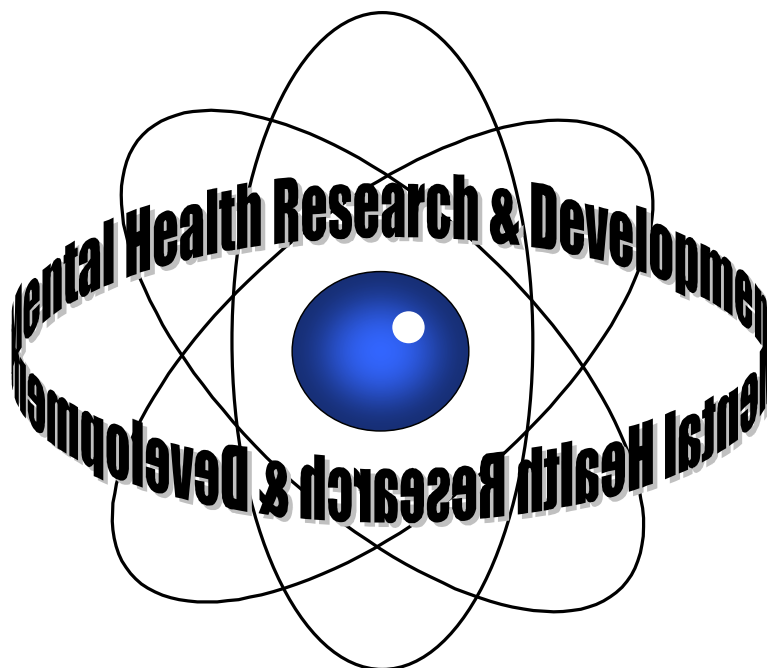


**'New Routes':  
Pilot research project of a new social prescribing  
service provided in Keynsham**



<b>Authors</b>	<b>Janet Brandling</b>	<b>William House</b>	<b>Debbie Howitt</b>	<b>Anna Sansom</b>
	Researcher	GP & Commissioner	'New Routes' Co-ordinator	'New Routes' Co-ordinator
	Mental Health Research & Development Unit The Blackberry Centre, Manor Road Fishponds, Bristol BS16 2EW		The Care Forum	The Care Forum
Email:	<a href="mailto:janet.brandling@awp.nhs.uk">janet.brandling@awp.nhs.uk</a>			
Tel:	0117 3784265			

Executive Summary.....	4
What is social prescribing? .....	4
Evaluating the pilot project .....	4
Findings.....	4
Conclusions.....	5
Future recommendations.....	6
Introduction .....	7
Principal Research Question.....	8
Aims & Objectives.....	8
Method .....	10
Service Setting .....	10
Project steering and implementation.....	10
University links and collaboration.....	11
Funding .....	11
Ethical considerations.....	11
Sample Size, Description & Data Collection .....	11
Qualitative sampling strategy .....	11
Data collection- Qualitative data .....	12
Participants.....	12
Quantitative sampling strategy.....	13
Details of Questionnaires .....	13
Data collection- Quantitative data.....	13
Data Storage.....	14
Data analysis.....	14
Results.....	16
Description of ‘New Routes’ Clients .....	16
Quantitative survey data .....	19
Wellbeing ratings using the adapted MYMOP tool.....	20
Referral mechanism.....	21
Additional data .....	22
Qualitative data- .....	24
‘New Routes’ Co-ordinator role (NRC).....	24
The early days- Setting up the project boundaries.....	24
Becoming a ‘known’ service.....	25
Referral into ‘New Routes’ .....	25
What referrers think.....	25
Keeping ‘New Routes’ on the horizon.....	26
Beyond referral and first assessment .....	27
Opportunities and successes .....	28
Being an alternative to medical solutions.....	28
Service credibility by association to the surgery.....	29
An opportunity to develop self-confidence .....	29
Taking away the strain .....	30
Becoming useful again .....	31
Someone taking an interest .....	32
Responding to client needs .....	33

Disengaging after success .....	33
Challenges and barriers .....	34
Lack of interest .....	34
Inadequate referral information .....	34
Misunderstanding the purpose of referral .....	35
Entrenched belief in medical solutions .....	36
Issues of motivation .....	37
Perceived stigmatisation .....	37
Lack of confidence .....	38
Where being social isn't the answer .....	38
Where the barriers to being involved are too great .....	39
Gaps in local provision .....	39
Finding a space to work.....	40
Engaging in research and evaluation .....	40
Defining success.....	41
And finally.....	41
Supporting the supporters .....	41
Other social prescription services .....	42
Discussion.....	44
Conclusion.....	48
Recommendations .....	48
References .....	50
Appendix A Data collection strategy .....	52
Appendix B Sample information sheet.....	53
Appendix C Sample consent form for interview .....	55
Appendix D Sample recruitment letter .....	56
Appendix E Sample Diary completion guidance.....	57
Appendix F Sample discussion guide of diary data with 'New Routes' Co-ordinator .....	58
Appendix G NRC Job description and person specification.....	59
Appendix H. NR Assessment form including MYMOP score .....	64
Appendix I- WEMWBS .....	67

## Executive Summary

### What is social prescribing?

Social prescribing is a way for health professionals to make links between health services and more social opportunities in local communities with a view to benefiting patients<sup>1</sup>. It is a way of helping patients to make sense of the broad array of support and interest groups available in the community. This is suitable for patients whose health needs are not being adequately met by the health services. A health care professional (HCP) makes a social prescription by referring a patient to this pilot project 'New Routes' (NR). The 'New Routes' Co-ordinator (NRC) aims to understand their problems from the point of view of opportunities for social engagement rather than medical treatment. Subsequent appointments refine the recommendations and can include accompanying the client to groups and activities to get them started.

Social prescribing is thought to have three main benefits (Friedli & Watson, 2004):

- Improving mental health outcomes
- Improving community well-being
- Reducing social exclusion

The intention is that clients will move from contemplation of change through preparation and into action (Prochaska & Norcross, 1999).

### Evaluating the pilot project

This pilot project was established in the discrete area of Keynsham, Bath and North East Somerset (B&NES), with working partnerships between the voluntary (The Care Forum) and statutory sectors B&NES Council, steering and providing the service. A concurrent research evaluation was commissioned to examine the impact of social prescribing on client wellbeing; and also to understand stakeholder perspectives of impact and usefulness of social prescribing services. This evaluation is reported here. This mixed method study used the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), the adapted MYMOP2 and semi-structured interviews with clients, stakeholders and referring health professionals to collect data.

### Findings

Ninety people were referred into the project over the pilot period. Their ages ranged between 16 and 100 years, 42% were aged between 40 and 70 years. Three quarters of the clients were women. Relationships were built up with clients over a period of months, taking a mean period of four months to fully engage or leave the service.

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<sup>1</sup> The terms client and patient are used interchangeably throughout this document. Where the person is under the care of a GP, they are referred to as a patient; when they become involved with NR they are referred to as a client.

General trends provided by the WEMWBS (Warwick Edinburgh Mental Wellbeing Scale, Tennant et al,2007) and adapted MYMOP2 (Patterson, 1996) indicate an improvement in mental wellbeing and general wellbeing. However people who disengage earlier may start at a slightly lower baseline. One surgery investigated NR clients and their history of surgery appointments and secondary care referrals, letters and investigations before and after referral to NR. This also shows a trend towards a change in use over the longer term, after 12 months.

The project had the opportunity to take time to set up the service boundaries, make good working relationships with stakeholders, and become known. This included a launch event.

Most of the GPs in each Keynsham surgery made some referrals to NR, while two surgeries provided 90% of the total. Interviews with referrers were positive, glad to have such a service available, and having had good feedback from their patients. Although remembering the service is available is variable, using a flagging system on surgery computers was not specific enough, so became invisible.

Having an alternative to traditional medical solutions was valued by both clients and referrers and being offered by the surgery gave this option credibility. The service itself helped raise client self confidence and took away the strain of finding out about social activities. It helped them feel useful again and also provided someone who took a personal interest in client wellbeing. The NRC were able to respond in a bespoke way to all their clients.

Challenges were that not all patients could see the relevance of the service to their needs and some misunderstood the purpose of referral. There was an entrenchment in medical solutions where none had been deemed suitable and often poor motivation to participate. Some clients didn't have the confidence to make the first move to social activity. Some deemed their problems were too great to be solved in this way.

The NRC were able to identify many resources for their clients but also gaps in local provision. With some additional funds and good relationships they were able to establish an arts group. Issues of access for clients with physical limitations and lack of transport were barriers to engagement.

The NRC were able to get a wide range of professional support for themselves in these new and evolving roles. They also engaged with another local service to provide a conference to promote social prescription.

## **Conclusions**

The focus on the social realm is central to social prescribing. That is to say social engagement and support networks can act as a remedy for social isolation and despondency with positive and measurable outcomes such as improved mental wellbeing.

It is clear that strong steering from a diverse group of stakeholders facilitated a successful project. In addition good relationships with all stakeholders are needed to continue to sustain this service. NRC are best placed to develop motivational practice to enhance the engagement of their clients. This could be enhanced with Motivational Interviewing training. Developing a 'handholding' service with volunteers is a way of also enhancing engagement with social activities, as is a support group for clients. Work with this group of isolated and poorly motivated people should be considered to be long term, since positive outcomes are slow and halting. The service should continue to provide outcome measures to gauge the continued success of the project.

This mixed method study provides a comprehensive picture of the role of the 'New Routes' co-ordinators, the process of social prescribing service and its value to the various stakeholders involved. It can have a positive impact on:

1. Mental wellbeing
2. 'Distance travelled' or improvements made on issues brought to the social prescribing service
3. Service satisfaction

By conducting this investigation it has been possible to illustrate the effects of the service to end users. It also illustrates a robust example of collaboration between health, social care and the voluntary sector.

### **Future recommendations**

1. Sustained provision of this valued NR service.
2. Maintain strong and diverse steering committee, with a wide range of stakeholders to continue the drive and motivation.
3. To maintain high quality of NR co-ordinators, maintain comprehensive job description and skill specification for new appointments to the role of NRC.
4. Continue the use of outcome measures, particularly during the assessment procedure and at varied time points to measure distance travelled. This ensures effective and accountable practice available to clients and stakeholders.
5. Seek sustainable ways of recording surgery resource utilisation before and after referral.
6. Provide Motivational Interviewing training as an additional skill
7. Standardise the upper threshold of contact time for people finding service engagement difficult to sustain.
8. Use case studies to identify indicators of effective practice and engagement.
9. Continue the enablement of reflective practice, with peer support, clinical supervision and reflection tools such as diaries.
10. Develop a next step support network for clients.
11. Continue partnership working with statutory and third sector organisations, particularly to develop new activities, groups and networks; and monitor the sustainability of these relationships.

## Introduction

Social prescribing is a way for health professionals to make links between health services and more social opportunities in local communities with a view to benefiting patients<sup>2</sup>. It is a way of helping patients to make sense of the broad array of support and interest groups available in the community. This is suitable for patients whose health needs are not being adequately met by the health services. The process of social prescription usually begins by a health care professional (HCP) referring a patient for a one-hour appointment with a 'New Routes' Co-ordinator (NRC). The NRC aims to understand their problems from the point of view of opportunities for social engagement rather than medical treatment. Examples of the type of signposting or connections 'New Routes' Co-ordinators (NRC) could make are becoming involved in a self help group; taking part in an arts or exercise group; volunteering; enrolling in an educational course or getting advice about caring or debts. Every community has a large number of such options, most of which are included in the third sector (voluntary, community and social enterprise sector) and a few in the statutory sector. At subsequent appointments the NRC will refine the recommendations and may include them accompanying the client to groups and activities to introduce them and overcome barriers of anxiety about first meetings. It is hoped that clients seen in the service will move from contemplation of change through preparation and into action (Prochaska & Norcross, 1999).

A number of projects have already been trialled in the UK, concentrated in Primary Care (for a sample see Brandling & House, 2007). It is thought to be suitable for people from vulnerable, minority or isolated groups, with mild to moderate depression and anxiety, enduring mental health problems and those that frequently attend primary care services (Friedli, 2007). Other common features that might be considered strong predictors for referral from primary care to social prescribing services are vague and unexplained symptoms, poor social support, caring responsibilities, multiple symptoms and a wide range of psychological difficulties (Brandling & House, 2007).

Previous studies have indicated that both experienced 'New Routes' Co-ordinators (Grant et al, 2000) and graduates with limited mental health training and limited local knowledge (Grayer et al, 2008) can make an impact on reducing psychosocial and mental health problems. Previously it has been difficult to attribute the benefit to any particular aspect of the social prescribing process but it is likely that the interest shown in the patient's problems, the willingness to try new approaches, and the actual involvement in third sector resources and groups. Social prescribing is thought to have three main benefits (Friedli & Watson, 2004):

- Improving mental health outcomes
- Improving community well-being
- Reducing social exclusion

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<sup>2</sup> The terms client and patient are used interchangeably throughout this document. Where the person is under the care of a GP, they are referred to as a patient; when they become involved with NR they are referred to as a client.

The outcomes of social prescribing for individuals are thought to be increased skills for improving and protecting mental wellbeing, uptake of leisure and community activities and improved social contact. For health service stakeholders outcomes may include reduced primary care attendance, reduced prescriptions for mild to moderate depression, and reduced waiting lists for psychological therapies (Friedli et al, 2008). Several services have already been established and have presented results in these areas (South et al, 2008). However, less is known about the impact on community groups and communities more generally.

Bath and North East Somerset Council have funded a pilot social prescribing project to be delivered in Keynsham over a period of 2 years. This is to be hosted by The Care Forum, a local voluntary sector infrastructure organisation, which will employ and manage the 'New Routes' Co-ordinators. This is a new service in this area, modelling itself upon a previous local project, the Amalthea project (Grant et al, 2000) and current work in Bromley (Bhan et al, no date available). 'New Routes' Co-ordinators have been appointed with experience in community, advocacy or mental health work. They accept referrals from health professionals in Keynsham, by working within general practices. They conduct approximately three to five meetings with patients to negotiate how best to meet their needs and how to make and sustain community engagement.

The NRC market the type of work they do to the health professionals who are potential referrers, such as GP's, practice nurses, district nurses and health visitors. They have not yet taken self referral or referrals from outside the GP surgeries, owing to concerns about an overwhelming number of requests. They have also built good working relationships with third sector organisations.

### **Principal Research Question**

1. What impact does social prescribing have on the wellbeing of individuals referred to the social prescribing service in Keynsham?
2. What are the stakeholders perspectives of the impact and usefulness of social prescribing through the 'New Routes' project?

### **Aims & Objectives**

1. To measure the impact on individuals':
  - a. mental wellbeing,
  - b. specific issues identified at assessment.
2. To assess user satisfaction with the social prescribing service.
3. To understand the nature of engagement with a 'New Routes' service from the different stakeholder perspectives.
4. To provide case studies of 'New Routes' that illustrate the type of work being conducted.
5. To use research findings as they emerge to inform the conduct of the social prescribing service during the service development and research period.

6. To use research findings as they emerge to inform the conduct and sustainability of the 'New Routes' service

## Method

This research investigated the 'New Routes' process, the type of clients the service assists, the work the co-ordinators become involved in and the impact of 'New Routes' on the stakeholders involved. This has been carried out from a mixed method perspective. Qualitative data are derived from interviews with participants with an interest in the service, such as clients, 'New Routes' facilitators, voluntary group organisers and referrers. It also includes analysis of 'New Routes' facilitator diaries. Quantitative data consist of a psychometric tool, the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) and an adaptation of the clinical tool Measure Yourself Medical Outcome Profile (MYMOP2) to measure the effect of 'New Routes' on client wellbeing.

## Service Setting

Social prescribing is provided by a new service called 'New Routes' where health professionals refer patients who wish to enhance their engagement in support and interest groups available in the community. This study has been conducted within the environs of Keynsham, a town in Bath and North East Somerset (B&NES). Three general practices in Keynsham refer to the 'New Routes' Co-ordinators. The 'New Routes' service is hosted by The Care Forum, a Bristol based voluntary sector infrastructure organisation. They have been the providers and employers for this service.

Stakeholders in the social prescribing service are:

- Health professionals referring to the 'New Routes' service
- 'New Routes' facilitators and The Care Forum
- People referred to the "New Routes" service
- Voluntary sector organisation leaders who take referrals from the "New Routes" service
- 'New Routes' service commissioners

## Project steering and implementation

The project steering group consisted of commissioners, stakeholders and evaluators.

- Sarah Shatwell- B&NES
- Ronnie Wright & Rachel Robinson- Care Forum
- Dr William House- GP representative
- Phil Birch & Steve Dale- Volunteer forum
- David Davies- Community Development Worker B&NES
- Valerie Bearne and Julia Burton- Library services
- Janet Brandling and Willm Mistral- MHRDU, Bath University and Avon & Wiltshire Partnership NHS Trust.

## **University links and collaboration**

The project was led by the steering group listed above, including a researcher (Janet Brandling) based in the Mental Health Research and Development Unit (MHRDU), a joint unit of Avon and Wiltshire Partnership NHS Trust (AWP) and the former School for Health (now Department for Health), University of Bath. The collaboration was between GPs in Keynsham, The Care Forum, the Volunteer Forum, MHRDU, and B&NES council.

## **Funding**

Funding for the provision of the social prescribing service was provided by Bath and North East Somerset Council to The Care Forum for the two-year project. The study of the impact of social prescribing was conducted by the Mental Health R&D Unit, and £20,000 funding was provided by Bath and North East Somerset Council over two years for this project.

## **Ethical considerations**

Ethical permission was obtained from the Bath Research Ethics Committee for 2 projects. The qualitative component (09/H0101/86) and the quantitative component (09/H0101/64) were obtained separately. Governance was provided by Avon & Wiltshire Partnership Trust Research and Development Department and the Pan Bath and Swindon Primary Care Research Consortium. Although participants are not NHS patients while they are in the social prescribing service, they are seen and recruited on NHS premises, hence the requirement for NHS ethical permission. In addition some of the stakeholders included in the qualitative component of the study are NHS health professionals. The NRC arranged to receive supervision from members of the local Community Mental Health Team, although this wasn't taken up, as well as their employers. They worked closely with the research team but were not research team members.

## **Sample Size, Description & Data Collection**

### Qualitative sampling strategy

The research sample was derived from a population of interested parties or stakeholders:

- Health professionals referring to the 'New Routes' service.
- People referred to the 'New Routes' service. This was opportunistic, based on respondents willing to participate after being sent an offer letter by NRC.
- Patients referred to but not seen by the 'New Routes' co-ordinators (non-responders and those who did not arrive). This was intended to aid investigation of any barriers to service involvement. It was anticipated that few of these potential participants would engage with the research.

- Voluntary sector organisation leaders who receive people from the ‘New Routes’ service. These were purposively sampled to represent a range of services associated with the new service. These were services who had taken multiple referrals as well as those less able to accommodate new members.

### Data collection- Qualitative data

Qualitative data collection comprised of two methods:

- Semi-structured interviews with the stakeholders listed above. These interviews took place 10 months after the service began taking referrals and over a period of five months. This allowed time for stakeholders to get a sense of how the service suited their needs. These were conducted on one occasion only. Interview topic guides included the perceived impact of the ‘New Routes’ service on individual mental wellbeing as a result of being involved; accessibility of the service; appropriateness and sustainability of the service; and its impact on linking clients to the third sector.
- Diary-Interview-Diary (Alanszewski, 2006): ‘New Routes’ co-ordinators agreed to keep reflective diaries of the process, cases and reflections throughout the duration of the project. They shared these diaries with the research team via interviews during and after diary completion. These interviews were intended to clarify diary entries and extend their descriptions of events.

### Participants

Participants in the quantitative data collection are shown in the results section and are derived from the whole client base of the ‘New Routes’ project.

There were 18 interview participants and one further participant who gave an anonymous written response rather than be interviewed face to face. One interview was conducted over the telephone. In addition the ‘New Routes’ Co-ordinators (NRC) also participated in interviews to supplement diary data.

<b>Past clients</b>	<b>Non- engagers</b>	<b>Referrers</b>	<b>Stakeholders</b>	<b>NRC</b>
N7	N2	N4	N6	N2

Table 1 Qualitative interview data distribution

‘New Routes’ facilitators were not part of the research team and were not responsible for collecting qualitative data. To maintain client confidentiality, researchers did not receive patient/client personal data. However, ‘New Routes’ facilitators were able to suggest appropriate stakeholders (other than clients) to approach for interviews and approaches were made by letter, email and telephone. For instance, they were able to indicate which third sector organisations they have been involved with, so researchers could approach them independently. A flow chart of the data collection process can be seen in appendix A.

### Quantitative sampling strategy

NRC sent invitations to all NR clients to offer participation in the survey component of the research. Responses to all research invitations were returned directly to the research team using a freepost envelope. Those not wishing to participate chose not to respond. Questionnaires were sent to all those persons referred over the duration of the pilot service. From the outset we estimated that there would be an average of two referrals per week to the social prescribing service (N168) and that the research response rate would be between 20% and 40%.

### Details of Questionnaires

The research tools were chosen by the steering group and the research team. They were used to explore the specific issues identified by the client, bring them to the social prescribing service, and also their mental wellbeing.

- MYMOP2 (Patterson, 1996) is a person-centred measure, where the client identifies the issues that bring them to the service and then measures the impact it is having on their life. They rate the effect of their issues on their life on a scale of 0-6, from 'as good as it can be' to 'as bad as it can be'. This has been adapted for use by the NRC.
- WEMWBS is a general, positive mental well being, 14 item Likert scale recommended for use in mental health promotion initiatives by Tennant et al (2007).

### Data collection- Quantitative data

Patients referred to the social prescribing service were offered an appointment, informed of the concurrent research and invited to become a research participant.

- Research data: Consenting patients were asked to complete a baseline mental wellbeing questionnaire (WEMWBS) and return this to the research team in the freepost envelope. A second WEMWBS was sent between 6 and 12 weeks after initial contact with the service to assess. A third WEMWBS was sent by post 6- 12 months after first contact to assess sustainability of change.
- Research data: As part of the assessment process all patients seen by the NRC's were asked to give brief demographic information and complete the adapted MYMOP2 tool at their initial visit. The adapted MYMOP2 was used as a clinical assessment or benchmarking tool. The adapted MYMOP2 was used again, between three and six months after first assessment and at six to twelve months after the first assessment.

The NRC obtained informed consent to share adapted MYMOP2 and demographic data before they shared this with the research team. This data was anonymised by The Care Forum and then sent to the researcher.

Additional data were sought by staff at one surgery, who examined their records to calculate the frequency of referral letters to secondary care, other letters to secondary care (not referral), attendance or telephone consultations with GP or nurse practitioners and diagnostic procedures such as XRay, Ultrasound or MRI scans. They looked for frequencies at 18, 12 and 6 month points before and after referral. Although this was not part of the original proposal it was offered as supplementary and anonymous data. It is reported in the results section

### Data Storage

Quantitative data shared with the research team was stored in SPSS and Excel databases on University of Bath and subsequently Avon and Wiltshire Partnership (AWP) Mental Health NHS Trust computers. Qualitative data were recorded onto an encrypting digital recorder and transcribed verbatim. Transcripts continue to be stored on AWP computers.

### Data analysis

Quantitative data have been analysed to provide descriptive statistics of changes in the measure dimensions, e.g. mental wellbeing. There are population norms available for the WEMWBS and it is possible to examine whether the study sample match these norms. In addition, 'distance travelled' or improvement on individual issues identified at initial interview using the adapted MYMOP2 scale have been examined. Descriptive statistics are also produced from demographic information regarding the population under study. This is a new service therefore data cannot be compared to any previous research or evaluation. Power calculations could not be made as previous similar studies and sample sizes are not known to the research team.

Analysis of qualitative interview data has been conducted using thematic analysis. This a method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). The approach is inductive, in that themes emerge from the reports of the participants, as opposed to a pre-existing theoretical perspective.

Analysis follows a step-by-step approach, as follows:

1. Immersion in, and familiarisation with, the breadth and depth of the data.  
This is done by re-reading the transcripts several times.
2. Generation of initial features or codes of potential themes.
3. Analysis of codes and consideration of how they might combine into themes.
4. Review of themes for coherence and their representation of the data set.
5. Definition and refinement of themes as they apply to the specific project and sample for the final report.

Qualitative analysis of diary data contributes to this thematic analysis. This accounts for the process of 'social prescription's', most prevalent issues arising in the work of the 'New Routes' service as well as isolated cases and points of learning. The diaries contained the following information on the instruction of the research:

- The process of service development
- Types of case, for case study development
- Barriers, bottlenecks and opportunities
- Co-ordinator reflections

The NRC shared their diaries with the researcher on three occasions over the period of the project. Subsequently they engaged in two long discussions at the middle and end of the project to clarify and summarise the issues arising. This was a semi-structured interview, with a schedule based on the diary contents. Case studies, provided by NRC, are also interspersed through this report, in order to illustrate their work.

## Results

### Description of 'New Routes' Clients

The service actively sought referrals from October 2009, with the first received on 20<sup>th</sup> October. The database of NR clients was closed for research analysis on 28<sup>th</sup> February 2011. The final questionnaires were also sent by 28<sup>th</sup> February 2011 and questionnaire data entry ceased on 28<sup>th</sup> March 2011. Ninety people were referred to the service over the period of the pilot, N68 (76%) of these clients were female. One NRC had 42 clients, the other had 48 on their caseload over the pilot period. The clients were distributed between the NRC at referral according to existing caseload commitments. The number of face-to-face appointments with each client ranged between 0-6, (mean appointments N1.8). The number of telephone calls or email exchanges with these clients ranged between 0-15 (mean calls/ email N3.87). The average time spent with each client ranged between 0-15 hours (mean time 5.03 Hours). Only 12 clients (10%) required the NRC to accompany them to activities and this was on one (N8) or two (N4) occasions only. An account for this is given in the qualitative section.

Thirty three clients (29%) engaged in between 1 and 4 different types of activities. There were 46 different types of organisations and activities. The most popular were volunteering, befriending, walking groups and arts groups. Nine clients (8%) engaged with 1-2 activities or organisations but then did not sustain this. Twenty eight (19.6%) NR clients were classified as having issues with transport, where reported. This may have limited their ability to engage with activities.

Figure 1 below shows the final known distribution of clients on the NR caseload. It divides cases between those that are disengaged and closed, those that have engaged and closed and those that remain open or ongoing.

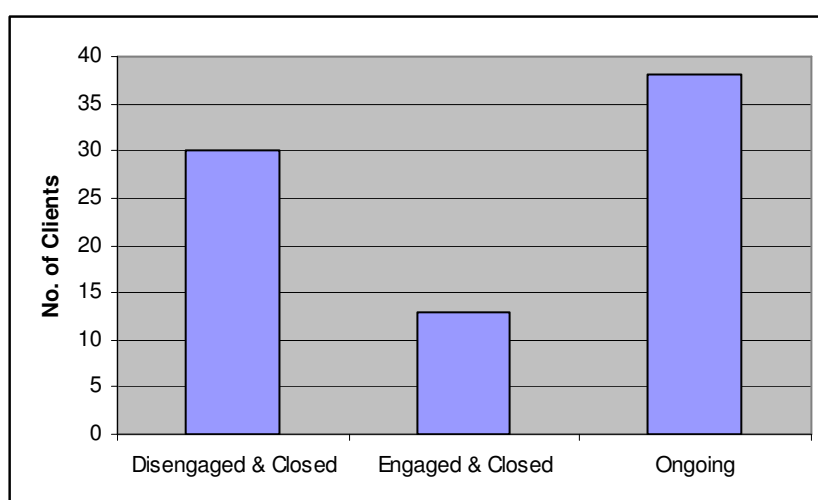


Figure 1 Number of clients disengaged, engaged or ongoing with New Routes

<b>Months engaged N81</b>	<b>Disengaged &amp; Closed N30</b>	<b>Engaged &amp; Closed N13</b>	<b>Ongoing N 38</b>
Mean	5.03	7.08	5.55
Standard Deviation	3.44	3.36	3.94
Range	0-13	1-12	1-15

Table 2 Descriptive statistics indicating months engaged with 'New Routes' service

Table 2 above illustrates the length of time in months for which clients engage with the 'New Routes' service. It is clear that this is a long-term relationship, which for many clients continues beyond the length of the pilot project. It would appear that on average it takes clients at least four months to decide whether to discontinue this relationship after the initial referral. There are some clients who have not been counted in these data as their cases are pending, which accounts for inconsistencies in the total numbers shown.

When examining the mean engagement period and mean number of interventions by NRC it is possible to see that clients who wish to remain engaged with the service but their case is currently closed require the largest amount of time spent with them. This is shown in table 3 below. Those who disengage completely either demand less intervention or decide to quit sooner than others. This illustrates a trend only, as the differences are small.

	<b>Mean No. months contact</b>	<b>Mean No. contact times</b>	<b>Mean No. calls/ email to client</b>	<b>Mean No. calls/ email on behalf of client</b>	<b>Mean Handholding</b>	<b>Mean hours F2F time</b>
<b>Disengaged &amp; closed N30</b>	5.03	1.04	3.93	0.72	0.14	1.24
<b>Engaged &amp; Closed N13</b>	7.08	3.15	4.39	2.58	0.25	4.08
<b>Ongoing Case N35</b>	5.8	2.03	3.49	1.94	0.18	2.91

Table 3 Mean months contact & time spent with/ on behalf of clients

As part of the assessment procedure some other demographic information was collected about clients. These anonymous data have been shared with the research team in order to show the range of clients using the service. Figure 2 below illustrates the age range of NR clients. Over 42% of the client group is aged between 40 and 70 years.

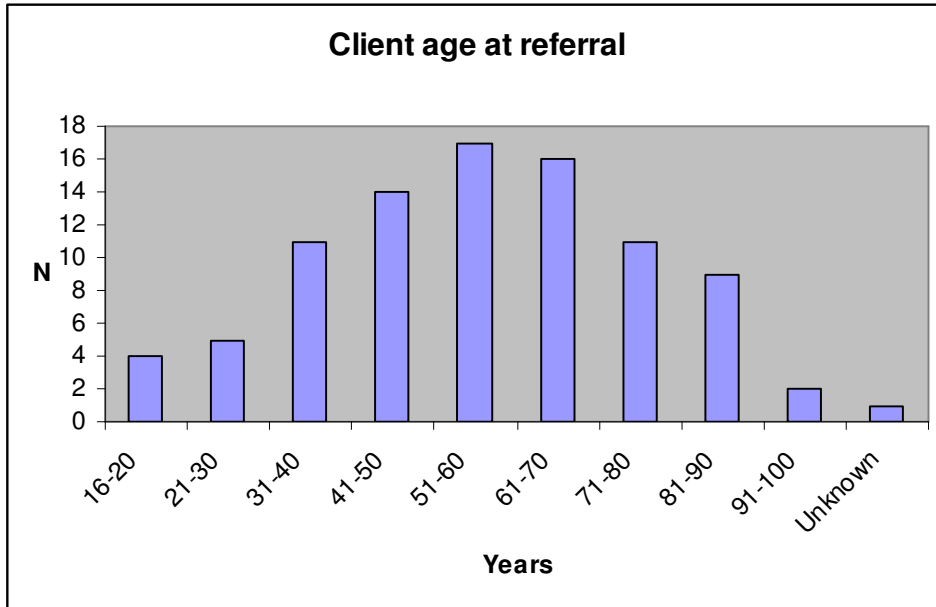


Figure 2 Age range of clients using the 'New Routes' service

Figure 3 indicates that of the 72 clients whose employment status was known, N28 (20%) were retired and N13 (9%) were unemployed.

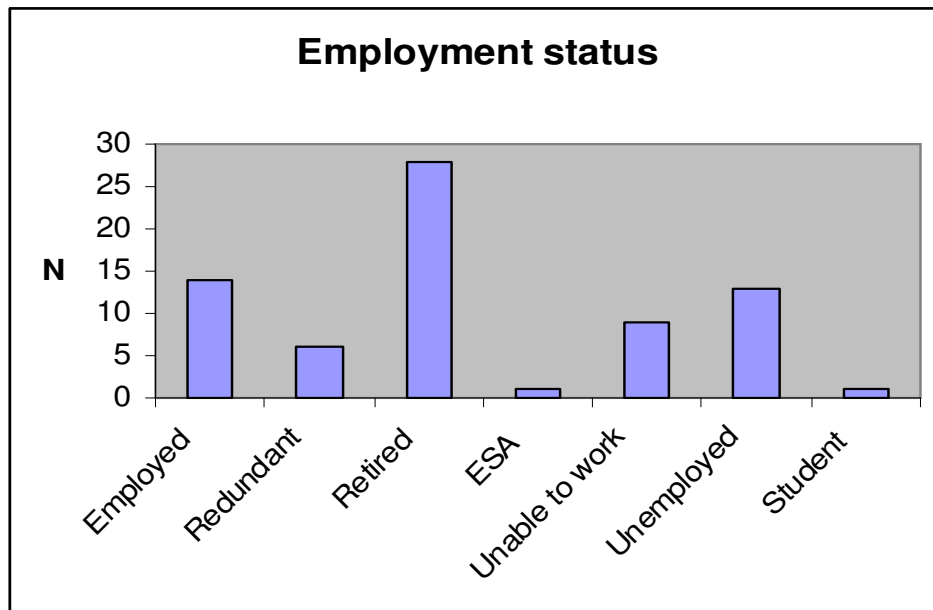


Figure 3 Occupational status of 'New Routes' clients

Of the 90 clients, 68 (61%) were happy to answer an assessment question about ethnicity. All of these respondents were White British. Fewer (N31, 28%) were prepared to disclose their religious affiliation or faith. Of these, N16 (52%) reported they were Christian, N1 (3%) reported they were 'Eclectic' and the remaining N14 (45%) reported they had no faith. Of those responding to assessment questions about disability (N37), N13 (36%) reported they had a disability. Of the N32 (36%) who were happy to disclose their sexuality, N25 (78%) reported they were heterosexual, and N7 (22%) said they would prefer not to say.

## Quantitative survey data

Two types of quantitative data were collected using the survey tools WEMWBS and the adapted MYMOP. Table 4 illustrates the response rate to both of these tools. For the WEMWBS scale some respondents did return questionnaires but these were abandoned as they were incomplete. Some respondents did not send back the first questionnaire but did send subsequent questionnaires. These were also abandoned, since they did not provide a baseline measure.

WEMWBS			Adapted MYMOP2		
Time 1 Before appt'	Time 2 6-12 weeks	Time 3 6-12 months	Time 1 At 1 <sup>st</sup> appt'	Time 2 Between 3- 6 months	Time 3 Between 6- 12 months
N33	N14	N7	N64	N18	N12

Table 4 Quantitative data collection distribution

Table 5 below illustrates that there is little variability in MYMOP scores at first assessment between those who engage with the service or not; except for those who have disengaged, giving their score for the last week. These seem to be the poorest scores of all.

	Mean No. months contact	1st MYMOP week score	1st MYMOP month score
<b>Disengaged &amp; closed N30</b>	5.03	4.5	4
<b>Engaged &amp; Closed N13</b>	7.08	3.43	4.67
<b>Ongoing Case N35</b>	5.8	3.89	4.33

Table 5 Mean adapted MYMOP score at baseline according to engagement/  
disengagement

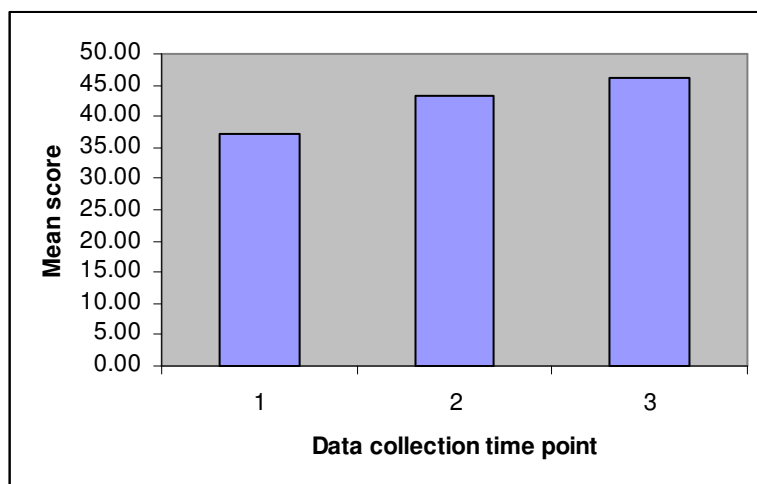


Figure 4 Mean WEMWBS score at baseline (1), at 6-12 weeks (2) and 6-12 months (3)

The WEMWBS uses a 5 point Likert scale. Lower numbers indicate that positive feelings are rare or infrequent (see appendix I for sample WEMWBS). Higher WEMWBS scores indicate more frequent positive feelings. Therefore we would hope to see scores rising with the NR intervention.

The WEMWBS mean scores in figure 4 and table 6 illustrate a general trend towards improved mental wellbeing over the period of the pilot project. However, the standard deviation and range show the variability between individual scores. This variability is quite large at time 3, where some individual scores were lower than at time 2.

	<b>Time 1 Before appt'</b>	<b>Time 2 6-12 weeks</b>	<b>Time 3 6-12 months</b>
Frequency	N33	N14	N7
Mean	37.24	43.29	46.29
Standard Deviation	9.68	8.11	14.37
Range	22-62	29-57	25-63

Table 6 Mean and standard deviation scores for WEMWBS

Therefore, we can see a general positive trend but owing to the low number of participants completing questionnaires no further conclusions can be made about these data.

### **Wellbeing ratings using the adapted MYMOP tool**

The adapted MYMOP scores were recorded at three time points during the client contact with the 'New Routes' service. In contrast to the WEMWBS, a reducing score shows a positive improvement and it would be desirable for scores to reduce with the NR intervention. Unfortunately the rate at which recordings of these measures were made dropped off for several reasons. For instance, clients did not progress through the 'New Routes' service or the NR co-ordinators did not feel it was

appropriate to take these measures. Nevertheless, the mean scores indicate that scores did reduce over time. These are shown in table 7 and figure 5. A reduction in score indicates an improvement in perceived wellbeing, both over the last week and the last month.

Adapted MYMOP		Weekly score		Monthly score	
		Mean	SD	Mean	SD
Time 1	N64	3.64	1.58	4.16	1.51
Time 2	N18	2.65	1.58	2.56	1.34
Time 3	N12	1.67	1.44	1.75	1.71

Table 7 Mean and standard deviation scores for adapted MYMOP scores for the last week and the last month

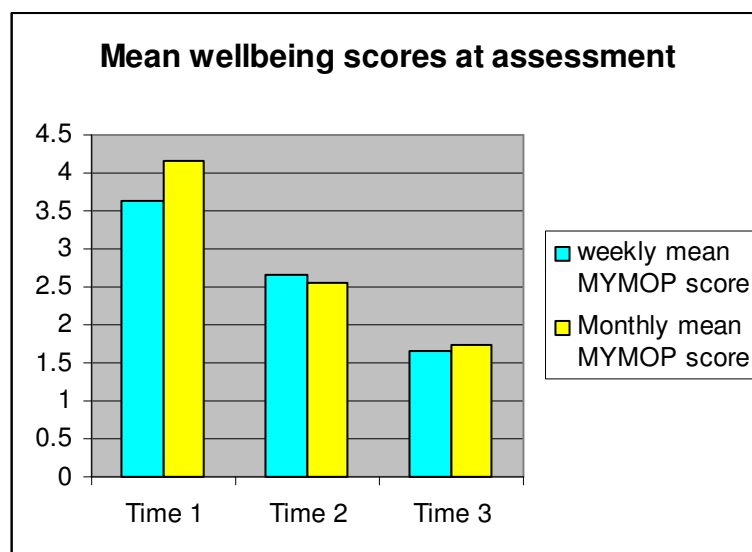


Figure 5 Mean and standard deviation scores for adapted MYMOP scores for the last week and the last month

### Referral mechanism

The referral mechanism was from health professionals in three GP surgeries in Keynsham. Table 8 below illustrates the number of referrals generated by each surgery over the period of the pilot project.

	Surgery		
	St Augustine's	West View	Temple House
No. (%) of doctors referring to NR by surgery	7 (100%)	5 (100%)	5 (83%)
No. (%) of NR referrals received from each surgery	44 (48.9%)	37 (41.1%)	9 (10%)

Table 8 referral generation from each surgery in Keynsham

Figure 6 below illustrates how these referrals were distributed over the period of the project. The ebb and flow of referrals can be seen here to reflect the novelty of the service over the first Christmas period, which dropped over the second Christmas period; with a resurgence towards the end of the pilot.

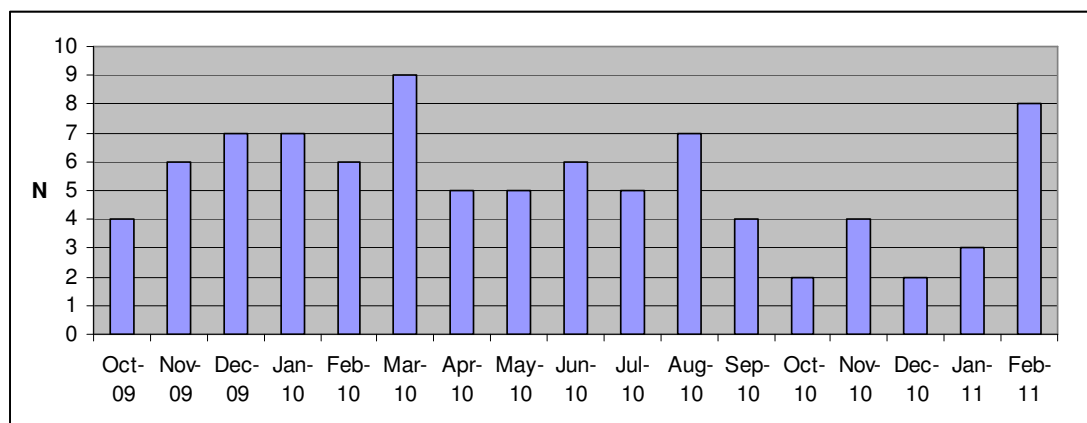


Figure 6. Referral pattern over period of pilot project

### Additional data

There are often hopeful suggestions that social prescribing can have an impact on its service users by reducing the frequency of attendance and level of resource use in GP surgeries. No such claims have been made here. However, one surgery was able to look at its records to see if being referred to the 'New Routes' project had any correlation with reductions in referrals to secondary care, having letters to secondary care (not referral), attendance at the surgery to see a GP, nurse practitioner or diagnostic tests. This is based on features identified by Brandling & House (2007). These frequencies were measured at three time points both before and after referral to 'New Routes', at 18 months, 12 months and 6 months.

The following table (9) illustrates the mean frequency, standard deviation and range of appointments and referrals before and after referral to 'New Routes' services. In particular it illustrates the wide ranging number of appointments attended with GPs or nurse practitioners\*. This sometimes increases after referral rather than reducing. This may be explained by concurrent health problems requiring appointments. Also where there are interesting drops in mean frequency, these are indicated with an arrow ↓. This indicates some general trends towards reduced resource utilisation over 12 months or more, although this is not conclusive. Calculations are made according to the length of time since referral, therefore referrals made 6 months or less ago are not included in the 12 and 18 month periods.

		18 month period		12 month period		6 month period	
		Before	After	Before	After	Before	After
Referrals to secondary health care	M	0.64	0.24	0.83	0.37	0.89	0.81
	SD	0.90	↓0.50	1.07	↓0.77	1.17	1.26
	R	0-4	0-2	0-4	0-3	0-4	0-5
Letters (not referral) to secondary care	M	0.24	0.15	0.12	0.12	0.09	0.15
	SD	0.61	↓0.57	0.46	0.33	0.28	0.55
	R	0-3	0-3	0-2	0-1	0-1	0-3
GP/ Nurse practitioner appointments	M	5.34	3.06	5.15	5.54	4.60	4.55
	SD	5.08	↓3.21	4.36	4.34	3.52	4.14
	R	0-19*	0-12*	0-16*	0-28*	0-13*	0-16*
Diagnostic tests	M	0.36	0.12	0.39	0.12	0.30	0.26
	SD	0.60	↓0.42	0.67	↓0.40	0.75	0.61
	R	0-2	0-2	0-3	0-2	0-4	0-3

Table 9 Mean frequency, standard deviation and range of appointments and referrals before and after referral to 'New Routes' services at St Augustine's surgery.

The table below (10) illustrates the analysis using t-tests. Sections marked with \* and in white indicate results showing a significant change between frequency before and after referral to 'New Routes'. It is possible to see that change is most obvious in referrals to secondary care in the eighteen and twelve month periods following referral to 'New Routes'. Over a period of twelve months this also includes diagnostic test. These results must be treated with caution, since a causal link cannot be made between referral to 'New Routes' and these changes but they are indicative of a relationship between them. There would be some benefit in examining this relationship further, where data can be collected and over the long term.

	18 months before & after NR	12 months before & after NR	6 months before & after NR
Referrals to secondary health care	t=2.267; df 32; p=0.030*; two tailed	t=2.179; df 40; p= 0.035*; two tailed	t=0.433; df 46; p=0.667; two tailed
Letters (not referral) to secondary care	t=0.594; df 32; p=0.557; two tailed	t=0.000; df 40; p=1.000; two tailed	t=-1.000; df 46; p=0.323; two tailed
GP/ Nurse practitioner appointments	t=2.003; df 31; p=0.054; two tailed	t=1.592; df 40; p=0.119; two tailed	t=0.093; df 46; p=0.927; two tailed
Diagnostic tests	t=1.854; df 32; p=0.073; two tailed	t=2.216; df 40; p=0.032*; two tailed	t= 0.321; df 46; p=0.749; two tailed

Table 10. T test results comparing frequency before and after referral to 'New Routes'

## **Qualitative data-**

Interviews were held with a selection of 'New Routes' stakeholders, General Practitioners, 'New Routes' clients<sup>3</sup> and organisers or leaders of statutory and non-statutory organisations taking referrals from 'New Routes'. In addition, 'New Routes' Co-ordinators kept diaries and participated in interviews to discuss the diary contents. Few diary excerpts will be used, since anonymity cannot be assured. The following comprehensive description acts as a narrative. It illustrates the thematic accounts given for the 'New Routes' service, its evolution as well as the challenges and opportunities. This is based on a thematic analysis of qualitative data.

### 'New Routes' Co-ordinator role (NRC)

There are two NRC working 18.5 hours each per week. The NRC are autonomous practitioners, with a structured supervision and management mechanism provided through The Care Forum. The job description and person specification can be seen in appendix G, as well as a steering group overseeing the pilot project. The NRC are the frontline of the social prescribing mechanism, accepting and dealing with referrals. Once a referral has been made, the service provides a holistic and in-depth assessment of client needs. This can take 60-90 minutes on the first occasion with several follow-up appointments to refine the client requirements. This includes the adapted MYMOP questions, the results of which are shown in the quantitative data analysis section. The NRC both appear very skilled at relationship building, not only with clients but also with other stakeholders. They have consistently had to seek out connections with statutory and non-statutory service providers to engage them in making and accepting referrals, finding ways of developing provision where none existed before. They report that their work has been a test of various interpersonal skills including relationship building, diplomacy, active listening, assessment and provision of support. Other administrative skills have included data management, time management and research.

### The early days- Setting up the project boundaries

A considerable period was taken to set up the pilot project. The NRC were both appointed in June 2009. The NRC were able to take until October 2009 to make contacts with stakeholders and referrers, develop their assessment and research systems and establish firm boundaries around their work. The NRC also used this time to become accustomed to one another and establish complementary working practice. This included decisions about referrals and the limit of accepting them only from health professionals.

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<sup>3</sup> As described before, the term patient and client is used interchangeably throughout this document depending on the context. Patient is used where references are made to health professional accounts and client is used by the NRC.

### Becoming a 'known' service

As part of the service launch the team held a launch event on 5th November 2009 to disseminate knowledge of the project and its remit. This was successful and a separate report details the outcome (Brandling, 2010).

Engaging GP's and bringing social prescription to their attention appears to be a negotiated process, facilitated by a GP on the steering committee. Gatekeepers to practitioners appear to be practice managers and good relationships here seem to be fruitful. The NRC spent time meeting with these collaborators in order to develop a successful service. A patient flagging system was established in one practice using criteria established in the social prescribing feasibility study (Brandling & House, 2008). This was anticipated to identify patients to GP's who might benefit from an offer of a social prescription. This is discussed further below.

Further relationships were made with the Primary Care Trust, who provided monies for 'extended engagement'. This provided additional time (2 hours) for the NRC, in order that they take referrals from the locality team. Negotiations were made as to the number of referrals that could be made (2 per week) in order that the service did not become 'flooded' with referrals. This idea of 'flooding' the service had been raised throughout by steering group members as well as NRC. The fear was that the need and demand for social prescribing could overwhelm the service. Contingency plans were made to suspend referrals if a waiting list of 3-4 weeks for an assessment appointment became likely. Members of the steering group felt that such a suspension could cause annoyance to referrers, who could see this becoming an inconsistent service. However, these plans have not been put into action so far.

### Referral into 'New Routes'

The 'New Routes' service is different from other services already provided. Surgery-based health professionals refer clients to the service when they note a particular level of social disengagement or low mood leading to a loss of connection to other people and for the surrounding community. This might include frequent attendance at the surgery for recurrent physical ailments, mild to moderate mental health needs, bereavement and be concurrent with referrals to other services. However, one client had attended the launch and referred herself into the service and needed to be directed back to the GP for a formal referral in. One of the NRC reflected:

*"We are starting to medicalise people by sending them to their GP where our original aim was the opposite..." (NRC Diary 2)*

### What referrers think

Health professionals report that referral to NR is part of a repertoire of tools or suggestions they can give to their patients. Tools might be mainstream or non-traditional:

*“...because you know there is a limit to what you can do as a GP, and sometimes it is a more of (a) social situation, as I said be in a low mood and not everybody can be given antidepressants or referred to psychological services. So it’s another tool in the box really” (Participant 17, GP)*

*“Well what I think of it, is that it is a really great idea, especially for who often there is no Western medical answer, we just sit hear and listen to them, and not really have a lot to offer them, I think it suits the isolated individual really, who want to get back into the community, try and get them doing something which means something to them and boosting their moral and confidence really.” (Participant 7, GP)*

Some of the participating GP’s characterised themselves or other doctors in the practice as more sympathetic to the needs of patients who might be considered a suitable referral to NR:

*“I think generally my clientele are slightly different to when they may come to other doctors here, I don’t have a big psych contingent, where I know that other doctors have got lots, and there is something about that patient type which will result in them coming back to see them again and again, some are psychologically needy patients” (Participant 7, GP).*

Whether the referring doctor knows if their suggestion has been adopted is variable. Sometimes the patient reports back to them, sometimes they are aware of summary letters from NRC:

*“Yes feedback from the patients, I have had some feedback from some of the patients, and a letter from ‘New Routes’... one or two, because the post comes back all of us, it comes into a folder in the office...” (Participant 17, GP)*

### Keeping ‘New Routes’ on the horizon

Referrers know about the service as the NRC have made several visits to the surgeries over the period of the project to raise the profile of the service and encourage its use. Making referrals is made possible by using a specific referral form. It would appear that some referrers keep this service in their mind, as they value it, whereas others don’t feel it is in the front of their minds:

*“I think also that if you are not using it regularly it’s not in your mind all of the time.” (Participant 7, GP).*

A digital flagging system was designed to be used in one surgery, by identifying potential patients at consultation with an on-screen message. The criteria for this

were identified by Brandling and House (2008). This was not considered a useful mechanism for identifying potential referrals as it appears so frequently it was no longer noticed:

*“It’s annoying.... it seems to be very broad.... it pops up all the time. And it pops up so often that I don’t even think about it now, I don’t make that connection, sadly. Now that you mention I had almost forgotten it’s there...”* (Participant 8, GP)

Referrals are supplemented by information sheets about the service. These are useful to some but not others. This is discussed later.

From the outset the referral system was limited to health professionals owing to a fear that the service could quickly be overwhelmed by enormous numbers of clients, since the need for the service was widely predicted to be enormous. It would appear that this was a wise decision, since the service received consistent numbers of referrals but did not have to put a waiting or prioritisation system into place to cope with too many referrals.

#### Beyond referral and first assessment

After the initial assessment the NRC are able to conduct their own research about potential social groups and activities that correspond to the areas identified by clients. This is given to the client and discussed. NRC can also offer a ‘handholding’ facility, where they accompany clients to the groups or activities they wish to go to. This is deemed to surmount anxiety aroused in doing something unfamiliar with new people:

*“...I have gone along to different things... {NRC} has come along with me, I felt apprehensive the next week but I thought no, you have to do it, go!”*  
(Participant 2, client)

Although to begin with the NRC felt this would be an onerous part of their job, taking up considerable amounts of time, this was not borne out by the database information. This was reportedly due to the limited time available to offer this service:

*“In truth, I haven’t pushed it or over-emphasized it... If I had more time and flexibility in my working day, I would have encouraged more clients to take up the offer of handholding To know that there is a team of volunteers who can support clients in this way would be fantastic as I wouldn’t have to gauge whether it was something I could genuinely offer but rather be upfront about it from the start and make it a given that every client could access handholding.”* (Email correspondence, NRC 1)

After referral, the NRC write reports back to referrers, which are entered into patient notes. These are a summary document to inform the GP of the referral outcome. It is

hoped that this completes the circle, by reminding the referrer of the service and the type of work that is carried out.

### **Opportunities and successes**

The majority of people engaging in the research were positive about the 'New Routes' experience. There was an overwhelming assumption that engaging in the social realm is a positive and helpful response for people who are not currently happy and well. It is seen as an opportunity to resume integration in the local community with companionship, distraction and occupational activity. Stakeholders talked about 'New Routes' project as a simple way of providing a social support network:

*"A lot of people are in the waiting room because they are lonely, or they are just depressed or something, and actually if you put something activity wise their way, people just feel better, it's not rocket science is it really? I think what 'New Routes' have done is tap into that idea that you give people something to do, or you give them a group to go to and actually that makes you start to feel a bit better, so therefore you feel a bit more better and you don't think I'll bother going to the doctor anymore, it's a snowball effect, I think that it's a really great idea"*  
(Participant 12, stakeholder in voluntary sector)

### **Being an alternative to medical solutions**

Some participants suggested that NR is a simple support mechanism and can be viewed as an effective alternative to a medical solution. This seems to take a common sense view based on instinct and experience rather than on knowledge of formal evidence:

*"it's much easier of course to think that it's a pill will cure, rather than to decide to go and put on your coat and hat and walk down the street and find something, that's much more challenging, that's why you need help to do it. But in the long run much more rewarding because you will make friends from doing that"* (Participant 3, Stakeholder in voluntary sector)

*"um, my doctor, I get really down about this.... and she said go on antidepressants, but I take 13 tablets a day already, that's half the problem. I hate taking them so she said try an alternative therapy really. Um so I went on the art course (on the recommendation of NR)... it was good actually, I didn't really want to go, I haven't been out meeting people, I haven't been out at all. So um the doctor said they'd be same sort of people like you, so I went and it was alright actually, there was. Yeah it*

*worked I think I came out with a smile on my face every time for the right reasons. But it did work so I'm glad I went for that."*  
(Participant 11, Client)

### Service credibility by association to the surgery

There appear to be assumptions that because a GP suggests NR then it must be okay. The credibility of the GP and associated health practitioners is extended to the NR service. This was a consideration from the outset, since the feasibility study (Brandling & House, 2007) had identified this as an area for consideration. This GP participant recognised that a social prescription may be accepted by a patient just because it has the credibility of being the doctor's suggestion:

*"So I know that once I have explained to them what Western medicine does offer them, they ... don't want that either, they are more than happy to try something different, I'm not sure whether they are just agreeing with me because I am a doctor"*  
(Participant 7, GP)

This may be an effective way of engaging clients who have high levels of faith in the medical profession, perhaps those who are frequent attenders at the surgery.

### An opportunity to develop self-confidence

As one of the NRC says in her diary:

*"it's another example of a social muscle not being used and getting neglected. If you get out of the swing of socialising, you forget how to do it and lose the confidence to try". (NRC 2 Diary)*

Many of the client participants felt that that engagement with 'New Routes' had improved their self confidence in the face of isolation and fear of going out and getting involved outside of the home. These interview excerpts speak for themselves:

*"They have been wonderful.... As I say I am far more confident, I get out more... you know some weeks there's nothing going on, and I don't even meet anyone out walking. I think I am here on my own, I go out , I am on my own, I go to the shops you only speak to the shopkeepers, and I just feel so isolated..."*  
(Participant 2, client)

*"God I hate being inside, I hate it...[I've] always been outside doing something, ... That's why I got so depressed .....I could have died then and wouldn't have cared then ... I can't go out and see my friends, well I couldn't at the time, and then it was*

*only a couple of months ago, that it has given me a load of confidence back, even though I didn't expect it to, I didn't expect it to do anything to be honest. Yeah, but it has, I don't know how it has worked, but it has. It's worked."*

(Participant 11, Client)

### **Case Study 1- Ivy**

Ivy is 82 years old and was referred by the GP to the 'New Routes' Coordinator. She is rapidly losing her vision, widowed and despite having a very upbeat personality reported feeling scared and alone. She seemed to have been waiting a little while for a social services assessment and although getting a lot of help from nurses every day coming in to help her inject insulin, it seemed as though her main needs were social and psychological. Without being able to read a book, watch TV or go out independently any longer, Ivy felt lost, bored and felt unprepared for her situation.

After visiting Ivy at home the 'New Routes' Coordinator made two referrals: The first was to Keynsham and Chew Valley Befrienders, so a befriender could call once a week to chat and go shopping etc. The befriending group organiser visited Ivy twice; once to make an assessment and second, with a potential befriender to introduce her too.

The second referral was to Vision Plus, Bath. They responded promptly and a support worker came out to see Ivy within a week. Not only was he able to help Ivy with some equipment, but he mentioned a new social group are started in Keynsham by Vision Plus for people with visual impairment. The group provides transport and can collect people from their own homes.

Now Ivy is in receipt of both these voluntary sector services and the 'New Routes' Coordinator is in the middle of making her an application for a grant to The Blind Society so that she may be able to go on holiday by the sea.

### Taking away the strain

The NR co-ordinator made the arrangements for clients by searching for opportunities when this was too difficult for the client to do themselves:

*"I would have still had to make the effort myself and that was the thing...I didn't, initially make any effort, {NRC} made the effort on my behalf, and as I say she kept trigger[ing] me to go to these things and would have gone with me if I had said well I can't go on my own and she would have gone. So that's really what got me out of myself"* (Participant 10, Client)

The NRC noted in their diaries that it was better to send the suggestions to the clients in advance of their next meeting, so they had a chance to consider their options:

*“In the future I’m going to send the prepared pack of suggestions to the client prior to meeting them a second time ... I wonder if (client) weren’t just a little shocked and felt on the spot by having to think about what he wanted right then...”*  
(NRC Diary 2)

### **Case Study 2- Simon**

Simon is 42 years old and was referred due to anxiety, depression and out of work owing to severe back problems. Throughout his life, Simon has done physical work but has always suffered anxiety and panic attacks, despite reportedly being supported and socially well integrated at work. The anxiety eventually affected his physical health with serious irritable bowel problems, headaches and repeated flu began. In the period before referral Simon thinks he must have visited his GP at least once a month. He was given various pills, including anti depressants, none of which seemed to help.

The New Routes Coordinator found Simon to be a very engaging, friendly character and full of determination and motivation to get better. Consequently there were endless voluntary and statutory sector options available to him. A list of suggestions was compiled including careers advisory groups, volunteering roles, paid work opportunities (data collection for the national census), courses at Norton Radstock College and with the council’s Community Learning Service, gardening clubs, chess clubs, walking groups, conservation work with Avon Wildlife Trust, arts groups, meditation classes, book groups and a history society. Simon took up volunteering once a month with The Woodland Trust in Abbots Wood, Keynsham, joined a supportive book group in Keynsham Library, trained to be a Volunteer Walk Leader, joined a photography course and made regular trips to the History Society.

When the New Routes Coordinator last spoke to him he reported “...(I’m) feeling much better...”. He said “It’s so nice to feel like I have control over my life. All I need now is a girlfriend. Perhaps that will be the next step!”

### Becoming useful again

One client described how finding a niche for herself through ‘New Routes’ helped her find a new purpose in life. She had become a volunteer via NR and now had other people who needed her:

*“I suppose I was at the needy stage [but]I had moved on, I was functioning, and I needed, I unconsciously needed to be needed, even though my son was only young, he... love him as I do, and he is in many, many ways a wonderful chap, he just didn’t need me”*

(Participant 13, Client)

### **Case study 3- Mary**

Mary was referred by her GP in October 2009 and first seen by the New Routes Coordinator in the same month. She is in her late fifties and works full time. She takes anti-depressants and had discussed with her GP her negative feelings regarding her job and her sense of self-worth. Mary had previously had a high-powered job but difficulties with mental wellbeing linked to family problems and alcohol had resulted in her changing her job to one which she felt gave her little fulfillment and did not make use of her skills. She had previously considered doing some volunteer work with young people, had approached a service, but had been told there was a long waiting list for volunteer training. She had felt de-motivated and not pursued an application with this service. When she met the NR Coordinator she knew she wanted to do something 'meaningful' and 'valuable' but was unsure how to go about this and lacked self-confidence.

The NR Coordinator was able to identify a number of volunteer opportunities and discussed these with Mary. One of the opportunities was a very local charity that offered volunteer befrienders to people with mental health problems. The NR Coordinator arranged for the organiser of this scheme to meet with Mary and Mary subsequently decided to train as a befriender. She enjoyed the training immensely and made friends with another woman on the course. Since completing her training she has been matched with a service user and befriends her once a week. Mary reports that she 'loved the training', is 'enjoying being a befriender', 'wouldn't have done it without New Routes', and feels 'more the in mood to reconnect with old friends'.

### Someone taking an interest

Another participant felt that having the NRC gave them someone from outside to observe them, an interested other. The NRC gave them time, support and direction and in turn this motivated them to engage with the activities suggested to them so as not to let the NRC down:

*"I didn't want to disappoint her ... I feel that I have gotten someone to report back to as well, maybe I, she's my boss in a way, I feel good, when I see her smile, and look excited about what I have done, she has made a difference to my life you know? It's great." (Participant 16, Client)*

This NRC diary entry shows how immediate and simple the intervention can feel:

*"We had a really good long chat about the nature of (self) confidence and why we lose confidence in ourselves. I told her about all the lovely things going on in Keynsham and about how accessible it all was. She seemed to have a revelation during the meeting and gave me a big hug when she left" (NRC 2, Diary)*

This interest may not need to be formal for some. One of the NRC reported a case in her diary, where a client did not take up any of the researched offers of activities but had self initiated group participation and other local activities after the assessment discussion raised her awareness of her needs. The NRC reflected that NR may have been a catalyst despite the lack of evidence of service engagement.

### Responding to client needs

Most onward referrals are made to existing groups and services. However, the NRC noticed a consistent request for arts and crafts related activities. In partnership with local services a short course was established, which was very popular with participants in interviews for this research. One participant reported:

*“All the people there, I would have never mixed with them in any other form of life, socially or anything, but for the group, at the art group it was perfect. There was disabled there and umm. And just ex-drug addicts, but it was all people who needed help, it was I didn’t think that I would be able to ‘Not bond’, but get on with people like that, but we were all in the same boat there. And it was a good laugh; it was like a relief really.”*  
(Participant 11)

The group has been reported by the NRC as informal, without learning objectives and therefore attractive for people who do not like formal learning or social environments. However, to date funding has not yet been secured to perpetuate a similar course. One stakeholder (P19) reported that she felt the NR service could not be particularly responsive to this kind of need, where other services could do this. It is interesting to note that services such as the Community Learning Service (CLS) have enabled this function in the past. However, discussions about assertiveness and confidence classes are on hold while the budgets are considered and the CLS are being integrated with local colleges. In addition, the Community Development team (CDT) provided an inter-agency forum to share information about current local projects. However, the CDT has been dissolved since the most recent re-evaluation of provision.

### Disengaging after success

Owing to the long term nature of engagement with the NR service, this challenge wasn’t immediate. It hasn’t appeared to be difficult to end cases where clients had not engaged but it has been more challenging where clients have been active, had engaged but lack the confidence to let go of the NRC. Cross-disciplinary learning may be possible here, since therapists face this challenge frequently (Hough, 2010, Lund, 2007, Sutton & Stewart, 2002).

## Challenges and barriers

Despite the positive aspects of the service, inevitably difficult issues arise and create challenges or barriers to engagement. This is for a range of reasons.

### Lack of interest

'New Routes' social prescription is offered quite widely to patients by doctors who see it as a potential solution, but only taken up by a few patients:

*Interviewer: And have you had anyone who has said outright no, right from the start?*

*GP: Yes, quite often, I would say probably most people respond like that actually. That makes me feel like that they don't want to be helped, or that they don't want that sort of help perhaps.  
(Participant 8, GP)*

After the initial referral it is clear that not all people referred to the service take up the offer of support and ideas for social engagement. Although the doctor or health professional suggests a 'social prescription' via a consultation with a NR co-ordinator it is not always taken up. The NRC recognised patterns and realised that if a client cannot take up a first appointment after 2-3 offers then it is not productive to pursue them further.

### Inadequate referral information

Some people referred attended the initial appointment without understanding what it was for or what they were being involved in:

*"I had no idea at all, I mean the doctor told me, but when you come out, I never even remember ....I'm so intent on listening it just goes out. So no I didn't, so when I got this letter,..., and I thought oh yes something does ring bell"* (Participant 2, Client)

*"... she said the doctor had told her it was about coming to the surgery every week to participate in a type of group counselling. This is the most starkly interesting misinterpretation of what NR is that I have heard to date!"* (NRC Diary 2)

It was clear from interviews conducted with GP participants that their understanding of the 'New Routes' service might be variable, some of their descriptions were a little vague. Not all of them used the leaflets either, as they become lost in a plethora of leaflets and take time to source in a short consultation:

*"I am just rubbish at giving out leaflets, I'm not proud of the fact that I don't do it, I think that it's actually a good thing, but I just*

*have that conversation, and I'm sure that there is pretty good evidence that if you follow it up with a bit of paper, they might then subsequently use it, but sadly old habits die hard, I'm just not very good at giving out leaflets." (Participant 8, GP)*

*"I have to look it up and find it so um, I find the referral, then print that off, I normally give my take on it, rather than the documentation that goes with it." (Participant 7, GP)*

These quotes illustrate a difficulty with giving consistent and fulsome information to patients in a limited consultation, which is fully understood by them.

Consideration should be made that this is a patient group for whom concentration might be difficult, especially if they have mild to moderate mental health problems or cognitive impairment.

#### Misunderstanding the purpose of referral

This participant is not representative of the data generally but should be considered, since it might illuminate difficulties with service engagement. The participant was referred to the service and did not feel it provided what she needed. She had anticipated friendship and company. It isn't clear if this is what was explicitly established during the assessment as her most prominent need and whether there were any services that could have provided exactly what she had wanted either:

*"She came and wrote notes on what she thought was best for me and umm, decided that she would send me a lot of information through the post...a lot of it I didn't find very interesting, and felt that a 'New Routes' project would be someone coming in to see you more and checking that you are getting on ok, while actually a lot of our conversation was through the telephone, which is fine but if you are home all day on your own, it's nice to have a bit of company."*  
(Participant 14, Client)

One NRC reflected in her diary that sometimes clients have no idea why the GP has referred them to NR. She considers whether this is simply a passive response to a culturally powerful medical advisor. This corroborates the previous account by a GP, indicating the credibility they bestow on the NR by merely referring people there:

*"...these have since turned out to be inappropriate and have said... that they simply have no idea why the doctor referred them to me. I think what is happening here is that the doctor is projecting their wants and wishes for the patient on to them and using their authority to make a suggestion that such a person hasn't the faintest intention of taking up. Perhaps people then*

*feel ... 'doc knows best'.... Perhaps they can't say to a doctor that they don't want the referral.”(NRC 2, Diary)*

### Entrenched belief in medical solutions

The early motivations for this project included the sense of frustration some health practitioners feel when patients attend the surgery frequently, yet there are no obvious medical solutions to their problems. It is not clear if GP participants recognised this as an indicator for considering social prescription. However, the referrers did recognise patient entrenchment in medical solutions for varied ills. The following participant excerpts illustrates this, where the referrer has ‘insight’ into a likely solution but nevertheless their experience means they regard the patient as unable to make the move at that time. Some patients are regarded as unable to move out of their current situation, regardless of its bleakness, by taking some action:

*“Some people you end up thinking alright you want to be like this, but you don't really want to change, if you are not... there has to be some inner motivations, a want for things to get better, rather than just to want to come and tell me how bad they are.” (Participant 8, GP)*

And another reiterates this problem:

*I think that some people, my patients, who are particularly entrenched in their own problems, ... sometimes it can be quite difficult to persuade them to change it's just that some people really don't want to, or say that they can't. One woman especially says that she is just too weak, or can't do this or that, but if she got up and did something, she would be a whole lot better. You know she just doesn't... you can't get her to do anything, she is just thinking about herself and her problems, and her many, many multitude of problems that she thinks that she has got, she would be a whole lot better basically, but I can't persuade her to... [she says ]“no, no when I'm better”, you say it's good, [she says] “but I don't want to take part in it at the moment”.” (Participant 17, GP)*

The NRC also recognised this problem and this diary excerpt illustrates this barrier to engagement in the social prescription model:

*“We discussed her hobbies and interests and whether she would be interested in pursuing some signposting suggestions from NR. I could not move her away from her focus on her pain and the subsequent limitations of this... I am very keen to support x to move to a more social model of health and wellbeing and to*

*encourage her to focus on her abilities rather than her limitations” (NRC Diary 1)*

These accounts engender frustration, since despite consulting an ‘expert’ the recommendations are not acted upon. This can be viewed from several perspectives. There may be an element of value judgement towards the patient/client, who cannot see the value or progress towards what an ‘expert’ prescribes. This compounds unequal balance in the relationship between practitioners. Another perspective is that contained within ambivalence, the missing components to drive change are energy, motivation and inner conviction that change will be positive.

### Issues of motivation

The NRC described barriers to engagement, particularly the client’s level of motivation to move from contemplation to action. Where movement from contemplation to action was made this seemed to be key to the success of the NR intervention:

*“I feel this may be a recurring theme: getting people from contemplation to action, and supporting them to understand the connection between improved social wellbeing and emotional and physical wellbeing” (NRC Diary 1)*

*“The issue is to do with motivation. You can make suggestions and support left, right and centre, but we can’t actually DO the thing for anybody. Essentially people have to want to make a bit of effort... How can I motivate people and get them to take the initiative? ... We need a group on motivation but then how could we motivate people to attend it?” (NRC Diary 2)*

By identifying what it is that drives change and action for individuals, NRC could be systematic in their interventions.

### Perceived stigmatisation

In addition to this entrenchment a couple of participants regarded the tenuous link to mental health services as a step too far towards stigma. This was compounded by the perceived link to mental ill health with the research tool WEMWBS:

*“And then she sent me all the information, and I thought oh my goodness, oh dear, mental health! And then I thought well yes, it doesn’t literally mean MENTAL health” (Participant 2, Client)*

*“She was very confused by the research element of the project and in particular quite scathing about WEMWBS... because she seemed to feel that such questions were about labelling her as depressed” (NRC Diary 2)*

Although this theme did not run throughout all of the respondents accounts, it does reflect an underlying cultural fear of the stigma of mental health conditions.

### Lack of confidence

One stakeholder (P20) involved in voluntary and statutory services had expected clients to attend the groups based on known referral from NRC. However, the clients were unable to attend. She described that they 'lost confidence at the last minute'. The 'hand-holding' element of the NR service is provided to overcome this difficulty and this participant has seen this handholding to be effective in other projects. However it is clear from the service database record that very few clients took up this offer (10%). This may have been due to the incompatible times of groups and NRC available time. Alternatively, they may have been unable to see the referral to fruition by taking the offer of help to engage with the activity.

### Where being social isn't the answer

Although this was not a common theme among the interview accounts, one participant eloquently described how experience had put her off social contact with other people. She accounted for this by describing a condition, known to include difficulties with social function, where she had previously experienced ridicule. She appreciated her contact with a NRC but explains that sociable activity is not what would be helpful for her and specially for people generally who do not conform to social norms:

*"Over(all) I enjoyed the contact with (NRC) because she showed care and interest over and above 'a project'... (but) I do not crave vast tracts of human company- quite the opposite. I do crave human contact and a reason for living, which I lost when I lost my professional status." (Participant 19)*

This participant went on to describe how she achieves human contact through digital means, rather than social activities. Another area where social contact is not all of the answer is unemployment:

*"One thing we are doing is finding groupings of people with similar needs. One obvious such grouping is men in their late 50's or early 60's, who have been made redundant and are totally lost as a result... Generally they are looking to go back to work, have financial worries and are facing age discrimination in the workplace...Social activities seem to be coming in as second best as suggestions for things to do" (NRC 2 Diary)*

### Where the barriers to being involved are too great

Barriers to being involved generated by clients include poor mobility and therefore accessibility issues and chronic ill-health such as pain. These physical limitations are barriers to engagement, whether they are surmountable or not. The NRC described some difficulties in finding suitable referral opportunities for people in these circumstances. Their diaries illustrated how they tenaciously persisted and overcame this. Other barriers are less visible and may be those described above, including low motivation. There is a danger that this motivational barrier could be perceived as less legitimate, since it has a psychological component. One NRC describes below how she feels that she has not been sufficiently convincing about the benefits. This seems to be taking a large amount of responsibility for the success of outcomes, where this can only be a joint venture between the NRC and the client:

*“...I felt I was not able to ‘sell’ the concept of NR in a way that was meaningful and relevant to the clients. So although the referrals appear appropriate it may take a more creative approach to deliver something of value” (NRC Diary 1)*

The NRC both appear to have been cognisant of the risk of ambivalence those clients, who appear difficult to please or have been unpleasant:

*“She is therefore quite capable of initiating services. I am feeling like I can’t really help...but I’m wondering if this (client) may be hard to please and continue to request further support/input. Trying not to pre-judge”(NRC Diary 1)*

It is this reflexive way of working that depends on the NRCs’ previous experience and their use of personal skills. It is this reflexivity that might also reduce the risk of directing clients rather than working in partnership to harness client motivation for change or action.

### Gaps in local provision

Other barriers to engagement are predictable. These are: money and transport to activities. Lack of transport is acknowledged by many health professionals to be a barrier:

*“One of the community nurses... spoke about the urgent need for people to have help getting to places” (NRC Diary 2)*

This participant suggests how lack of funds can be a barrier and in many, less than obvious, guises:

*“Living on a minimum wage does not allow much free money to do things. Even for ‘free’ events, one is supposed to dress in a certain way, travel, buy refreshments, etc. One does not like*

*feeling the poor neighbour... There must be a way of enabling the prescribed to 'pay' for activity in such a way as to retain dignity- I hate 'charity' and would not accept it but the financial implications of prescriptions are implicit" (Participant 19)*

The NRC also identified specific gaps in provision, which they have reported back to The Care Forum. One particular difficulty has been finding a placement for a person with physical limitations, despite an enthusiasm for working as a volunteer. At every turn access or needing to be supportive of volunteers became a barrier to engagement:

*"It's such a struggle and I really am aware she was one of my first clients. It's taken this long to even get an appointment with someone about some voluntary work for her" (NRC 2, Diary)*

### Finding a space to work

For the NRC there have been logistical issues in finding a space to work in Keynsham, since they needed somewhere accessible, safe enough for lone working and with office space in order to deal with phone calls and use the internet. The surgeries were able to offer rooms but these retained a clinical atmosphere which was unsuited to the work of the NRC. They inhabit the social rather than medical realm. Although they did use these clinical spaces predominantly for first appointments, thereafter they frequently conducted their work in clients' homes or in social environments such as cafes. The NRC felt this reinforced their encouragement to engage in the local community and enter social spaces. They also found that some of the social places provided wireless access to conduct their online, digital business while they waited between appointments or when clients did not arrive. However, a drawback was lack of confidential space for making telephone calls. This remains an area for development.

### Engaging in research and evaluation

As is often the case when research and practice realms meet, the requirements for systematic research or evaluation tools to be used at specific time periods clashes with the needs of the clinical or practical situation. Tools can seem to be too restricted in their focus or not suit the clients understanding of their self or their situation. For instance, a criticism levelled at the Warwick Edinburgh Mental Wellbeing Scale is that it places too much pressure on people to have to be at the positive end of the spectrum; with a subsequent sense of failure if they do not match this description:

*"(She) did not understand the meaning and purpose of the WEMWBS... she seemed insulted by it! ...it does seem to imply a person is supposed to be feeling great all of the time"*  
(NRC Diary 2)

Despite this, data were collected where possible. Since this was a pilot project and evolving as the NRC learned what worked, the time points for quantitative data collection shifted and eventually had a wide window within which they were sent. In addition, the requirement to ask standard questions did not always seem appropriate to NRC. In these cases data collection was omitted. This is a judgement that can only be made by practitioners when they undertake their work.

It would appear that using measures of mental wellbeing and mental health trust logos on letters tapped into stigma about mental ill health, as previously discussed. This may have been off putting, as the following interview quote suggests:

*“...When the envelope came and it had mental health written in red on the front of the envelope, I felt really cross, and that was how it went...”*

(Participant 5, Client who did not sustain engagement)

### Defining success

When asking the NRC for their definition of success, they described this as a client engaging with NR and ideally going on to engage with other community activities/resources. In more detail this is someone who shows up to appointments, identifies one or more thing from the signposting suggestions and follows this through. This means committing to doing something once, deciding whether to do it again or to choosing to do something else. They go on to say that occasionally a client doesn't take up any of the NR suggestions but something in the process of meeting with the NRC helps them to self-initiate something new.

Generally the NRC's don't give up on a client, instead it is the client who doesn't turn up for appointments, becomes impossible to contact, or reports that they don't want/need NR. However, there can be a point where, through joint discussion with the client, it is recognized that all NR options are exhausted, and the case is closed. The NRC examined whether the client engaged or disengaged and what led to case closure. The NRC judge when someone is ready for their 2<sup>nd</sup> (3-6 months) and 3<sup>rd</sup> (6-12 months) assessments and use these for discussions of other support – if any – the client might need. Sometimes the 3<sup>rd</sup> assessment is just about follow-up and closure, sometimes it leads to additional signposting and support. However, the number of NR contacts any one client receives varies on the needs of the individual client.

### **And finally.....**

### Supporting the supporters

Strong support mechanisms for the NRC were helpful, since they are regularly dealing with vulnerable and often distressed individuals. There were times when clients were downright unpleasant, leaving the NRC feeling her personal boundaries had been encroached upon, whether that be dealing with inappropriate physical proximity or unpalatable political views. Moreover they reflected often in their

diaries about the sheer volume of work they were dealing with, which at times felt overwhelming and frustrating:

*“I’m slightly concerned about the amount of time it is taking with each person...It’s taking such a long time for people to make decisions about just doing anything at all. And this is completely regardless of how much they say they want to do stuff in theory” (NRC 2 Diary)*

It is clear that having two NRC provided a mutual, peer support arrangement in addition to the more formal structures. The diaries are full of entries where the NRC discussed cases and difficulties, including entrenchment, disappointment in lack of success and capacity issues.

The NRC have received support and supervision from their employer, The Care Forum and the project steering group throughout. Initial discussions were held with a community mental health team to help provide support. This did not come to fruition. The active mechanisms appear to have been a strong supportive structure. This may have felt conflicting for the NRC at times, including and adhering to multiple different interests and motivations of the different organisations involved. The NRC acknowledged their own vested interest in making the project work effectively as well as for the client group.

#### Other social prescription services

Some limited comparisons may be made to other local services, especially since a social prescribing service has recently been established in South Gloucestershire. This is run by DHI (Developing Health & Independence, borne of the Drugs and Homelessness Initiative), who won funding from the AMP scheme (Alternative Provider of Medical Services). They are working in a different way to NR, based in GP surgeries with direct access to surgery appointment systems. They are reputed to be engaging with people with different demographic backgrounds than those of NR but like New Routes they have begun using volunteers and have set up an art group for their clients. The NR team has developed links with the Orchard Practice team, to share learning as well collaborate in a local event to promote the social prescription model. This relationship enabled a local conference to showcase local knowledge of good social prescribing practice and alternative strategies to wellbeing. This was recognised by Bath GP Practice Education (<http://www.bathgped.co.uk/>). Conference presentations were given by the two social prescribing providers, village agents from Chew Valley, the author of this document and a keynote speaker, Alex McNeill. The presentations can be found on The Care Forum website (<http://www.thecareforum.org/pagesocial-prescribing.html>). There are opportunities and challenges to this kind of partnership, since there are profound differences in driving forces and service provision; but also the competitive marketplace may inhibit transfer of good practice models. Strengths identified in the South Gloucestershire service, which could transfer to NR, are the motivational

interviewing technique employed in assessment and the ability to refer to statutory services directly. This is discussed below.

## Discussion

As described in the results section there is a lot to be learned from the establishment of a social prescription service. It is possible to triangulate these data collected from the different sources to understand the facets of a service; thereby illustrating the trends and effects of the service on the different patients/clients and stakeholders. It provides some confidence in deciding what the quality and impact of social prescribing has on these different parties and therefore the usefulness (or not) of the service.

This project benefited from having a discrete area in which to become established, with three general practices that agreed to become involved. As is indicated by the quantitative data, two practices had wholehearted commitment, with all of the doctors making referrals. The third surgery moved location during the period of the project, which may have had an effect on the commitment and focus for the service.

The project also benefitted from having a 'lead in' period so that the ground work could be established, making relationships with all stakeholders, defining referral and assessment criteria, holding a launch event and developing a working practice. This enhanced the consistent image of the service to outsiders and an explicit understanding of mission or purpose. This was supported by networks of supervision and project management by stake-holding steering group members. Reflexive practice by the NRC enabled them to be proactive and responsive. NRC were experienced, with varied work backgrounds, which gave them personal resources on which to depend in such a novel and evolving pilot project and service. Presently there is no way of substantiating what the differences were between each NRC, despite acknowledging subtle differences in personality and working style. It is clear that the advanced social skills and previous experience of the clinical and therapeutic arena has been effective in this pilot project and that they have used 'the self' to full effect to engage clients and develop relationships with them. In future it would appear that attention to the job description, person specification and interview process need to be as specific and thorough as on this occasion.

The NRC were able to identify and suggest a large number of organisations to their clients, from which they could pick and choose. There were few empty zones, where no activities or organisations could be found that suited the clients; especially if they could travel into the City of Bristol. The NRC identified some areas of need, particularly for low cost, sociable craft activities, without any pursuance of qualification. With small funds a short-term group was successfully established, to the great delight of research participants. Regrettably this has not been sustainable as further funds have not yet been forthcoming. Lack of transport to activities seems to be an insidious reason for non-engagement, with a fifth of respondents noting this.

Participants who responded to this research gave predominantly favourable accounts of their engagement, whether they were referrers, clients or voluntary organisations. This suggests it is a credible alternative to medical solutions,

especially when it is linked to GP practice. It can enhance self-confidence and take the strain out of making moves towards change. It allows people to feel they are useful and that someone is interested in them and responds to them individually. Ultimately the clients who put themselves forward to participate in research interviews are likely to be those with the strongest views and perhaps the most satisfied clients of NR, who would be more likely to say positive things. However, these findings are corroborated by the general trend towards improvement in the WEMWBS and MYMOP2 scales, which suggest improvement in these areas too. Moreover, tentative examination of one surgery's referral and attendance data indicates that there may be some relationship with reduced resource utilisation.

Nevertheless, the challenges and barriers to social prescription exist and fall into several camps. These are external factors amenable to the support and provision provided by both GP's and NRC. Stakeholders can adapt and evolve the service to maximise positive outcomes for clients. There are also internal factors, which include the client's personal motivation to change and their entrenchment in the medical model as a solution to life's ills.

By concentrating on external factors, the NR service can continue to promote its service with GPs and in the wider health community to establish itself as a credible option to deal with social disengagement. This may require a review of digital flagging systems and also a digital store of information leaflets as part of the referral process. It may also include clarification of the purpose of NR so there is little room for misunderstanding. It is also dependent upon the provision of open and regular communications between stakeholders; for instance, meeting stakeholders to promote the service; providing feedback of outcomes; and building bridges between organisations and sectors. There is also room for a next step beyond the one-to-one support provided by NRC, where groups of similar clients can meet and support one another. This may aid sustainability of impact of the NRC intervention. However, where there is low client motivation it will need support, although this could be a volunteer role.

The NRC are best placed to further identify the internal factors that they see as limitations or barriers to client engagement. Specifying the specific factors where success is made could ensure that future referrals are as appropriate as possible. This would include systematically identifying cases that are successful as well as those that are not and looking for and documenting commonalities in these cases. For instance, it is clear that this service was able to engage with more women than men and it is not known whether this is because referrers see this as more suitable for women or the service appeals more to women and they engage most.

Other ways of creating boundaries to the service may mean standardising the number of occasions that approaches are made to those not responding to referral and appointments. The database records show that the number of contacts, by phone, email or face to face can vary widely and this may need an upper threshold. This will also mean that rather than feeling responsible for making the service attractive enough to clients through continued contact, the responsibility is placed

on potential clients to embrace an offer of help and support within set parameters. If it takes four months for clients to decide not to engage with the service, this is a considerable drain on resources. Furthermore, clarity needs to be found over the rationale for offering a 'handholding' service and whether this is a useful aspect to be pursued more widely. This clearly cannot be accommodated regularly and consistently within the time limited NR interventions but volunteers could be utilised to sustain the 'handholding' service. Presently the NRC still feel this is a desirable function of NR.

A cautionary note: while a system of limiting or screening out referrals that might be deemed to be less than successful would enhance the reputation of the service for success with clients who progress, it could run the risk of excluding, less able or less motivated others. Some supportive contact, though overtly unsuccessful, might lead to behaviour change in the future. It appears from the NRC diaries that they have taken an exceptionally supportive role over extended periods in which to enhance engagement. This appears to set the work they do apart from other fixed-term and goal-focussed projects. It is important to create ways of understanding the sustainability of the effect intervention as well as the service itself.

The mean length of service engagement is six months and so far suggests that behaviour change is a long-term process. Moreover, changes in surgery use may not be immediate but over the longer term. Therefore judgements about outcome must be tempered to reflect this. Small positive changes in mental wellbeing and specific issues over this period are reflected in the quantitative measures. They may predict the sustainability of behavioural changes over the longer term. However, owing to the small numbers of respondents this is as yet an unknown quantity. Should this service be continued into the future, it is recommended that continued measurement of the impact of social prescribing is continued. This should be done from within the service, so that it is salient and useful to NRC but is not disruptive to their work with clients. For example, a psychometric measure should be used on more than one occasion in order to measure distance travelled. If it is also a clinical measure, helping NRC and clients assess progress, attrition rates of research measures can be mitigated. Analysis should reflect the needs of the service, in order that it can evolve to meet the needs of clients, while also assuring commissioners of the projects effectiveness.

As part of further study it may be possible to evaluate whether NRC are able to respond most effectively to acute phases of disempowerment and disengagement; such as those of bereavement, redundancy and sudden ill health. Further monitoring may also measure whether NRC intervention can also address change or positive movement in those who are perceived to be chronically disengaged. It is this entrenchment in the medical model and seeing the self as ill that appears to contribute to limited individual motivation to action. The NRC have informally identified that being unable to make a move from contemplation to action means that it is difficult for them to sustain productive working relationships with clients. The Trans-theoretical or Stages of Change model (Prochaska & Norcross, 1999) can be applied to this group of clients to illustrate the situation they find themselves in

and account for their motivational state. The components of the model, as applied to social prescribing, are shown in box 1. The model describes five stages in relation to engagement with NR: pre-contemplation, contemplation, preparation, action and maintenance.

**Box 1, Stages of Change  
(Prochaska & Norcross, 1999)**

Pre-contemplation: There is no insight or no intention to change behaviour viewed by others as problematic. In this case clients are not aware that their social situation, such as isolation is compounding the problems about which they visit their GP.

Contemplation: Awareness of a problem and change is a serious consideration. However there is no commitment to action. This might be where the referral and appointment is made with New Routes but suggestions may not be immediately followed up or appointments are not kept.

Preparation: Action is intended and small steps are made towards new behaviours. This might be where appointments are kept with NRC and interest is shown towards suggestions. Arrangements are made to attend social activities and first visits are made.

Action: Modifications are made to pre-existing behaviours and these take time and energy to sustain. This might mean regular attendance at social activities and continued engagement with NRC.

Maintenance: Changes are continued and maintained beyond initial engagement. This may mean continued social engagement without long-term support from NRC.

In addition to using this model to understand existing behaviour, there is a need for ways of dealing with entrenchment and poor motivation. Here learning can be derived from the other local social prescribing project. The fellow project has an established practice of using 'Motivational Interviewing' (MI) techniques. This is an established counselling intervention and has been successfully used in various fields, such as addiction, mental health and chronic health conditions. Rollnick, Miller and Bulter (2008) describe how this can be applied in varied health care settings, by activating and guiding motivation to change health behaviours, taking into account readiness to change. They suggest that the technique does not utilise persuasion as a technique for change, since this is likely to encourage resistance or further entrenchment. Instead they suggest skills of collaboration, evocation and honour for autonomy (Ibid p6). The authors suggest that blame for lack of motivation should not be levelled at the patient or client but that by using MI, practitioners can be skilful in guiding them to find what they need themselves. The technique has established principles and might seem prescriptive but seems to incorporate much of the NRC working style already. In particular it will be useful to promote engagement where there is ambivalence, a low sense of self-esteem and self-efficacy; also in defining the areas for change, planning goals and identifying barriers and supports to sustain change. There is training locally available and it could be a useful tool in the NRC repertoire.

It is clear that a focus on the social realm predominates within the ethos of social prescribing. That is to say social engagement and support networks can act as a remedy for social isolation and despondency with outcomes such as improved mental wellbeing. However, it must be remembered that one participant did not feel this was the answer to her circumstances and other experiences and political and cultural factors may be at work here. Where unemployment and redundancy is intractable, social engagement cannot provide a complete solution. Social prescription is merely a tool among others to deal with these issues as well as attendance at the doctor's surgery.

## **Conclusion**

This mixed method study provides a comprehensive picture of the role of the 'New Routes' co-ordinators, the process of the social prescribing service and value to various stakeholders involved. It provides a view of its strong steering group model, with interested and diverse stakeholders driving its development; its desirability and acceptability to stakeholders; its effectiveness in meeting the needs of clients; and its ability to create a bridge between health and third sector organisations. It can have a positive impact on:

1. Mental wellbeing;
2. 'Distance travelled' or improvements made on issues brought to the social prescribing service;
3. Service satisfaction.

By conducting this investigation it has been possible to illustrate the effects of the service to end users. It also illustrates a robust example of collaboration between health, social care and the voluntary sector.

## **Recommendations**

1. Sustained provision of this valued NR service.
2. Maintain strong and diverse steering committee, with a wide range of stakeholders to continue the drive and motivation.
3. To maintain high quality of NR co-ordinators, maintain comprehensive job description and skill specification for new appointments to the role of NRC.
4. Continue the use of outcome measures, particularly during the assessment procedure and at varied time points to measure distance travelled. This ensures effective and accountable practice available to clients and stakeholders.
5. Seek sustainable ways of recording surgery resource utilisation before and after referral.
6. Provide Motivational Interviewing training as an additional skill
7. Standardise the upper threshold of contact time for people finding service engagement difficult to sustain.
8. Use case studies to identify indicators of effective practice and engagement.

9. Continue the enablement of reflective practice, with peer support, clinical supervision and reflection tools such as diaries.
10. Develop a next step support network for clients.
11. Continue partnership working with statutory and third sector organisations, particularly to develop new activities, groups and networks; and monitor the sustainability of these relationships.

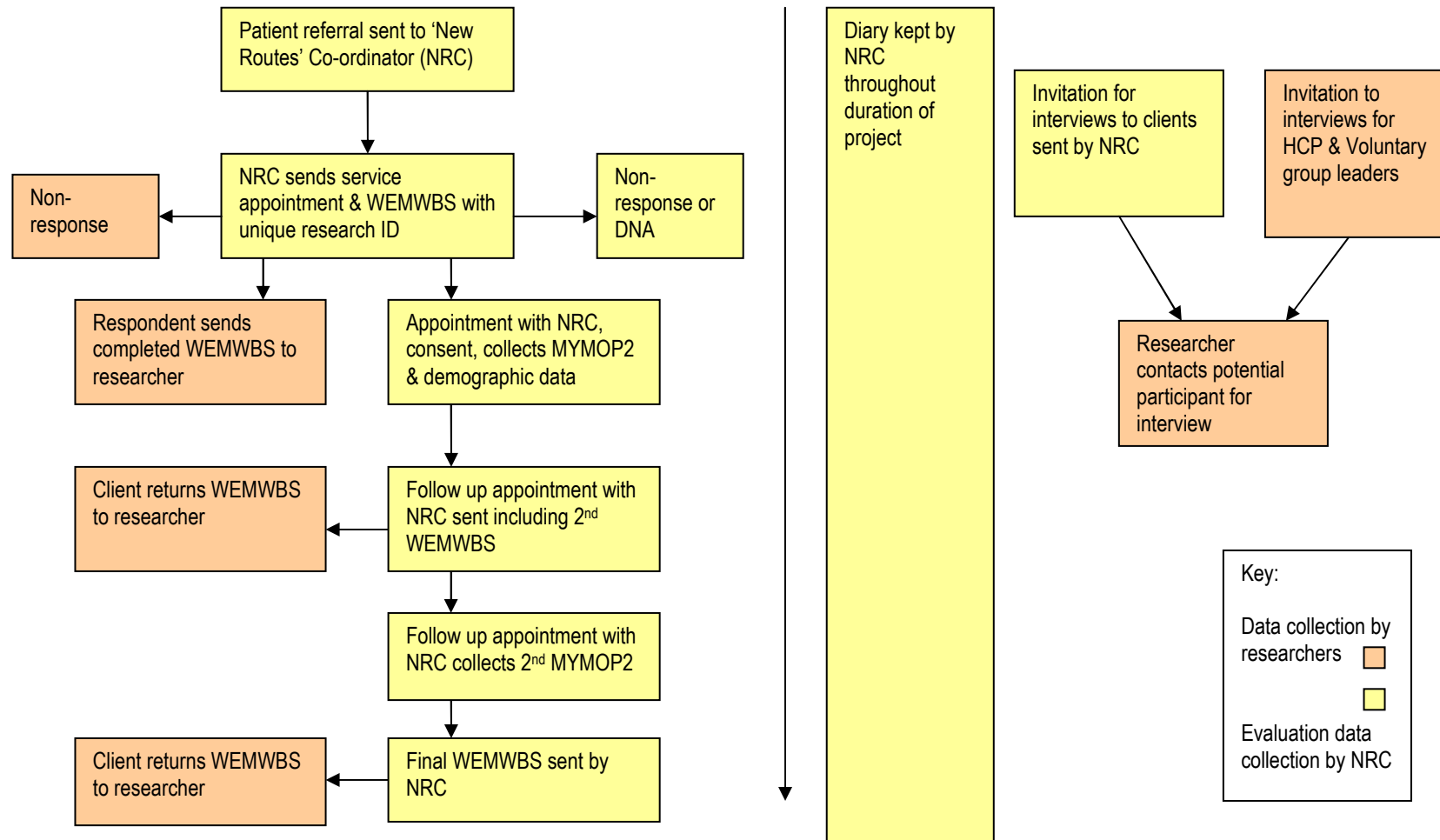
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## Appendix A Data collection strategy



## Appendix B Sample information sheet

### PATIENT INFORMATION SHEET

Title of project: Measuring the impact of referral to a social prescribing facilitator

#### **Are you willing to help us with our research?**

##### **What the research is about**

This is an invitation to take part in a research project to assess the impact of a new service. The service aims to make available more options for helping with your health problems. Many illnesses get better on their own and some can be helped with medicines. But at other times there may be no good treatments or patients and doctors prefer to find solutions other than tablets. Already, doctors suggest looking for help outside the NHS, such as going on an exercise programme or getting support from a charity such as Age Concern. This is called 'social prescribing'. However, it is very difficult for patients and doctors to know all the possible sources of help. A local group made up of B&NES Council, Keynsham GP practices and The Care Forum has decided to tackle this problem by employing two 'social prescribing facilitators' to help patients to find the right opportunities. We need to know how well this works before doing it in other areas. The University of Bath, School for Health has been asked to measure the impact of this new service and this is where we need your help.

##### **What does the research involve?**

The research project is designed to measure changes in your overall health and any benefits (or otherwise) for the particular health problems you are encountering. Another part of the research will also assess any impact on the local health, social care and voluntary services.

If you would like to take part in the research we ask you to firstly complete the short questionnaire included with this mailing. This will provide a picture of how you are now feeling in yourself – your wellbeing. By completing the questionnaire you are not committing yourself to continue with the research – you can change your mind at any time. Please can you complete this *before* your appointment with the social prescribing facilitator.

The prescribing facilitator is not part of the research team but you can ask her questions about the research project. If you have decided to take part in the research, she will give you a consent form to sign. During her work with you, the social prescribing facilitator will be aiming to understand your health problems so she can help you find the right opportunities. By agreeing to take part in the research you will be consenting to the facilitator sharing some of this information with the research team in an anonymised form. This is so that the team can understand what sorts of problems and people the new service can help. No other health records will be shared with the researchers. After meeting the facilitator you will be asked to complete the same short questionnaire again after a few weeks and about six months after meeting the facilitator. A £5 gift token will be offered to cover the inconvenience of completing the full set of three questionnaires.

##### **How confidentiality will be protected**

Your name will be removed from all notes and questionnaires and replaced by a unique research code so your information cannot be linked with you personally. The notes will be kept secure and confidential to the researchers and destroyed after five years.

##### **What happens if you do not wish to take part?**

You are free to take part or not. If you change your mind, you are free to leave the project at any time without giving a reason. You can also ask for all your information to be removed until six months after using the service. If you decide not to take part in the research, your medical care and your use of the social prescribing service will not be affected in any way.

##### **Who is paying for the research and who is responsible for it?**

The costs of the research are being covered by B&NES Council. The lead researcher is Ms Janet Brandling (address below). Any questions or worries about the research project should be directed to her. Overall responsibility for the conduct of the research is with the Avon & Wiltshire Partnership Trust (AWP).

Ms Janet Brandling  
Mental Health Research & Development Unit

Room 3.19, 22/23 Eastwood House  
University of Bath  
Claverton Down  
Bath, BA2 7AY

Telephone: 01225 383654

email: [j.brandling@bath.ac.uk](mailto:j.brandling@bath.ac.uk)

Web:

<http://www.bath.ac.uk/health/mhrdu>

Further general information about research contact INVOLVE:

<http://www.invo.org.uk>

Fax: 02380 652 885

Telephone: 02380 651088

Textphone: 02380 626239

## Appendix C Sample consent form for interview

Consent Form

Participant number: \_\_\_\_\_

**Research project title:**                      **Social prescribing and mental wellbeing**

**Researcher:**

J Brandling  
Researcher  
Mental Health R&D Unit  
3.19 Eastwood House  
University of Bath  
Claverton Down  
Bath, BA2 7AY  
Tel: 01225 383654

Please initial box

1. I confirm that I have read and understood the information sheet dated 21/05/09, version 2.
  
2. I understand that my participation is entirely voluntary and that I am free to withdraw until data is anonymised without my legal rights being affected. I do not have to offer an explanation for my withdrawal.
  
3. I agree to have the interview recorded onto digital recorder and transcribed into text and notes. My identity will be confidential. However if I disclose harmful or unlawful practices the researcher will discuss reporting this to their supervisor/ manager or authorities with me.
  
4. I understand that work containing my contribution to the study may enter the public domain through reports and publications, but my identity will not be exposed.
  
5. I agree to take part in the above study.

\_\_\_\_\_  
Name of participant                      Date                      Signature

\_\_\_\_\_  
Researcher taking consent                      Date                      Signature

Contact address and telephone number for participant:

## Appendix D Sample recruitment letter

MHRDU  
Blackberry Centre  
Blackberry Hill Hospital  
Manor Road  
Fishponds  
Bristol  
BS16 2EW

Dear

I am writing to you because you have been referred to 'New Routes' by your family doctor some time over the past year. The 'New Routes' service in Keynsham is quite new so the people providing this service are trying to understand if it is helpful or not. I am conducting some research to explore how the service works, whether it is valued and how it can be developed in the future.

This letter is an invitation to participate in a research interview to talk about 'New Routes'. It doesn't matter if you did or did not have an appointment with 'New Routes' because we would like to hear why people do not use the service as well as those that do.

Included in this letter is an information sheet explaining the research in more detail and a freepost envelope for your reply. 'New Routes' forwarded this letter to you on my behalf, so I will not contact you again unless you reply to me.

Thank you for taking the time to read this letter.

Yours sincerely

Janet Brandling  
Researcher

## Appendix E Sample Diary completion guidance

### Reflective diary for the 'New Routes' project.

This should be completed as often as possible, perhaps once per working day if this is feasible.

If you have any suggestions for the diary format or need to contact the researcher, Janet Brandling

Email: [J.Brandling@bath.ac.uk](mailto:J.Brandling@bath.ac.uk) Tel: 01225 383654

	Date/ time
Daily Notes	This section might be a general place to download thoughts or notes to come back to later. Reminders of things to reflect upon
Practical issues	This might include barriers such as: time available, finance, people (either organisations or clients), or bureaucracy. Opportunities Recurring issues Numbers of referrals Plans for developing the service
Case studies	Entries here might form a narrative or story with regular entries about a specific case. This could be every case at the beginning but then later be typical cases or unusual cases as you see fit.
Reflective notes	These reflections might be things you just notice, feelings about the job, how the project is working or not, rating the sense of success, what it's like keeping a diary, participating in the research, thoughts for the future , how it is working with each other and other stakeholders.

## **Appendix F Sample discussion guide of diary data with 'New Routes' Co-ordinator**

### Summary discussion with 'New Routes' Co-ordinators 22/02/11

What is the main impact of 'New Routes'?

What is the uptake of your suggestions? Length of contact?

What is your definition of success or lack of success?

Have you monitored engagement?

How do you deal with this?

What is the unique selling point of 'New Routes'? How does this compare with other providers?

Who are your clients, what are the demographics? Has this changed? Are they frequent attenders?

What is the best kind of service you refer to?

What are the barriers to you providing NR service? What are the gaps in services?

What is the future for be-friending?

What are your skills, how would you define them?

Have you changed your practice over the period of the project?

How do you feel about Motivational Interviewing now?

What are the areas of learning, positive and negative?

Has the 'conference' had an impact on this service and in a wider context?

What are the similarities and differences between you?

Who are the essential partners in this project?

How has the relationship with GP's developed? And other people? Intermediate care team?

What works to stimulate referrals? What are the barriers to referrals?

How does the medical model help and hinder your work?

How do you see the future of 'New Routes'?

How has the research been?

How would you change it to provide evidence in the future?

Will you be able to generate case studies?

## Appendix G NRC Job description and person specification



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### **Social Facilitator Social Prescribing Project**

<b>JOB TITLE:</b>	Social Facilitator, Social Prescribing Project
<b>HOURS OF WORK:</b>	<b><i>18.5 hours per week - occasional evening or weekend work may be required.</i></b>
<b>SALARY:</b>	Hay Scale Grade H7 pt 31 - 34, £26,079 - £28,422 pro rata
<b>PLACES OF WORK:</b>	The Vassall Centre, Gill Avenue, Bristol and GP practices in B&NES.
<b>RESPONSIBLE TO:</b>	<b>The Information Services Manager</b>
<b>RESPONSIBLE FOR:</b>	No one

#### **Aims of the Post:**

1. To improve access to, and sustain people's engagement with, services for people referred through GP practices. That includes Voluntary Community and Social Enterprise Sector (VCSES) and statutory sector services.
2. To evaluate the benefits in relation to health and well being of individuals referred to services.
3. To evidence the impact on VCSES groups involved with the project of providing preventative health and well being services.
4. To promote effective working relationships between primary care, VCSES groups, statutory services and service commissioners.

## Main tasks:

### **1. Improved access to services**

- a. To provide an assessment and signposting service to patients referred to the scheme and where necessary support them to access local groups and services, primarily using The Care Forum web-based database of local services 'Room 102'.
- b. To work on a one to one basis with clients accessing the social prescribing service to ensure that each individual client is supported to achieve maximum benefits from the services.
- c. To arrange introductions, referrals and provide support and advice to overcome any potential barriers to accessing services for any client referred through the social facilitation project.
- d. To obtain and maintain information on the range of local services available including identifying any gaps in service that become apparent through the project.
- e. Collect and collate monitoring information and feedback on the project and where appropriate implement improvements to the project.

### **2. To evaluate the benefits in relation to health and well being of individuals referred to VCSES services.**

- a. To work with people referred to the project via regular follow up meetings using a range of established wellbeing evaluation measures.
- b. To monitor and follow up clients referred to social activities to ensure that clients' needs are being met.
- c. To coordinate a reference group of people who have been referred through the project to enable them to hear about project developments and to contribute to the development of the project themselves.

### **3. To evidence the impact on VCSES groups involved with the project of providing preventative health and well being services.**

- a. To work with a range of VCSES providers of social activities in the B&NES area to promote access to services for clients of the project.
  - b. To build relationships with local VCSES groups to develop understanding of the impact on them of providing services.
  - c. To coordinate a reference group of local VCSES groups who services people have been referred to, to enable them to hear about project developments and to contribute to the development of the project themselves.
- 4. To promote effective working relationships between primary care, VCSES groups and service commissioners.**
- a. To co-ordinate, facilitate and support links between primary care and voluntary and community sector projects to increase their capacity to work together.
  - b. To liaise with practice and community nursing staff, attend practice meeting and provide feedback on the scheme.
  - c. To work with members of the project Steering Group including Bath University researchers, GP practices, The Care Forum, local service commissioners from the B&NES Partnership for Health and Wellbeing.
- 4. Other Duties**
- a. To produce monitoring reports as required by the funders, the Social Prescribing and Libraries Partnership and The Care Forum Executive.
  - b. To work within the aims and objectives, key values, anti-discriminatory and equal opportunities framework and other policies of The Care Forum.
  - c. To work within the wider staff team of The Care Forum, attend staff meetings and participate in training opportunities appropriate to the post.
  - d. To carry out such duties, in consultation with the Information Services Manager, as are consistent with the responsibilities of the post.

Successful applicants will be required to complete a CRB (disclosure) application form.



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**Person Specification – Social Facilitator  
Social Prescribing Project**

This person specification outlines the principle experience, skills and knowledge that the post holder will need in order to successfully undertake the work of this post.

		Essential Criteria
<b>Experience</b>	<b>1</b>	At least 3 years experience of working in or with the health and social care voluntary sector
	<b>2</b>	Experience of community development and working with and supporting volunteers
	<b>3</b>	Negotiating and working in partnership with statutory agencies and in a multi-agency setting
	<b>4</b>	Experience of research, carrying out interviews with clients and collating information
	<b>5</b>	Experience of producing briefing papers and information
<b>Skills</b>	<b>6</b>	Excellent IT skills including word processing, E-mail, publisher, spreadsheets and use of databases.
	<b>7</b>	A high level of organisational, planning and prioritisation skills including an ability to work to deadlines, use initiative and keep abreast of new policy developments in the health and social care field.
	<b>8</b>	Excellent interpersonal and communication skills, both written and verbal
	<b>9</b>	Ability to represent the organisation at a high level on a local, sub regional or regional basis
	<b>10</b>	Ability to listen carefully, check understanding and work sensitively with patients.
	<b>11</b>	Ability to cope with clients who at times may be emotional or distressed.
<b>Knowledge</b>	<b>12</b>	Knowledge of central and local government policy towards health and social care services and the role of the voluntary and community sector

	<b>13</b>	Understanding and experience of the support needs of an individual involved in seeking or using primary care services
<b>Equal Opportunities</b>	<b>14</b>	Strong commitment to equal opportunities and non-discriminatory practice
<b>Personal</b>	<b>15</b>	Flexibility to meet the demands of the post – occasional evening and weekend work

**Appendix H. NR Assessment form including MYMOP score**

Date:
-------

ID:
-----

**1. Personal Details**

<b>Name (and preferred name)</b>	
<b>D.O.B</b>	
<b>Address and Postcode</b>	
<b>Phone (and best time to call)</b>	
<b>E Mail</b>	
<b>Transport Requirements</b>	
<b>Language Requirements</b>	

**If you would like to tell us about the following it could help us to find appropriate and tailored services for you.**

<b>Your ethnicity</b>	
<b>Your gender</b>	
<b>Your sexuality</b>	
<b>Your faith/cultural requirements</b>	
<b>Do you consider yourself disabled?</b>	

**What has brought you here today?**

OFFICE USE ONLY: Does client understand the referral?
---



**Other Comments/Reflections**

Appendix I- WEMWBS

# The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

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