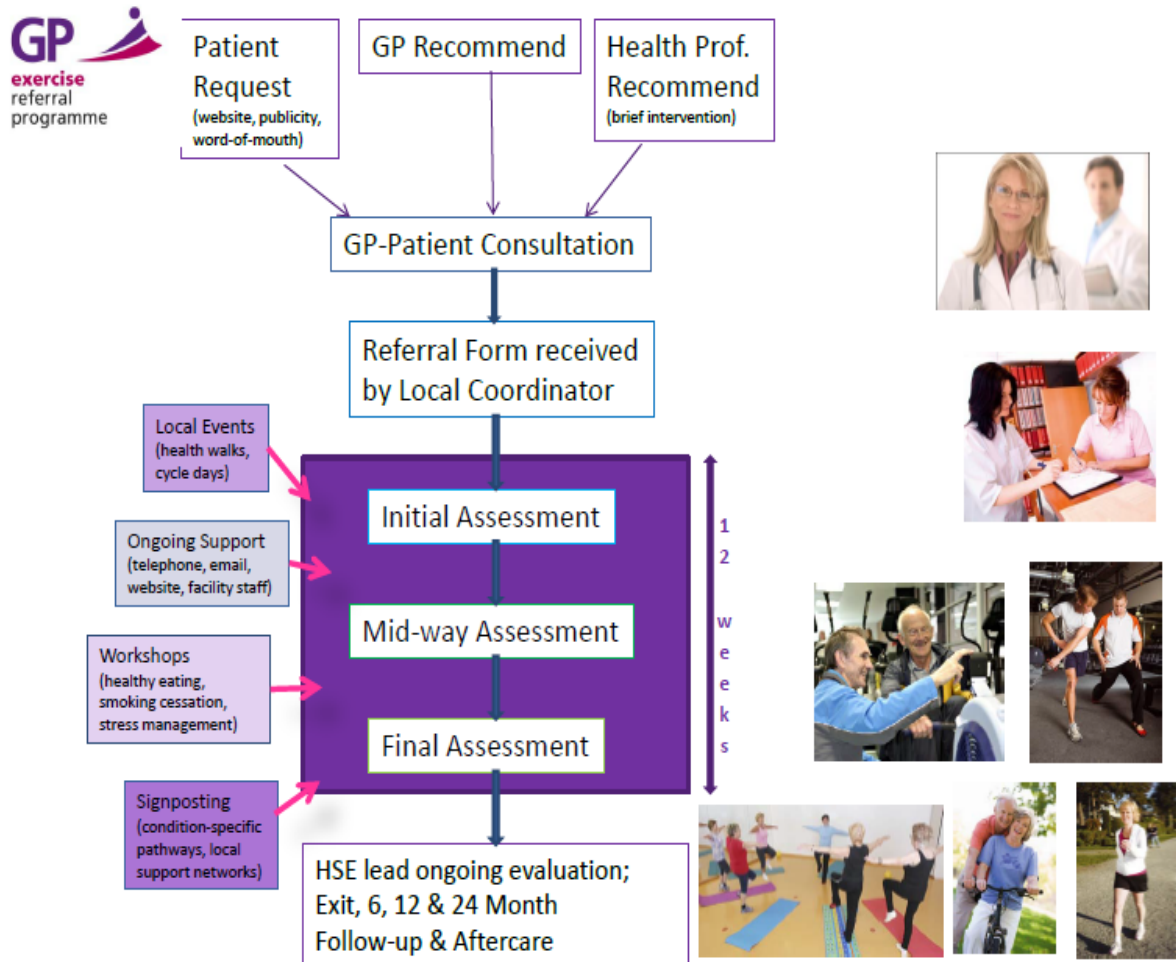


Source: Extract from: Friedli et al (2009)

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

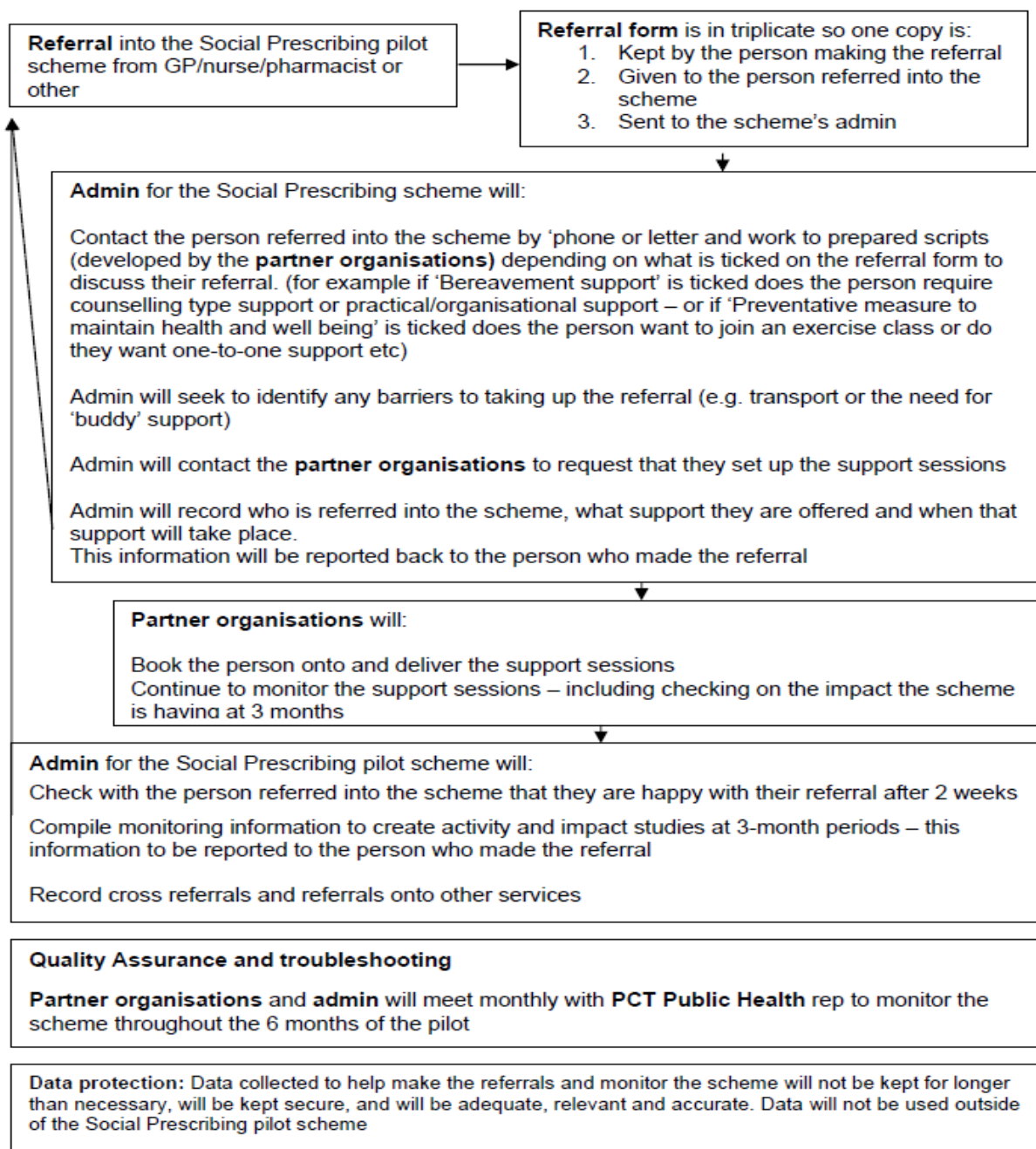


Ref.: White, J., Joice, A., Petrie, S., Johnston, S., Gilroy, D., Hutton, P., and Hynes, N. (2008) STEPS: Going beyond the tip of the iceberg: a multi-level, multi-purpose approach to common mental health problems. *Journal of Public Mental Health* 7 (1).



www.gpexercisereferral.ie

Social Prescribing Model



Referral forms are then screened by Hartlepool MIND to determine whether they can deal with the case themselves or whether a secondary referral is required.

Source: Social Prescribing within the North East: Current programmes and challenges for the future North East Mental Health Development Unit (Neil Johnson and Louise Ross May 2011) e.g of a Social Prescribing Pathway

Appendix 2.2 Examples of Evidence Based Approaches for Social Prescribing

Evidence Platforms

TIMING	PLATFORM	ACTION	
AT THE VERY BEGINNING.....	STRATEGY 0	FOUNDATIONAL INFORMATION (this is a one-off strategy that may need updating from time to time)	Have in place information about the workplace; its origins, mission statement, aims and objectives, its programme structures, accountability structures, background about the MT service, etc.
ONGOING	STRATEGY 1	DOCUMENTING all work you do on regular and frequent basis	Clients attending MT; session formats; highpoints; meetings attended, liaisons and networking;
	STRATEGY 2	LOGGING THE UNEXPECTED	collect anecdotes, thanks yous, record peak moments of your service, collect expert evidence if timely, etc
AT REGULAR INTERVALS	STRATEGY 3	INTERNAL SERVICE REVIEW	Ask clients / carers / staff / managers to complete questionnaires / other scales to evaluate MT service
	STRATEGY 4	SERVICE REVIEW	Collating strategies 0-3 in annual/ 6-monthly reviews.
AT STRATEGIC TIMES	STRATEGY 5	SERVICE EVALUATION (e.g., when MT service funding is under review; when the service needs expanding)	More formal use of instruments to collect value judgments from clients / carers / staff members, plus drawing together cumulative information from Service Reviews
OCCASIONALLY; WHEN TIME & RESOURCES ALLOW	STRATEGY 6	CLINICAL EVALUATION	More complex, usually collaborative, research that aims to contribute more widely to published music therapy literature.

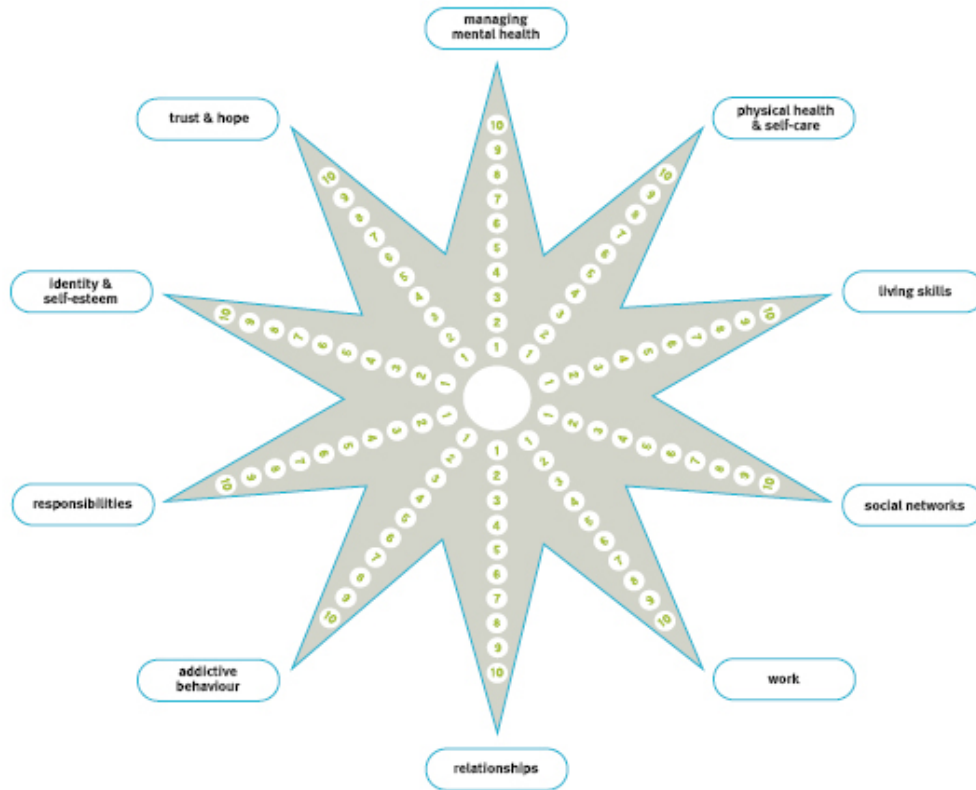
TABLE 3: EVIDENCE PLATFORMS

Source: Extract from Presenting the Evidence 2009 (Second Edition) Nordoff-Robbins Music Therapy Research Department

Friedli et al 2009 pages 13-14 Outcomes, Indicators and Measures

Outcome	Indicator	Measure	
1. Improve population mental health	Increased levels of mental wellbeing	WEMWBS	
2. Improve population quality of life	Increased levels of life satisfaction	Local surveys including question on how satisfied individuals are with their life as a whole nowadays	
3. Improve individual mental health	Increased levels of mental wellbeing	Affectometer 2	
	Increased levels of social contact and social support	SSQ-B	
	Increased uptake of activities	Patient questionnaire	
	Increased awareness of skills, activities and behaviours that improve and protect mental wellbeing - eg the adoption of 'positive steps for mental health'	Patient questionnaire	
4. Ameliorate symptoms of mental distress	Reduced depression and anxiety	CORE 10	
		Patient Health Questionnaire (PHQ9 and GAD7)	
		HADS	
		BDI	
		Beck Anxiety Inventory (BAI)	
		GHQ12 for possible mental health problem	
		CIS-R - for depression and anxiety	
		Work and Social Adjustment Scale (W&SA)	
5. Improve range and choice of, and access to, primary care provision	Reduction in waiting lists for counsellors and psychological services	Service provider system	
		Number of patients who attend less than 12 times per year	Primary care data system
		Reduction in inappropriate prescribing of antidepressants for mild to moderate depression, in line with NICE guidelines (NICE, 2004)	Primary care data system
		Increase in the range of voluntary and community providers	Commissioning system

Recover Star



Recovery Star © Mental Health Providers Forum and Triangle Social Enterprise Limited.
Authors: Sara Burns and Joy MacKeith of Triangle Social Enterprise Limited.

www.mhp.org.uk
www.triangleconsulting.co.uk

Appendix 2.3 Example of Standards of Practice

WELLNESS SERVICE STANDARDS Winters et al 2010

A Wellness Service provides support to people to live well, by addressing the factors that influence their health and well-being and building their capacity to be independent, resilient and maintain good health for themselves and those around them.

These standards provide a benchmark for the provision of a Wellness Service.

A. Improving Outcomes

1. The Service measures the achievement of outcomes in relation to:
 - Population health, well-being and inequalities
 - Customer defined health & well-being
 - Cost effectiveness
2. The Service has been developed following consultation with the public on their needs and preferences for delivery and assets for healthy living.
3. An equity audit has been undertaken to ensure that services are targeted at and accessed by those in greatest need.
4. Services are provided and tailored to particular excluded groups or those facing multiple challenges e.g. people with severe and enduring mental health conditions.
5. The service supports broader skills and capacity building for health and well-being, beyond individual risk factor management, to enable independence and resilience in individuals, families and communities to live well and care for themselves.
6. The service builds the role, skills and knowledge of all practitioners to affect the health and well-being of individuals, families and communities, so that every patient/ client contacts is a health promoting opportunity.

B. Improving Quality

1. The service measures the achievement of quality in relation to:
 - Service standards
 - Customer satisfaction
 - Wellness Services evidence based review and examples of best practice
 - Equality & Diversity
2. The Wellness service has integrated data collection, data exchange and clear communication between providers.
3. The service uses NICE guidance and other quality standards to continually improve delivery.
4. The service provider is a health promoting organisation that adds health and social value through its business, as reflected in its organisational mission statement and plan:
 - With a clear organisational Health & Well-being Strategy
 - With wellness services provided to staff
5. The wellness service demonstrates a clear commitment to increasing self-care and co-production of health.
6. The service uses strengths based approaches that acknowledges and builds the strengths, skills and capacities of people to live healthy lives alongside the assets within the local community.
7. There are opportunities for community members and users to be involved in local delivery, monitoring and improvement.
8. The service is easily accessible and flexible and uses social marketing approaches to enable better uptake.

C. Service Integration

1. The wellness service offers a single integrated and coherent approach to supporting people to live healthy and well.
2. There is a single point of access, with a central booking and triage system.
3. There is seamless integration of different wellness services through clearly defined pathways and co-ordinated community referrals/ social prescribing across the system.
4. There is a common, holistic assessment that incorporates psychosocial well-being, physical health and lifestyle behaviours.
5. Generic wellness services are provided with access to specialist interventions.
6. Well-being is an explicit component of all the wellness service interventions.
This addresses the psychological factors for healthy living and capacities to make and sustain health change e.g. sense of control, coherence, self-efficacy, motivation, self determination, self value; and the social factors for Wellness Services evidence based review and examples of best practice health living and behaviour change e.g. social networks and support, access to healthy living environments.
7. A range of delivery models are used, determined by community preference.

For example:

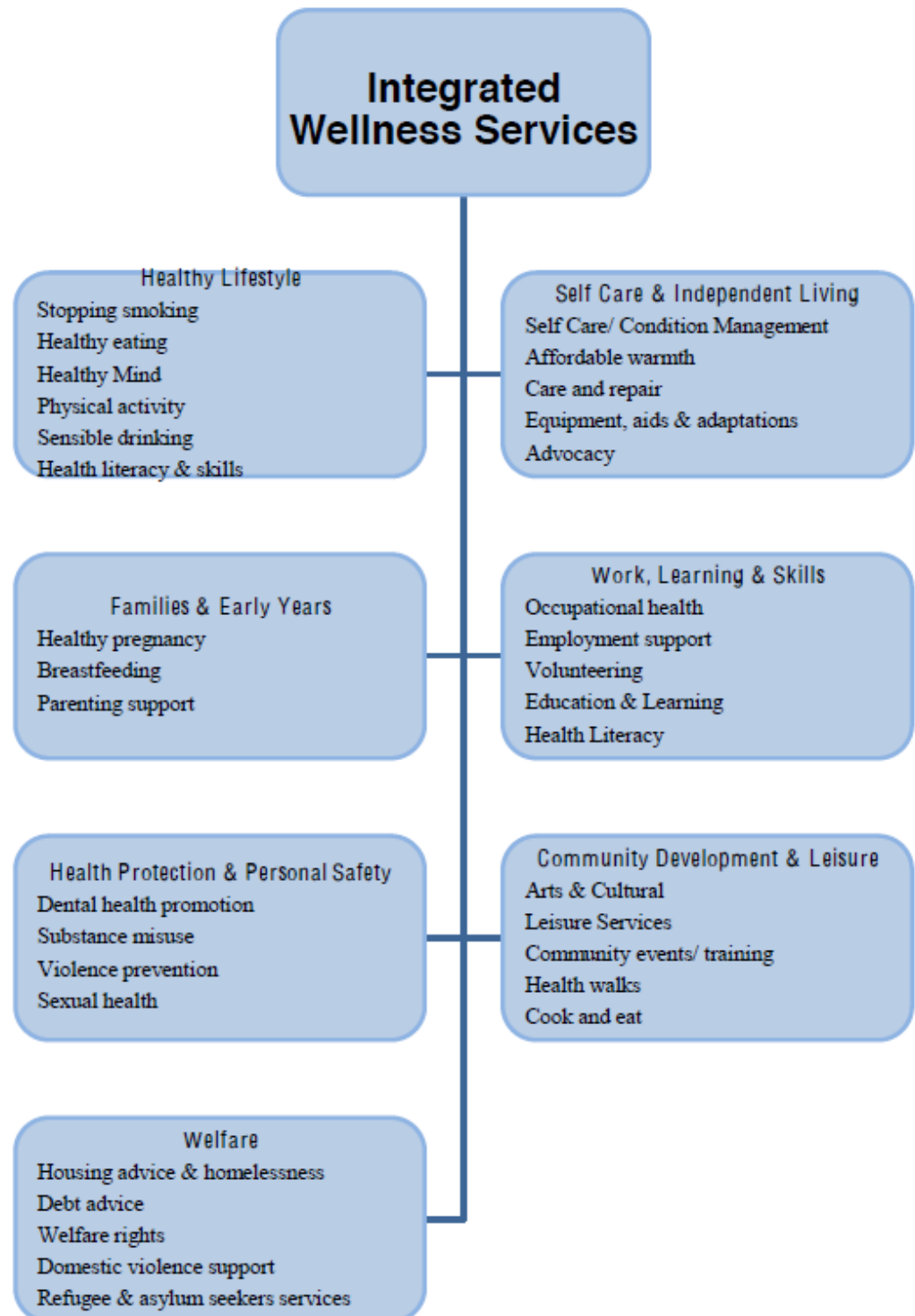
- Information provision
- Health assessment
- Computerised support
- Brief advice and coaching
- Brief intervention
- Intensive behaviour change support
- Peer support/ buddying
- Group specialist support
- Self help/ supported self help
- Signposting
 - Social prescribing
 - Community development
 - Community education and training
 - Pro-active outreach
 - Social marketing

8. Services are provided in the most accessible and preferred places through face to face and digital contact using new technologies. Places that provide face to face contact could include:

- Streets
- Neighbourhoods/ Communities
- Workplaces
- Public Services

9. The wellness service includes support for people in relation to a range of issues as exemplified below:

Figure 4: Integrated Wellness Services Model



D. Stakeholder Engagement & Whole System Fit

1. There is a strategic plan and joint vision for wellness services within the locality.
2. There is a multi--agency wellness service partnership that oversees partnership alignment and development.
3. The service is informed by and linked to GP consortia, local authority, public health service, community service providers, voluntary and community sector and partnership infrastructures.
4. The wellness service is jointly commissioned by relevant partners and has joint outcome accountability.
5. The wellness service is developed as part of the overall system and infrastructure for health improvement.

E. Efficiency Improvements

1. Cost efficiencies have been modelled and will have ongoing monitoring e.g. releasing efficiencies through streamlining services, reducing the number of admissions to secondary care, reducing prescribing
2. Value for money is ensured through benchmarking the service with other areas.

F. Sustainability

1. The service vision promotes sustainability through addressing the determinants of health and ill--health.
2. The service tracks the sustainability of outcomes through appropriate follow-up.
3. The service trains other front line workers in providing health promoting contact.

Appendix 3.1 Directory of Activities

This directory is offered as an illustration of the range of activities that regularly come under the definition of social prescribing. It is not intended to be exhaustive.

General Social Prescribing

Internationally

Greenwich SPLASH

Greenwich Teaching Primary Care Trust has established an online resource to identify non-medical services in the area. This novel resource has general categories such as volunteering opportunities, self help services and advice and support on healthy living, which are then broken down into more specific categories, identification of location and then the service available. The service details are provided including cost, opening times, location and a description of the service and service provider. The service is aimed at GPs and health professionals but referrals can be made by anyone using the referral forms on the site. Health professionals can also track the progress of patients. This service has been funded by the Neighbourhood Renewal Fund.

<http://www.greenwichsplash.org/mainframeset/index.html>.

Social Prescribing- Bromley, Penge

The Bromley work has been long established and set out to improve the health and well being of patients, through provision of short term support and facilitating access to local groups for non-clinical need (i) to prevent ill health, (ii) assist in identifying and using care pathways and (iii) reduce GP demand with alternative referrals (Sowter and Stone, no date available,). The pilot project operated within one GP practice and was reviewed by Suzie Sykes (2000). It was found that it effectively complemented primary care and bridged the gap between primary care and the voluntary sector. Health workers in the practice could refer to the social prescribing service and patients could also self refer, where non clinical circumstances impacted on health and well being. The referral usually resulted in signposting to services but for some this extended to liaison between the patient and the organisation to facilitate access or even attending on the first occasion with the patient.

Evaluation: Outcomes were suggested to be increases in self esteem and confidence, reduced isolation and resolution of practical issues (Sowter and Stone, no date available,).

Lewisham Social Prescribing Project (LSPP)

This project involved 6 surgeries and provided a directory of 50 voluntary services, with patient introduction forms. As a back up when patients displayed complex needs or could not be matched to the organisations within the directory appointments were made with a LSPP worker. Furthermore health professionals were encouraged to telephone LSPP to find appropriate referrals. This was used by patients too. Voluntary groups made presentations to surgeries about services but this was often logistically difficult. Recommendations from the project include placing the LSPP worker in the surgery, use an extensive referral information source and further evaluation of the usefulness of the referrals (White et al., 2002). Lewisham social prescribing project directory can be found at the following site <http://www.lewishampct.nhs.uk/lspdirectory/>

Social Prescribing in Bolton

A formal framework has been devised so that health professionals can refer to non-clinical services to address social and emotional problems. There is capacity for self referral, apart from the exercise referral programme. They have developed the SP Directory, which

contains information on how to make a referral and listings of services. This was disseminated to GP surgeries and Health Centres. This was part funded with regeneration monies. Difficulties encountered were lack of time to commit to training and through changes to working practices. Monitoring has been conducted with evaluation planned for the future (Kahraman, 2005). www.bolton.nhs.uk/services/socialprescribing

Social Prescribing in General Practice- Bradford South & west PCT

This scheme was set up by the Community Health Advice Team (CHAT). Referrals to the CHAT worker are accepted by self referral or from health professionals when non-clinical needs have been identified. The patient and CHAT worker discuss needs for up to 45 minute appointments and identify appropriate support in the community or voluntary sector. The CHAT worker can accompany the patient to the service. Services ranged from IT training, day centres and voluntary work. **Evaluation** was conducted by interviewing patients and staff and found that the service was valued, particularly as an individualised service and appeared accessible. Benefits included reduced isolation, increased confidence and levels of support as well as access to expert information. The CHAT worker was the key component to the service with good interpersonal skills and flexibility. It was thought to provide a good bridge between health and community services (South et al., 2008).

The Well Family Service This is a social support service in primary care for people exhibiting complex psycho-social problems. Early referral to the service is reputed to prevent development of more serious issues. It provides Family Support Coordinators who give advice, information and access to support services in surgeries and health centres. Referrals are direct from patients and health professionals. Evaluation seemed to indicate success in speed between referral and appointment, accessibility, and a variety of services that are less stigmatising than statutory sector provision. This led to reports of the prevention of crises or escalation, a sense of personal control over difficulties, reduced visits to GP and prescriptions and improved family relationships. Staff reported that the service filled a gap in expertise, was accessible and provided additional time to spend with the patient.

Social prescribing in Ireland

Health Options Project Erris (HOPE) is provided by the Family Centre, Castlebar in partnership with local Family Doctors, the Erris Primary Care team, Local Community organisations and the Health Service Executive. The project is funded by The National Office for Suicide Prevention. The team comprises a Primary Care Development Officer and Castlebar Family Centre involving representatives from Primary Care Belmullet, a Public Health Nurse, community mental health representative and health promotion. The project aims to identify adults with mild anxiety/depression, high deprivation, living in very remote – rural areas and the unemployed. The newly appointed project worker is to carry out an assessment, factors impacting on health, identify exercise community groups and identify what the specific needs of the community are. The project will also focus on developing sports partnerships: PCT obesity management in 35 – 65 yr age group. The project is still in the early stages of development.

Self Help

Computerised therapy

Books on prescription/bibliotherapy

Bibliotherapy in Ireland : The Power of Words

In March 2007, the North Inner City Partnership in Primary Care (Dublin), in collaboration with Dublin City Public Libraries, piloted the first book prescription scheme in Ireland. The objective of the scheme was to give GPs, mental health professionals and their patients choice in the treatment approach to some mild and moderate mental health difficulties. The scheme provides GPs and other professionals with a list of high-quality self-help books which they can recommend to patients who are likely to benefit from their use. The books are stocked by local libraries and therefore readily accessible. There were over 2500 books issued from six inner city libraries in the first year of the scheme. In February 2009, the Library Council of Ireland, the HSE and the Irish College of General Practitioners introduced the 'Power of Words' a national bibliotherapy scheme to support and aid people with mild to moderate anxiety and depression. This information was made available to all GPs registered in the country(The Library Council of Ireland. The HSE. ICGP, 2009)

Healthy Reading Scheme

A new scheme has been launched in Mayo - **Mayo Healthy Reading Scheme** is designed to guide individuals in their choice of self help book which can then be used in tandem with any suggestions for treatment made by a health professional. This scheme is an initiative developed by the HSE and Mayo County Library. The books in the **Mayo Healthy Reading Scheme** have been recommended by health professionals to assist with a variety of emotional or psychological problems. This ensures a high level of quality and relevance for those consulting them. Topics covered include bereavement, depression, relationship problems, parenting and self esteem.

<http://www.mayolibrary.ie/en/ReaderZone/HealthyReadingScheme/>

Signposting:

Borders: Doing Well by People with Depression Self-help Service

The Self-help service in the Borders consists of three elements: guided self-help, the Toolkit, and a variety of multi media self-help materials. Self-help: Two self-help coaches (also known as advice workers) based in two Health Centres provide guided self-help to people in the catchment area of these Health Centres. Guided self-help support is offered to people suffering from mild and moderate depression, anxiety and psychosocial problems. The self-help coaches also function as a hub to refer to other services that are part of the Toolkit.

Toolkit: this is a sign-posting database containing information about local health, social care, and voluntary services. It provides information to patients, carers, and professionals and facilitates networking between participating local services. Self-help materials include booklets and relaxation CDs. These well received and sought-after materials are disseminated to patients and a wide variety of associated statutory and voluntary organisations.

Pathway Initially, only GPs in the participating practices were able to refer patients to the Doing Well Self-help service. However, this was later extended to enable health visitors and nurses to refer patients. Patients are given an appointment at reception on the referral day and are offered up to three sessions with a self help coach. In the course of these sessions

the patients are assessed and the coach judges whether and how to make use of the self-help materials and the Toolkit. If deemed appropriate the self-help coaches accompany a patient to their first appointment with another service. Information about the service is disseminated to patients, carers, and organisations by all services that form part of the Toolkit (McCollam et al., 2006).

Social prescribing can also be integrated within the '**stepped approach**' to care as piloted in the Doing Well programme (McCollam et al., 2006) which involves the delivery of low intensity, low cost treatments (for example supported self-help), as a first option prior to referral to higher intensity, high-cost care.

Signposting- North Staffordshire

This project was situated within two general practices and was designed to promote mental health for all as well as reduce social exclusion faced by people experiencing mental distress (Blastock et al., 2005). It involves a recommendation of appropriate local services and resources rather than making a formal referral, given by primary care staff. Reception staff gave prompts to service users about the service, practitioners offered appointments when a need was identified and used a directory of services. Those with complex needs were signposted to PALS (Patient Advice & Liaison Service) or when a service could not be found in the directory, service users were signposted to a community facilitation service.

The service was evaluated by analysing the service user wellbeing assessment forms and by making contact with service users through postal questionnaires or telephone questionnaires. Telephone interviews were conducted with practice staff. Results were obtained from 12 people only but indicated that the offer of such a service was valued and was a beneficial additional service. It was found to be a straightforward process but increased workload for the staff. The directory was comprehensive but not exhaustive. It was recommended that other projects should consider training staff who have contact with service users to conduct this kind of task, both in the process but also to familiarise them well with the available services. It was also acknowledged that there may not be an appropriate service for all service users.

Exercise

Internationally

Examples of Exercise referral programs UK and Scotland

North Exercise Referral examples

Loughborough University has recently mapped Exercise Referral programmes on a region-by-region basis. When the research was completed, in 2008, the North East had 15 schemes out of the 136 available within England. They found that those with mental problems were less likely than the general population to enrol on Exercise Referral schemes. They therefore concluded that more needed to be done to proactively engage with such vulnerable groups. The following examples, taken from within our region, demonstrate that attempts are being made to engage with those with mental health needs.

Ayr Gym project

The gym project was part of a National Waiting Times for Psychotherapy Pilot Implementation project in 2002. Patients with a mixture of anxiety and depression were referred to a local gym for six weeks, with follow up by a nurse delivering guided self-help. The aim was to assess whether a combination of gym and self-help had a positive impact on symptoms and could be used as an alternative to referral to mental health professionals.

Evaluation used a range of rating scales, including BDI and GHQ, to measure depression and general health prior to, immediately afterwards, and at 6 months. All 20 patients referred experienced a reduction in symptoms and went from caseness to non caseness, sustained at 6 month follow up. Qualitative feedback from patients indicated that the social contact of gym attendance was valued more highly than the self-help.

Contact: Catherine Kyle catherine.kyle@aapct.scot.nhs.uk

Northumberland Exercise Referral

This programme is open to all population groups but has a specific focus on those with mild to moderate mental health problems. The primary sources of referral are GPs and other healthcare professionals. The programme begins with a consultation with a Physical Activity advisor. The patient is then offered a 24 week physical activity programme during which they receive two, 1:1 review meetings held at 12 and 24 weeks. On completion, the patient can then access the mainstream exercise programme and at 1 year receive a follow-up questionnaire. **Contact:** coral.hanson@northcountryleisure.org.uk

Newcastle Inner & Outer West

This programme is targeted at a number of at-risk groups including those with a Long Term Condition and takes place in 2 centres: Lemington and Benwell. The primary source of referral is any healthcare professional. The programme begins with a 1:1 assessment with an Exercise Referral Assessor to discover the patient's medical history, their medication use, their lifestyle and to set goals. The patient is offered a variety of options including personalised gym programmes in either of the centres, healthy eating advice, and support from a Health Trainer. The patient may also be signposted on to a range of external activities and advice. The service is offered at a discounted rate for 1 year.

Contacts: Rachel Silcock & Beverley Shepherdson
rachel.silcock@hwn.org.uk / beverley.shepherdson@hwn.org.uk

Newcastle City Leisure Services

This programme is open to all population groups but has a specific focus on those diagnosed with depression or low mood. The primary sources of referral are GPs and other healthcare professionals. The programme costs £2 per session. The programme begins with a consultation with a Health and Fitness advisor. This includes some basic health checks and the completion of a fitness/lifestyle questionnaire. The formal programme includes two sessions per week over a 10 week period. A post-review consultation then takes place where the health checks and assessments which were carried out pre-consultation are repeated. The patient is then offered a personal exit route

Contact: Physical Activity Officer, Lightfoot Centre 0191 278 2800

Stockton Active Health

This is an exercise referral programme which lasts for 12 weeks. Each referred individual is assessed at the beginning and the end of the programme and is advised throughout concerning the development and progression of their fitness levels. The project aims to offer individuals the opportunity to participate in structured sessions of physical activity, help individuals to manage and improve their medical conditions, increase awareness of the benefits of leading a more active lifestyle and offer individuals the support to achieve the required input to maintain a physically active lifestyle upon completion of the 12 week programme

Further information:

www.stockton.gov.uk/citizenservices/leisureandents/sportsdevelopment/healthylifestyles/exerciseonprescription/

Glasgow Live Active Exercise Referral

Greater Glasgow NHS Board and Glasgow City Council jointly introduced an exercise referral scheme in 1997. The aim is to allow sedentary adults and those who might benefit from exercise, for example as part of a cardiac rehabilitation programme, to be referred by GPs, practice nurses and physiotherapists to physical activity counsellors.

Evaluation: Of the 5,173 patients referred, 78% attended for baseline interviews. More than half of these patients failed to return for further assessment. 31% of all those referred continued and the patients who participated at length in the exercise programme reported significant health benefits. Many mentioned improved social contact as an unanticipated but welcome effect. While only a relatively small number of patients offered free access to a supervised exercise programme will accept, those who participate for a short time will perceive significant improvements in physical and social wellbeing. Those who persevere will show objective improvement and are more likely to continue to exercise beyond the period of the programme. On the basis of these results, support for the scheme continues, although some of the details are being reviewed to improve patient acceptability and uptake. (NHS Greater Glasgow, 2003)

Ireland

GP Exercise Referral Programme

National GP Exercise Referral Programme www.gpexercisereferral.ie Led by the HSE Health Promotion in partnership with the ICGP and ILAM (the Irish leisure industry body). The National GP Exercise referral programme evolved in 2008 after a series of three pilot studies were successfully carried out and evaluated in Cork, Kerry and Limerick. Evaluation of the project in Cork identified that the GP Exercise Programme was an effective means of increasing activity levels in patients who participated. Approximately 78% completed the programme and had sustained the level of activity one month later. Reaction by participants, GPs and organisers was overwhelmingly positive. The use of a web based database enables accurate data collection across all delivering facilities. Individual patient data is collected across the 12 week exercise referral programme and at 6, 12, and 24 months and is evaluated. There are 500 GPs registered on the programme and each GP can refer 5 patients who fit the inclusion criteria per week. An evaluation of the National GP exercise referral programme is due for completion in April/May 2012.

The Walking Back to Happiness Initiative is aimed at adults with mental health difficulties and it aims to give them an opportunity to take part in some regular physical activity in a safe and supervised environment with the idea that it can help improve both their mental and physical health. Contact Shane Hayes, Sligo Sports Partnership 071 9161511.

Green Activity/ecotherapy

Internationally

The **Island Health Walk Scheme** in the Isle of Wight was established by the West Wight Primary Care Group in 1999. Short volunteer-led walks are offered for those who lack confidence or physical ability to walk alone. While targeted at people with mental health problems and learning disabilities, these walks are particularly beneficial for older people and have been very successful in enabling older people to make new friends and forge

community links. Participant feedback has demonstrated enhanced self-confidence, self-esteem, improved physical fitness and increased independence.

Green Gyms are emerging as a UK-wide movement which offers people a way of meeting others, getting physically fit and improving the natural environment. Scotland's strategy for conservation and the enhancement of biodiversity includes an objective to: improve opportunities for people to enjoy and care for biodiversity through increased awareness, volunteering, local action and lifestyle, with a specific commitment to increase the number of, and participation in, green gyms (Scottish Executive, 2004e). Green gyms are run by trained volunteers and are already available in Bristol and Bath. They are held at least once a week, working on local projects such as community gardens and include warm up and cool down exercises. More information can be found at the following site

<http://www2.btcv.org.uk/display/greengym> BANES also support the use of green gyms

<http://www.bathnes.gov.uk/BathNES/leisureandculture/fitness/greengyms.htm>

Ireland:

The Green Prescription Programme piloted in Cloghan, Co. Donegal

Donegal has been chosen as a pilot site for its introduction nationally. It involves a health professional's written advice to a client to become more active in the natural environment as part of the patient's health and quality of life management. The programme seeks to prevent and tackle obesity and to promote health while reducing stress and increasing self esteem and social well being. The Green Prescription is a health improvement programme which involves a General Practitioner or an allied health professional prescribing exercise in the outdoor environment which aims to both prevent and tackle obesity among all age groups and groups across the social gradient.

Green Gyms Sligo: Sligo Sports and Recreation Partnership has established a Green Gym Program to promote the use of the new outdoor gyms based around Sligo to initially familiarize people of all ages and abilities with how to use the gym equipment and then to participate in a weekly session under the guidance of a qualified fitness instructor. They are also encouraged to use the outdoor gym facility at their own time/leisure. Contact Sligo Sports Partnership 071 9161511.

The Green Exercise Walking Group was first initiated by the Donegal Family Resource Centre and part funded by the HSE Health Promotion and Seirbhis Iompair Tuaithe Teoranta (SITT) Rural Transport in September 2009. The aims include: To give people an opportunity to experience the peace and serenity of walking in an unspoilt environment; To give people a chance to recognise how beneficial walking is for their physical and mental health; To create a walking community that people can feel part of and draw from; To bring people 'out of themselves' through walking and talking; To act as a point of social contact for people who may be experiencing loneliness or isolation; To encourage people to appreciate and respect nature and the green environment; To enrich peoples sense of place through local history, folklore, stories and poems shared in an informal way. Contact: journeyinwonder@gmail.com

Community Gardens

Healthy Food for All is an all-island initiative which has produced a good practice guide for community food initiatives, demonstration programmes of community food initiatives and a directory of community food initiatives in Ireland and Northern Ireland.

Arts

Internationally

Bringing together artists with patients in healthcare settings across Gloucestershire. <http://www.gloucestershire.gov.uk/index.cfm?articleid=18385> Art Lift Phase 2 (2009-12) Art Lift brings NHS patients together with professional poets, painters, singers and craftspeople in GP surgeries across Gloucestershire. A wide range of patients and carers can enjoy trying a new art form in an informal group setting. Art Lift is sponsored by Gloucestershire NHS.

Arts for Health Cornwall and Isles of Scilly aims to improve health and well-being through creativity. They organise creative projects across Cornwall and the Isles of Scilly led by trained and experienced creative practitioners who share their art-forms with all sorts of people to positively impact on their lives. They have won two national awards for their projects. The art-forms include music, dance, design, crafts, visual arts, theatre, writing and singing. Arts for Health Cornwall and Isles of Scilly work closely with Health and Social Care settings to bring creativity into the lives of the people that use their services. They also use the arts to change health care buildings; creating more inviting and relaxing environments for the people that use them. <http://www.artsforhealthcornwall.org.uk/>.

Gedling Borough Council. The Arts on Prescription referral programme helps people aged 16 and above overcome problems like stress, depression, anxiety and other mental health issues through a series of weekly workshops. The scheme uses experienced artists to help participants build confidence, learn new creative skills and broaden their horizons through a variety of creative activities including creative writing, batik cloth decorating, photography, textiles, print making, pottery and sculpting classes. Arts on Prescription is delivered in Gedling by a partner organisation City Arts.

Stockport Arts on Prescription

This is a project that has secured mainstream PCT funding and provides art activities for people with mild to moderate depression and/or anxiety. Its focus is to promote mental well-being but also prevent mental ill-health. It consists of a series of sessions introducing participants to drawing and painting after a referral from a mental health worker. The mental health worker also provides support and information to the group.

Evaluation is conducted via a before and after questionnaire and suggests that service users report improved self concept, a reduction in the deterioration of mental health and some evidence of improvement. Participants also appear to use fewer resources and increase their engagement in social activities. (www.wlct.org/gmahn/socpres.pdf)

Examples of other Art on prescription projects in the UK include Arts on Prescription Stockport, Good Times, Prescription for Art, Creative Alternatives, Arts on Prescription Nottingham, Arts on Prescription Devon, Arts on Prescription Pendle (Bungay and Clift, 2010)

Durham Arts for Wellbeing The County Durham Primary Care Trust commissioned an evaluation (White and Salamon, 2010) of the Arts for Wellbeing programme they provide. Results of the evaluation identified that it motivates positive social engagement and health gain. It notes that despite the challenge of getting vulnerable people to participate in arts

activities the drop-out rate is remarkably low. This study also highlights the UK-wide study which evaluated 22 arts and mental health projects (Secker et al., 2007). Results demonstrated very strong evidence for empowerment, with less strong but significant evidence for improvement in mental health and social inclusion. The report concluded that 'the results justify support for arts and mental health work from statutory services'. It suggested caution that arts provision for people with mental health needs is not a case of one size fits all and project design should reflect this learning.

The interim evaluation of a pilot Arts on Prescription project by **Arts and Minds in Cambridgeshire** reports substantial reductions in participants' levels of depression and anxiety, on the GAD-7 (Anxiety) and PHQ-9 (Depression) scales. Following the programme, participants were given information signposting them to further arts and craft activities in the area.

An evaluation of a similar scheme developed by **Healing Arts on the Isle of Wight** - 'Time Being 1' – resulted in 74% saying they would continue creative activities long-term; 64% showing lower indicators of anxiety and depression; 69% recording improvements in social health; 64% in self-confidence and self-esteem and 63% in their physical health and outlook. Quoted in 'A prospectus for arts and health', published by the Arts Council of England.

Project evaluation by the University of Gloucestershire has confirmed a significant improvement in patient wellbeing from patients involved in Art Lift. A cost-benefit analysis shows that ArtLift generates savings in healthcare spend, so that the programme may well pay for itself.

City Arts Nottingham develops arts opportunities that bring people together, stimulate change and create stronger, healthier communities. Current programmes include arts and wellbeing, outdoor arts, projects with children, young people and schools, artist development and much more. Further information: <http://www.city-arts.org.uk/xhtml/default.asp?UserLinkId=103952>

Sidney De Haan Research Centre for Music, Arts and Health has recently completed a systematic review of research on singing and health, conducted a cross-national survey of choral singers in Australia, England and Germany, and undertaken a formative evaluation of the 'Silver Song Club Project' run by Sing For Your Life Ltd. Currently, the Centre is undertaking further research on singing for the well-being and health of older people, Chronic Obstructive Pulmonary Disease patients and people with enduring health problems. The Centre is working in partnership with the Eastern and Coastal Kent Primary Care Trust, Kent and Medway NHS and Social Care Partnership Trust, Sussex Partnership NHS Foundation Trust, the Centre for Health Service Studies, the University of Kent and Sing For Your Life Ltd. The Centre is a partner in the Advancing Interdisciplinary Research in Singing Project (AIRS), based at the University of Prince Edward Island, Canada. Further information: <http://www.canterbury.ac.uk/Research/Centres/SDHR/Home.aspx>

Arts on Prescription Ireland

Waterford Healing Arts Trust (WHAT) is one of Ireland's longest established arts and health programmes. WHAT also supports the development of the arts and health sector in Ireland through professional development and www.artsandhealth.ie, a national arts and health website developed by the Waterford Healing Arts Trust (WHAT, see chapter 3.1 for details) and **Create**, the national development agency for collaborative arts in social and community

contexts. The website provides a resource and focal point for the field of arts and health in Ireland via information, support, advice and news, and generates discussion between artists, arts organisations, health service users, carers, healthcare professionals and others interested in the dynamic area of arts and health.

Conversation in Colours Evaluation of an Arts for Health Partnership Programme 2005/6 (Russell, 2006). Arts for Health is a partnership between the Health Promotion Department, HSE South, West Cork Arts Centre, West Cork Community Hospitals, Cork County Council and West Cork VEC. The partnership set out to implement an arts programme in five West Cork Community Hospitals to support the development of new structures for arts in healthcare in West Cork and to influence policy on a regional and national level. Arts for Health originated through a pilot project, which was implemented in Skibbereen Community Hospital, as a result of the former Southern Health Board's (now Health Service Executive South) 'Ageing with Confidence' Strategy, a blueprint for the development of services to improve the health and quality of life of older people. One of the recommendations made in the report was to employ artist/s to deliver an arts programme within the long stay unit setting. The results of the evaluation identified that the provision of an arts programme to these long-stay facilities very significantly enhanced the lives of a large proportion of patients, staff and family members, even those who did not overtly engage in the activity provided. The improvements reported included pleasure in the activity, increased socialisation, reduction of isolation, improved memory and eye-hand co-ordination, enhanced relationships with family members and staff and increased self-esteem.
<http://www.artsandhealth.ie/directory/>

Kids' Own Publishing Partnership is a children's arts organisation and publishing house working to empower children, families and communities to share their stories through cross-sector partnerships, artist-led creative processes and published outcomes using emerging and traditional technologies. Through their work within the early years context, they empower parents and caregivers to engage in creative learning with their children in a community context. They focus on supporting parents' role as primary educators and develop their creativity and wellbeing in collaboration with their children and professional artists. The aim is to build strong families that actively participate within their own communities. Their publication *Wiggly Woo agus a Chairde* is a collection of rhymes to support family literacy. Parents and their preschool children in County Waterford created this book in partnership with Waterford County Library Service and Waterford County Childcare committee. Further information: www.kidsown.ie

The Creative Well, a new integrated pilot initiative, was launched in Naas, Co. Kildare. The aim of this programme is to develop a social model for supporting wellbeing and mental health through the arts and within the context of local communities. Long term mental health service users often suffer from feelings of social isolation which prevents them from engaging in meaningful activities within their community. However few of the programmes available to service users provide avenues for connecting with others outside of the mental health system. The Creative Well offers free, daytime arts workshops open to all adults in the community and a key objective is to ensure a mix of population. Therefore participants have opportunity to learn about the arts, develop skills, and also to connect with others in their locality. The pilot programme will run for ten weeks and following evaluation, it is planned to facilitate further programmes in other areas in County Kildare.

The Creative Well is an initiative of Kildare Arts in Health in partnership with HSE Kildare West Wicklow Mental Health Services, Kildare County Council Arts Service, HSE Health Promotion, Kildare County Mental Health Association and NásnaRiogh Housing Association.

For more information contact Nicola Dunne: nicoladunne@kwaras.ie.

Helium, is an Arts and Health organisation serving children, their families and health care communities nationwide. Helium has developed a project in primary care settings called Infant Imaginings which creates performing arts pieces for babies and parents at child health clinics. Two professional performing artists (a puppeteer and musician) visit health centres to engage creatively with service users and staff. www.helium.ie

Ag Cruinniú 'Gathering' is an innovative collaboration between North West Hospice and 8 local professional artists. It came about from a North West Hospice wish to creatively enhance what is a clinical environment and is rooted in the belief that every human being has the right to live fully until they die. Following on from a successful exploratory pilot project in 2011, Ag Cruinniú will introduce varied arts, in a non-intrusive and creative manner. It will explore the benefits for all involved: patients, visitors, staff, artists, and the organisation itself. The project centres round a 12 month residency (2 days a week), due to start March 2012, where the Artists will practice their art forms in the Hospice and engage sensitively with their new working environment. Each session will be monitored and supervised to ensure that the Artists are adequately supported and we can all learn together from the project. Research on the project will be published early in 2012. Contact Annemarie.ellison@hse.ie for further information.

Community Education and Supports

Cambridgeshire Council for Voluntary Services held a national conference to share experiences and examine how the primary care and the voluntary sector are currently working together. They identified that practitioners face barriers in implementing and maintaining programmes through difficulties securing resources, providing good evidence, overcoming cultural and institutional barriers, and professional isolation (Edmonds, 2003). It was identified that a social model of health needs to be integrated with the predominant medical model and that there needs to be some common language and understanding of each other's culture between the health and voluntary sectors. Models of partnership working can have a positive impact on whole communities as well as individuals and their treatments. "The voluntary sector can offer public trust, engagement with the marginalised, a service user focus, flexibility and an ability to innovate" (Edmonds, 2003 pg.2) An example of a successful project was given, Ripon CVS community care scheme. It was suggested that it was important for the service to be located in a GP practice to make it accessible, trusted and credible, but that the voluntary component brought experience of training and managing volunteers with its strong links to the community and other groups. Key issues for social prescribing are "the resource implications of increased referrals from primary care for voluntary organisations, ensuring joint ownership of schemes across the sectors, addressing cultural differences between the sectors, addressing differences in working practices and styles, and ensuring that everyone involved is clear about the purpose and value of the work" (Edmonds, 2003 pg.2).

The community is being recognised as a valuable resource in providing education with a view to employment for example, job seeking and interview skills, basic computing, literacy etc. Information on a wide range of community supports and education can be found at: www.aontas.com; www.volunteeringireland.ie; www.thewheel.ie; www.mabs.ie and www.citizensinformation.ie

Various organisations provide forms of peer support opportunities some of which are facilitated by programme leaders, for example, Grow and Aware. Some are purely peer led such as Alcoholics-, Narcotics- or Gamblers- Anonymous. In recent years Ireland has seen a ground swell of suicide bereavement support groups and groups which respond to other specific stressful life events and challenges: separation, domestic violence, eating disorders, single parenting, Lesbian/Gay/Bisexual/Transgender groups etc.