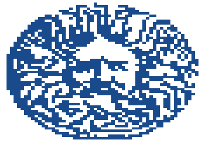

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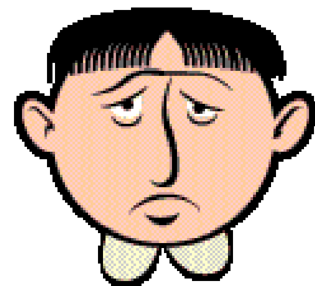
Social Prescribing- New Routes

How did it begin?

Who needs social prescribing?

- High primary care use: Poor social support, poor mental health, family dysfunction (Bellon et al 2008)
- Frequent attenders: Unexplained medical symptoms, psychological difficulties, social problems (Hayward et al 1998)
- Need psychological or practical support, reduce social exclusion (Friedli et al, 2009)



Who can help instead?

- Statutory, voluntary, community and social enterprise sector
  - Volunteering increases happiness, self-esteem and satisfaction (Thoits & Hewitt, 2002, Borgonovi, 2008)
  - Social participation lowers psychological distress (Ellaway & MacIntyre, 2007)
  - Engagement has impact on anxiety, general health & quality of life (Grant et al, 2000)

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Projects in 2008-2009…..

- Feasibility study found multiple projects
  - Signposting- North Staffs
  - Stockport- Arts on Prescription
  - Books on Prescription
  - Green Gyms
  - CHAT- Bradford
  - Bromley
  - Communities on Prescription- Cambridge
  - Social prescribing- Lewisham
- Local RCT project- Amalthea project

Styles of Social Prescribing

- Information only
- Information & telephone line
- Primary care referral to SP service, non-clinical and opportunistic
- Practice based generic referral worker
- Practice based specialist referral worker
- Non-primary care based

Other differences

- Short term, structured advice and guidance, with strong motivational and outcome ethos
- Longer term, individualised and holistic, support relationship

What does social prescribing do?

- Common aim- reduce dependence upon physician and related health services
  - Strengthen psychosocial, life, coping skills
  - Increase social support buffer mechanisms
  - Increase access to statutory and non-statutory resources and services
- Wider goals- regeneration, reduce health inequality, increase wellbeing and quality of life
- Supports other services, IAPT, Village Agents, Health Trainers

Feasibility

- Surgery audit
  - Frequent attenders-
    - N462, 7% 8-11 appointments in 12 months
    - N349, 5% 12+ appointments in 12 months
  - Potential referrals to social prescribing service
    - Surgery 1: N6; Surgery 2: N3; Surgery 3: N10
  - Incidence of mental health diagnosis
    - Ever diagnosed- N1743, 18%
    - Excluding learning disability and psychosis- N844, 9%
    - As above in last 10 years- N395, 4%
  - Patients with 3+ referrals to secondary care in last year-Surgery 1 N168; 1.75%
- Interviews with potential referrers, stakeholders and clients

Common features

Strong indicators:

- Vague/ unexplained symptoms; or diagnoses including IBS, fibromyalgia, recurrent/ chronic pain
- Frequent attendance
- Poor social support mechanisms, loneliness or a carer
- Many symptoms affecting multiple systems
- Psychological difficulties e.g. low self esteem, past history of mental health problems, alcohol/ drug misuse

Medium indicators:

- Somatic preoccupation
- Dissatisfaction with results, referral or discharge from secondary care
- Poor results with mainstream treatments
- Recurrent re-evaluation and revision of prescriptions due to lack of effect or side effects

Weak indicators:

- Several chronic illnesses (2+)
- Repeated visits to A&E or out of hours service (3+ in 12 months)
- Obsessional traits

Recommendations

- Develop strong links with VCSES
- Partnership working
- Up to date listings
- Identify & develop service model
- Handholding
- Flagging system
- Remove focus from frequent attendance
- Evaluation

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Evaluating New Routes

- Quantitative
  - Warwick Edinburgh Mental Wellbeing Scale (Tennant et al 2007)
  - MYMOP (Paterson 1996, 2004)
- Qualitative
  - Interviews
    - Clients, referrers, stakeholders
  - Diaries