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# **Social Prescribing**

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## **A review of the evidence**

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## Social prescribing: a review of the evidence

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	9/7/2015	Sarah Kinsella	Brendan Collins, Caroline Laing, Fiona Johnstone, Beverley Murray Nikki Jones	Added mention of existing local initiatives, removed information about Timebanking

### Report Overview

<b>Abstract</b>	Review of the current literature and evidence of effectiveness of social prescribing interventions (for adults)
<b>Intended or potential audience</b>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Community &amp; voluntary sector organisations, particularly those involved with people with mental health problems</li> <li>Councillors and Constituency Managers</li> <li>CCG and CT colleagues</li> </ul> <p><b>Internal</b></p> <ul style="list-style-type: none"> <li>JSNA Bulletin</li> <li>One Brief</li> <li>DMT (plus other departmental DMTs)</li> <li>Relevant LA Heads of Service</li> </ul>
<b>Links with other topic areas</b>	<ul style="list-style-type: none"> <li>Mental health (particularly anxiety &amp; depression)</li> <li>Other Long Term Conditions</li> <li>Debt/finances/benefits</li> <li>Community development</li> <li>MECC (Making Every Contact Count)</li> <li>Arts/social &amp; cultural activities</li> <li>Continuing adult education</li> <li>Bereavement</li> <li>Community Safety</li> </ul>

## Executive Summary

- Social prescribing is a way of linking primary care patients with psycho-social issues, with sources of appropriate, non-medical support in the community
- Suitable referrals to social prescribing initiatives are vulnerable and at risk groups such as: people with mild to moderate depression and anxiety; low income single parents; recently bereaved older people; people with long term conditions and frequent attendees in primary and secondary care
- Social prescribing has been described as having the potential to improve mental health outcomes, reduce demand on statutory services, improve community wellbeing and resilience and reduce social exclusion
- Prescribed activities run by existing schemes have included arts and creative activities, physical activity, learning and volunteering opportunities and courses, self-care and support with practical issues such as benefits, housing, debt and employment
- The evidence on the impact of social prescribing is currently limited and inconsistent. Some initiatives have shown improved outcomes for patients and potential for cost-savings (in the longer term), but few have been subject to economic analysis or the kind of rigorous evaluation which would inform commissioners
- Accordingly, any new, local social prescribing initiatives should aim to add to the current evidence base and conduct transparent and thorough evaluation (addressing the questions of when, for whom and how well does the scheme work? What impact does it have? What does it cost? Is it cost-effective?)
- Many of the components of social prescribing initiatives have been shown to be effective (outside of the umbrella of social prescribing schemes), and may already be offered by local voluntary, community and third sector groups. It is important to note where these activities or structures already exist, so as not to re-invent existing provision.

***‘A formal means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services and provides a framework for developing alternative responses to meet need.’  
(Brandling & House 2008)***

## **What is social prescribing?**

It is now widely understood that wider social, economic and environmental factors have a significant influence on health and wellbeing (Friedli et al 2007).

Evidence suggests that as little as 20% of health outcomes are attributable to clinical care and the quality of care. Health behaviours account for 30% of influences, whilst the physical environment accounts for around 10%. By far the most important influence on our health and wellbeing however, are socioeconomic factors – 40% of all influence (Kimberlee, 2014).

Social prescribing can help address some of these wider determinants of health by linking patients in primary care with sources of support in the community (York CRD, 2015).

There is no single, agreed, understanding of what constitutes social prescribing and schemes vary enormously. Typically, they provide GPs with a non-medical referral option via the creation of referral pathways to activities provided by local voluntary, community or third sector (VCT) providers. Activities offered are varied and can be anything which helps promote wellbeing and self-care, encourages social inclusion and builds resilience for the community and individuals. Schemes often use facilitators (terminology differs from scheme to scheme, but these can be community health workers, community navigators, health trainers etc...) who use local knowledge to break down some of the barriers to people accessing and making best use of activities that could improve their health and wellbeing.

Schemes enable patients to access health resources and social support outside of the NHS such as opportunities for arts and creativity, physical activity, learning and volunteering, mutual aid, befriending and self-help, as well as support with, for example, benefits, housing, debt, employment, legal advice or parenting (Friedli et al 2007, South et al, 2008). Although they differ, social prescribing interventions tend to share certain key features:

- A direct primary care referral, usually from a GP practice, to VCT provider
- The VCT provider has a remit to provide support locally, underpinned by good knowledge of local services so participants can be linked with appropriate sources of support
- Interventions have been developed and sustained jointly by the primary care provider and the VCT provider
- The VCT provider addresses need in a holistic way (referral to debt, housing assistance)
- Projects seek to improve well-being

Social prescribing is sometimes referred to as 'community referrals' by those who prefer terms with less medical connotations. Social prescribing has been used here as it is more widely-used and avoids confusion with referrals to NHS community services.

### **Why the current interest?**

Current interest in social prescribing is based on its potential benefits in three areas: reducing prevalence of and improving mental health outcomes and therefore demands on health services; improving community wellbeing; and reducing social exclusion. Schemes vary widely but usually have some or all of the following aims:

- Increase public knowledge of positive steps for good mental health e.g. exercise, sensible drinking, eating well, stress management, building and maintaining social networks, talking things over
- Increase social prescribing as first line treatment for symptoms of mild to moderate anxiety and depression and other common mental health problems
- Reduction in inappropriate prescribing of antidepressants for mild to moderate depression, in line with NICE guidelines
- Reduction in demand for health services

The treatment and management of common mental health problems in particular, constitutes a large proportion of the work of primary care, with around 30% of all GP consultations (50% of regular attendances) for some form of psychological problem – mainly anxiety and depression (Brown et al 2004). There is a recognition that a large number of these consultations arise because of social problems – in one study, the most common social problems (which had resulted in psycho-social issues) presented to GPs were financial and debt problems, housing issues, worklessness and loneliness (Popay et al, 2007).

Treatment options for such issues tend to be limited however, often confined to medication (which may not be effective as a first line response for mild to moderate depression and anxiety) and talking treatments (where demand often outstrips supply). Related to this are concerns about potential over-reliance on medication and growing evidence for the benefits of psycho-social interventions in helping recovery (Friedli et al 2007).

Prescriptions for antidepressants increased by 95% in the ten years between 1998 and 2008 (18.4 million to 35.9 million prescriptions) whilst GP consultation rates also surged in recent years. In 1995, patients visited their GP 3.9 times a year on average; this has now increased to 5.5 times per year (Kimberlee, 2014) and the causes are increasingly chronic, complex and social in origin.

Research also indicates that attempting to respond to the often complex social causes of ill-health is a frustrating experience for health professionals, with many feeling that their attempts are not supported at an organisational level (Popay et al 2007). Given that such a considerable amount of primary care time is spent on the consequences of social problems (or medical problems exacerbated by social problems), improving the options for referral could not only save time, it could offer more job satisfaction to health professionals who feel that they are providing 'sticking plasters' for what are essentially, social issues (Popay et al 2007).

*The multiplicity of options is one of the key challenges (for social prescribing). The idea is simple but the reality is complex. How can busy professionals in primary care know what is available? How is it done? You can't write it on an NHS prescription. What is the evidence that it works? Which patients might benefit? Is it yet another unwanted role to be foisted onto GPs, or a welcome path away from the medicalisation of society?*  
**Brandling et al (2009)**

## Who is it suitable for?

Social prescribing has been used for people with mild to moderate mental health problems and there is also a growing interest in social prescribing as a route to reducing social exclusion, both for disadvantaged, isolated and vulnerable populations in general - and for people with severe and enduring mental health problems (Bates, 2002; Gask et al, 2000). Social prescribing is one route to providing psycho-social support for:

- Vulnerable and at risk groups such as, low income single parents, recently bereaved older people, people with chronic physical illness
- People with mild to moderate depression and anxiety
- People with severe and enduring mental health problems
- Frequent attendees in primary and secondary care

It was noted by Davies et al (2014), that the majority of patients may not realise the potential (positive) impact of being prescribed arts engagement or other health promoting activities that promote recovery and wonder what this has to do with the health condition they have attended for. Social prescribing needs to be placed in context and explained in a way that people will relate to, in order that they don't just feel that they are being 'fobbed off'.

## Examples of social prescribing interventions

Whilst there is no widely agreed definition of what activities or interventions constitute community referrals or social prescribing, the current literature suggests the majority of initiatives fall into the broad categories show in **Box 1** (right).

### **Box 1:** Example social prescribing interventions

- **Arts and cultural activities**
- **Physical activity**
- **Healthy eating, cookery, food preparation**
- **Befriending**
- **Learning and educational opportunities**
- **Financial advice and benefits support**
- **One-to-one coaching and support**

## Evidence of effectiveness

The University of York Centre for Reviews & Dissemination concluded in a recent briefing (York CRD, 2015), that overall there was currently little good quality evidence to inform the commissioning of social prescribing.

They go on to say that despite there being a large number of publications and reports available which detail how various social prescribing programmes and pilot projects work and have been implemented, many, "fail to provide sufficient detail to judge either success or value for money". Cost effectiveness information is also lacking (CRD, 2015).

One example of a scheme which *did* carry out economic analysis however, was Rotherhams Social Prescribing initiative (piloted 2012-14 and since funded for a further year). The initiative used patient-level Hospital Episode Statistics (HES) provided by their local CSU (Commissioning Support Unit), to analyse patients' use of hospital resources, including unplanned care. A total of 559 patients of the total 1,500 patients who participated in the pilot phase of the initiative were followed up (only those for whom either 6 or 12 months of post-referral data was available were followed up) and findings showed:

- Reduction in A&E attendances of 20% in the 12 month cohort and 12% in the six month cohort. For those patients who had been referred onto voluntary/ community activities specifically funded by the initiative (as opposed to existing voluntary or community activities), the reductions were even greater: 24% in the 12 month cohort and 16% in the six month cohort
- Reduction in outpatient appointments of 21% in the 12 month cohort and 15% in the six month cohort. For patients referred onto funded voluntary/ community services, the reductions were greater in the 12 month cohort (29%) but less in the six month cohort (4%)
- Reduction in Inpatient admissions of 21% in the 12 month cohort and 14% in the six month cohort. For patients referred onto a funded voluntary/ community activity, the reductions were 25% and 22% in the twelve and six month cohorts

Analysis of an additional cohort of patients (n=280) whose well-being measures had been followed-up after 3-4 months found 83% had experienced positive change in at least one outcome area (e.g feeling positive, managing symptoms etc...).

The scheme was set up at an initial cost of £1m and economic analysis estimated that the costs of delivering the service for a year would be recouped after 18 to 24 months (which is consistent with other research indicating schemes need to run for at least this length of time for benefits to accumulate). Different scenarios were examined (e.g with different levels of patient drop-out) and findings indicated that after 18-14 months, the potential cost savings could be anything between £1.41 for every £1 invested, to £3.38 for every £1 invested (Sheffield Hallam University, 2014). Researchers were at pains to point out however, that the sample (currently) was insufficient to be able to calculate statistical significance.

A recent report on Social Prescribing in Bristol carrying out a different form of economic evaluation, one which attempts to quantify the social value of interventions (SROI or Social Return on Investment), reported an SROI ratio of £2.90: £1, meaning that for every £1 of investment, researchers estimated that the intervention resulted in the creation of £2.90 of social value (Kimberlee et al, 2014).

Overall, schemes which have been subject to any kind of economic evaluation were rare as York CRD point out – and results are not consistent. For example, one RCT from 2000 assessing the cost-effectiveness of social prescribing concluded that participants appeared less depressed and anxious, but their care was more costly compared with routine care and their contact with primary care was not reduced (Grant et al, 2000).

Overall, it is difficult to say with any clarity whether social prescribing as a mechanism is either effective (whether it works to reduce psycho-social distress) or cost-effective (does it pay for itself or even better, does it save money by reducing primary care attendances for example).

Few studies located for this review carried out comprehensive evaluation. Many stated that they used WEMWBS pre and post intervention, but then failed to show WEMWBS results. Some said they used WEMWBS, but then amended it, which means they used a non-validated tool (WEMWBS is only validated if used in its original format). No evaluation located by this report used any form of control group to compare their findings against (meaning bias cannot be discounted). Many did not actually state what the intervention(s) or activities were and/or didn't state how they collected their information. Many of what were called evaluations on the topic of social prescribing were actually progress reports and did not contain evaluative information at all. Many of the reports also refer to the same or similar studies/interventions. This is an important point, because it can give the illusion that there are many, effective initiatives, supported by a large body of literature, when in reality, few schemes are supported by robust research evidence, but those that are, are widely publicised.

Bungay et al (2010), points out that often, qualitative methodologies are used to evaluate social prescribing initiatives, which is appropriate, as they capture the experience of participants. Qualitative methodologies do not however, quantify health gain or lend themselves to economic analysis, which is increasingly required by commissioners to justify investment in social prescribing.

All that being said, there was some evidence for the activity components common to many social prescribing schemes (not necessarily cost-effectiveness evidence), some qualitative, and this is detailed below.

### **Individual components of social prescribing initiatives**

The National Institute for Health and Clinical Excellence (NICE), has released guidelines on the management of anxiety and depression which do include approaches that potentially fall under the social prescribing umbrella, for example, exercise-referral, self-help, CBT (cognitive behavioural therapy) based approaches including computer-assisted CBT, bibliotherapy and social support. The NICE guidelines do not include referral guidelines (NICE 2006b), but as NICE have specific thresholds for effectiveness and cost-effectiveness, it can be safely assumed that the activities listed are supported by good quality evidence.

Timebanking was originally included in this briefing, as many of the stated aims (building community resilience, self-efficacy etc...) are shared with social prescribing, but ultimately, it was felt to be outside of the remit of this review (but may possibly be reviewed as a separate topic at a later date).

## **Arts & Cultural Activities**

Reviews of arts on prescription interventions found evidence that active involvement in creative activities can promote well-being, quality of life and health (York CRD, 2015). Other qualitative studies reviewed found enhanced social skills and community integration, increased self-esteem and empowerment, provided a sense of purpose and contributed to people's ability to relate to – and work with – others (Bungay et al, 2010).

## **Exercise Referral**

A good quality review of referral for exercise schemes (8 schemes included, all in the UK) for predominantly older patients (aged 51-74), found that although there were no significant differences in fitness or physical activity levels at follow up, two schemes did report significant reductions in depression (York CRD, 2015). This is an interesting finding, indicating that exercise referral schemes potentially have more impact on mental health than promoting physical activity. Also interesting, is that a UK based social prescribing initiative in Bristol found that improving mental health resulted in greater levels of physical activity (Kimberlee 2014).

## **Befriending**

The same LSE report found befriending had a modest but significant effect on depressive symptoms (at least in the short term), but evidence suggested that group interventions may be more successful than one-to-one interventions in alleviating social isolation and loneliness and befriending was found *not* to be cost saving, at least in the short term (LSE, 2010).

## **Community navigators**

Community navigators are volunteers from the community who have been trained in reaching out to vulnerable groups, providing them with emotional, practical and social support, skills and help to access appropriate services. They are also a crucial part of many social prescribing initiatives. LSE considered the costs of supporting somebody through a community navigator scheme (against potential benefits) and concluded that there was economic benefit (as well as quality of life benefit to the individual) of such schemes amounting to approximately £900 per person in the first year (LSE, 2010).

Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year (PHE, 2015).

*“We know that the evidence for some medicines is good, but that evidence has been generated as the result of millions and millions of pounds of investment by the drug companies. Unfortunately there is nobody who is investing in generating the evidence for our model in the same way. We do know that there is emerging evidence from good practice around the country but it's not a level playing field.”*

**Guy Pilkington, Chair of Newcastle West Clinical Commissioning Group  
(People Powered Health)**

## **Making the case for social prescribing**

As with many interventions - particularly those which are preventative and work on the very widest determinants of health - absence of evidence to show positive impact does not necessarily mean that interventions are ineffective or do not work. It could be that if more robust evaluations were carried out, a more solid evidence base on which to make decisions may emerge.

Consequently, monitoring the outcomes from any local social prescribing interventions, or existing interventions which already provide activities often included in many Social Prescribing schemes (e.g the local Health Action Areas programme) is extremely important.

It has been suggested that improved outcomes may be captured via the General Health Questionnaire (GHQ) Social Functioning (SF) or Patient Health Questionnaire (PHQ) scores, the ONS4 personal wellbeing questions, the Lubben Social Network Scale (LSNS) or the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Other short and medium-term outcomes which matter to patients and could also provide a basis for assessing whether social prescribing has made a difference might include:

- Increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at risk groups
- Increased levels of social contact and social support among marginalised and isolated groups
- Enhanced quality of life and wellbeing, confidence and feelings of control over their own health
- Reduced levels of inappropriate prescribing and reliance on medication for mild to moderate depression
- Reduced waiting lists for counsellors or psychological services

## ***The challenges***

The below list (not exhaustive) outlines some of the common challenges identified by schemes identified for this review:

- Schemes rely heavily on the ability to share data. This is currently more problematic than it has ever been in the field of Health and Social care
- Successful programmes will need a system in place to make the referral process as straightforward as possible, including procedures within practices and clinics that systematically prompt a social prescription for patients who meet the criteria. Crucially, these systems should not rely on clinicians having a detailed knowledge of all the alternative provision in the local community
- Brandling (2009) makes that point that the NHS - with its near constant re-organising - is hard enough for primary care professionals to keep up with, whilst community groups and initiatives come and go even faster than statutory ones. Also, patients given information about services will not necessarily take them up without encouragement (hence the role of facilitators being necessary – which also help with the challenge mentioned in the previous bullet point)
- Increasing the number of referrals from primary care to voluntary/ community-based activities may place pressure on voluntary organisations, who might not be able to respond to increased demand

- Joint ownership of social prescribing programmes across health, social care and the third sector is important, but often difficult because of cultural differences between these sectors
- The benefits of social prescribing may take around 18 months to 2 years to accumulate. Evaluation of the Expert Patient Programme (EPP) for example, showed that in the short-term, EPP patients did not consult less, but they did show improvement on quality-of-life measures, increased energy and self-efficacy. Habits of seeking help from the NHS do not change quickly. It is not surprising therefore, that cost-effectiveness studies over the short-to medium term do not show NHS savings (Brandling et al 2009) and commissioners should be prepared for this
- Few schemes are thoroughly and rigorously evaluated – which is a huge missed opportunity. Any local pilot should only be approved on the basis that it systematically collects the kind of quantitative and qualitative outcomes listed in the previous section in order to inform commissioners

*“We have seen how hard it is to engage some people, and how much patience and time some people need. In health we are often quick to judge, slow to listen, and feel too busy to care in the way we would want. Having a local social prescribing project as a partner in our striving to deliver good care for our registered population is like having an extra pair of arms. The team are amazing in their resourcefulness and we are very much richer for the work they are doing”*  
**(GP referring to their local social prescribing project, Kimberlee, 2014)**

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