



Public Health
England



AHP as social prescriber

When should I take on the role of social prescriber?

AHPs are likely to undertake social prescribing themselves when they are already providing long-term intensive support to a person as part of their job role. AHP social prescribing is for individuals needing specialist assessment and intervention outside the competency of a link worker or when the social prescribing forms a natural part of the individuals therapy.

Social prescribing is much more time intensive than active signposting, and carrying out social prescribing yourself will be more time intensive than referring to a link worker.

It will involve supporting people of all ages to work out which local groups and services would be beneficial to them and helping them to access them in a variety of ways. You may need to work through multiple options with a client and accompany them on first visits.

Some AHPs are likely to do more social prescribing themselves than others because of the nature of their role. Occupational Therapists, Physiotherapists and Speech and Language Therapists for example, are more likely to carry out social prescribing activities than Diagnostic Radiographers who are likely to have short, one off interactions with clients.

The following case studies highlight some of the ways that different AHPs have taken on the role of social prescriber:

Ben Read, Occupational Therapist, Community Mental Health Team



I am an Occupational Therapist, who works in a community mental health team as a care-coordinator. This involves providing treatment to patients with a variety of mental health conditions as well as arranging and coordinating care from other related professionals, such as Psychologists, Psychiatrists etc. I am also trained in and provide cognitive behavioural therapy for my service.

I worked with a young male patient, who was referred following a serious suicide attempt. He had low self-esteem due to having an abusive parent, which had resulted in him developing anxiety, particularly in social situations. He had developed co-morbid depression alongside this. He was socially isolated and lacked any meaningful occupation when I met him other than a job he did not enjoy.

In the course of our work we agreed that it would benefit him to

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engage in an activity he enjoyed, as he lacked pleasurable experiences, and something that helped him overcome his anxiety. He enjoyed exercise and there was a popular local running club that we agreed would meet his needs. It was free, so there was no cost barrier, and met several times a week, including evenings and weekends so was something he could do regularly. There were also different subgroups running at different levels to meet different people's needs, which meant it was easier to start but also allowed progression and a sense of achievement.

The barrier to engaging was his anxiety, which we worked on and once he had attended the first session he flourished in this environment. The club had an active social program too, which he engaged in and helped further with his anxiety in different settings. He was discharged after engaging in the club for a few months and has not been re-referred.

Chloe Baker, Speech And Language Therapist, Learning Disability Team and Autism Diagnostic Team for Adults



I work as a Speech and Language Therapist for the Swindon learning disability team and autism diagnostic team for adults. I also support the autism diagnostic team with assessments and

post-diagnostic signposting to services.

Our team has recently started a social prescribing project which I co-run. As part of this we have developed a directory of local services that we think may support our clients following a diagnosis. Following a comprehensive ASD assessment we offer clients the opportunity to liaise with ourselves to access these wider services. We discuss with our clients what their needs are and then recommend and signpost them to a range of organisations and local groups which meet their wider social and leisure needs.

The groups we refer to range from education (adult learning courses), mental health support services, carers and advocacy groups, volunteering, leisure and hobby activities and more! We are continuously updating and refining the directory.

We also support clients to access these services for the first meeting if they think this is something that would be beneficial. We find that this increases take-up as often our clients lack confidence.

For more information, please **contact Chloe.**

**Claire Bampton, Art Therapist,
Community Learning Disabilities Team**



I work as an art therapist in North East Hampshire and part of Surrey and am a member of multi-disciplinary community adult learning disability and mental health teams; I take referrals from other professionals within these services. I am referred people who either have a diagnosis of psychosis (for whom art therapy is in the NICE guidelines) or other diagnoses but whom for some reason struggle to engage in other therapies or treatments.

I recently worked with a white British male in his mid-40's and used social prescribing within the therapy sessions as part of his discharge planning. He lived alone in social housing in an urban area outside London, had struggled with poor mental health for most of his adult life and had in the past managed this by using alcohol and drugs. He suffered early childhood trauma and has one child with whom he does not live but whom he sees regularly.

He was not working at the time of the treatment although he had worked in the past and planned to do so again, he was experiencing anxiety and low confidence, closely connected to

shame about his past and about his mental health and finds it hard to talk to people.

Towards the last five or so sessions of therapy, we began to write a discharge plan together, we talked in detail about local and national support organisations and we agreed some which might be useful. I then looked some of them up and printed information for him to take home and read, we also discussed and agreed what he felt able to read or take away on each occasion so he would not feel overwhelmed.

I phoned up some of the organisations to find out what kinds of questions he could be asked if he decide to contact them himself. We discussed in the therapy sessions what the process of getting support could look like using the information I had from the phone calls – we did a lot of ‘talking about talking’ with the aim of making the process of asking for help less strange.

He did make contact with a couple of organisations during the last few sessions of therapy and within the sessions we were able to talk about these experiences. We also discussed who might support him to use the organisations if he was feeling unwell or vulnerable, or what he might be able to do instead that would be helpful. We were able to place the social prescribing support within a broader landscape of options that he might feel more or less able to connect with at any one time, depending on his understanding of his needs once he had been discharged.

It is my opinion that the overall value of the therapy was enhanced by the process of embedding discussions and ideas connected to specific issues for this man, which we could then link to support which was based outside statutory services. The activity of ‘social prescribing’ became part of the therapeutic dialogue which connected the work in sessions to daily life. Accessible, up to date and locally relevant information which

supports social prescribing opportunities is crucial to being able to provide this part of services within healthcare settings. Local information hubs which help connect people to information networks and public libraries are valuable for this, as well as national and local support organisations.

Claire Doran, Community Occupational Therapist



I work as a Community Occupational Therapist at the Sheffield Teaching Hospitals NHS Trust and the role is very broad. We receive referrals from hospital therapists to support patients who have been discharged home. We see people who have been referral via the GP or district nurses to prevent hospital admissions.

We provide interventions to support patients to regain independence with activities of daily living, we are able to assess for specialist equipment, and we also assess and support people with mental health conditions, such as anxiety, depression and poor memory.

Sarah was referred to Occupational Therapy via her GP for a shower assessment and provision of equipment to support her activities of daily living. As part of our initial assessment, a

cognitive screen was completed which indicated Sarah was low in mood and anxious about leaving her property.

Over a number of weeks, Sarah was supported to engage in activities to build her confidence, improve her mood and reduce her social isolation. She was referred to third sector organisations who were able to provide information on local groups; this included a cookery class, a women's support group and physical activity.

**Claire Frost, Specialist Occupational Therapist,
Community Learning Disability Team**

Leanne is a 23 year old lady with a mild – moderate learning disability and no physical disabilities. She suffers with depression and anxiety. Leanne lives in 24 hour supported accommodation where she has her own flat and is at risk of social isolation – her main source of contact with others is via the staff support she receives and online.

Following OT assessment and intervention around ADLs, Leanne identified that she would like to join a drama group. I researched what was available locally and found a group who are welcoming of people with additional support needs. I liaised with Leanne and the group to ensure that all of her support needs would be met whilst attending the group and any risk assessments were completed.

Leanne has thrived at this group. She travels independently to and from the session, she is managing her anxiety well and is learning how to develop new skills around performance which she can also transfer to real life scenarios. Leanne is no longer at high risk of social isolation; her support hours have reduced and she is looking for other opportunities to get involved in her

local community.

A second example is Sally, a 32 year old lady with severe learning disability and autism. She lives at home with her family and attends day service a few times during the week. Sally has various sensory processing problems and these can cause her to carry out unhealthy behaviour whilst seeking the sensory feedback that she requires.

The way Sally processes sensory information means that she often cannot get appropriate tactile and vestibular sensory response by simply touching her environment. Sally will seek this sensory feedback by spinning herself around very fast and then throwing herself to the floor landing very heavy on her knees. Sally would do this behaviour numerous times throughout the day causing concern about the health of her knee joints.

During joint working with Physiotherapy it was identified that a softer landing would be more appropriate for Sally. She would continue to seek the sensory feedback by spinning and landing but it is possible this could be done in a more constructive and safe way. Plans were made to take Sally to a local trampoline centre where she could try the equipment when there were no other people around. Sally was able to jump and spin and land without the risk of injuring her knees. Risk assessments were done jointly between OT, Physiotherapist and the trampoline centre. Sally was also taken to an outdoor park where she was able to use the swings.

Sally has reduced the amount of spinning and landing when she is at home or at day service. She now accesses the trampoline centre with her family 2-3 times per week when it is quiet and the staff there know her. She also has a small trampette which she uses at the day service. The risk to damage to her knees has reduced and Sally is able to get the

sensory feedback that her brain requires.

Kelly Holehouse, Physiotherapist, MSK Conditions

‘Healthy Mind, Healthy Body’ is a cost effective intervention aimed at addressing the co-existing public health issues associated with MSK conditions. This unique initiative is an example of a collaborative service redesign that empowers, supports and informs the MSK population to manage their own overall health and wellbeing in line with Public Health England priorities.

Blackburn’s population is one of the 20% most deprived in England; the patients accessing physiotherapy demonstrate low levels of physical activity, biopsychosocial issues, multiple physical problems and co morbidities (Draft Pennine Plan, 2017. Public Health England Fingertips, 2018).

In order to better manage the wider aspects of health witnessed in an MSK setting, a monthly multi-disciplinary, advice and sign posting session was devised to facilitate uptake and streamline the transitional process into with the local Wellbeing service and Mindsmatter (community based physical and mental wellbeing services). Each Physiotherapy-led session lasted 90 minutes and consisted of an overview of available support. A patient representative provided a detailed narrative of their own experience of these local services. The session could be accessed at any stage of the patient’s physiotherapy journey allowing it to be fluid and flexible to meet patients changing needs.

This project reconfigured the utilisation of existing resources so no additional funding was required in this service redesign, providing excellent value for money and sustainability. Ongoing patient engagement via feedback questionnaires throughout the project has ensured constant service re-evaluation. Initial

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results from completed patient feedback questionnaires show 100% intent to make lifestyle changes following attendance at the session. Whilst proving financial benefit is notoriously difficult to measure in the short term with public health interventions the results would suggest positive impact.

After attending the session:

- 91% of patients opted into one or both of the additional management options.
- 82% self-referred to the Wellbeing service, (56% of this cohort actually attended)
- 32% self-referred to Mindsmatter, (81% of this cohort actually attended)

Qualitative patient feedback showed:

- 91% found the session useful
- 100% intended to make lifestyle changes

Key themes were the:

- Motivational power of patient representative insight
- Link between mental and physical wellbeing
- Awareness of management options within the area

This signifies the relevance and appropriateness of the services in addressing an unmet need.

For more information, please **contact Kelly.**

**Kieran Potts, Paramedic, North West Ambulance Service
NHS Trust**



An individual was identified as a frequent caller of 999 services as part of the frequent caller reporting systems within North West Ambulance Service NHS Trust.

Interventions began in June 2018 with the creation and implementation of a Community Care Pathway in agreement with the individual. This occurred following a visit from the Community Specialist Paramedic. Support for this CCP was provided by the Community Matrons and General Practitioner. In July 2018 it was identified that this individual was also contacting 111 services and GP services frequently - it was discussed with the individual and decided that NWAS would look to provide information to our contact centres to arrange a 'warm transfer'. This would result in transfer of this individual's calls to a clinician if they were triaged as not immediately life-threatening (Cat1). This was organised through collaboration between the Community Specialist Paramedic and also the NWAS Frequent Caller Team.

In August 2018 it was discussed with the individual regarding social support regarding their health and wellbeing. The individual consented to referral for 'Social Prescribing' -

resulting in attendance at luncheon clubs once weekly. A review of the individuals medication was requested by the visiting Community Specialist Paramedic.

In September 2018, the individual was seen to be regularly attending the luncheon clubs - one of which was jointly attended by the Community Matron's and the Community Specialist Paramedic, to provide support to the individual. Throughout October and November 2018, it has been noted that a great reduction has been seen in the individual's 999 contact. Ongoing support continues to be offered to the individual and appears to be greatly appreciated and accepted. The data shows a spike in 999 calls during May/June 2018 - following the interventions noted above, the data shows a great reduction in 999 calls, attendances at scene, and also hospital admissions.

Kirsty Basnett, Speech And Language Therapist, Young People and the Care System



I am a Speech and Language Therapist working in No Wrong Door in North Yorkshire. No Wrong Door is a new way of providing support to young people who are within or on the edge of the care system. We have two hubs and each is supported by speech and language therapists.

Sarah is a teenager who is in specialist foster care. She had high risk behaviour including self-harm and suicidal thoughts. I had known Sarah for several months and knew she had real difficulty finding calm within herself – physically as well as emotionally.

I had been supporting her tuning and recognising the physical manifestations of emotions/feelings as they arose. I had also been trying to encourage her foster carers to support her through guided relaxation together (imagining yourself walking along a beach), but they struggled to engage with this.

Her placement hit a crisis and the foster carers gave 28 days' notice as they felt they could no longer manage her high risk behaviour including self-harm and suicidal threats. Reduced timetable at school was also not going well.

After having a chat with Sarah about her interests as well as her difficulties (which included sitting still and tuning in) I decided it would be more helpful for her to tune into her body while it was in gentle movement rather than still. I recommended swimming. Her foster carers were very unsure as she could not swim and she might be very conscious of self-harm scars on her arms. However she was very willing and I accompanied her for the first session. The first time she swam one length. I have also accompanied Sarah for three more swimming sessions together.

Thanks to an intensive support package from No Wrong Door, and my input, the foster carers retracted their 28 days' notice. Her foster carers have now enrolled her in a local swimming class that she is really enjoying. She aspires to work for the RSPCA which means that she has to be able to swim so this is supporting her in her future aspirations too.

For more information, please **contact Kirsty.**

Linda Briggs, Occupational Therapist, NHS Community Team

I am an Occupational Therapist working in an NHS community team. We deal with long-term conditions, acute admission prevention, hospital discharge and at present a very large proportion of posture management.

I worked with a gentleman last year who had a diagnosis of Guillan Barre and self-discharged from hospital. He was in his 40s. Prior to his illness he had been working himself into the ground as a security guard, which he attributes to being due to bereavement of a family member. He lived with a supportive partner and teenage son. He was discharged home – with no equipment other than an inappropriate wheelchair.

Occupational Therapy in our team was involved in respect of home adaptations (mainly bathing and ADL equipment), prescription of wheelchair and also upper limb sensory work. Physiotherapy was also involved with clinic appointments. He continued to improve at home functionally. However the over whelming problem for him was inevitably fatigue. I tried some fatigue diary work, and pacing. However this gentleman had a background of depression and anxiety prior to the onset of his illness and was very reticent to engage or accept his limitations. In our team we do not have capacity to offer specialist rehab.

We had recently had some training from Headway, and following discussion with them, and consent from the patient I was able to make a referral to them even though they were a little reticent due to the problem not being a head injury per se. They were going to support him into a group to deal with getting back to work and social activities which was his main goal, and look at the fatigue management. The charity took the lead from

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then on and the case was closed to us.

For more information, please [contact Linda](#).

Vicky Lack, Speech And Language Therapist, Outpatient Cognitive Rehabilitation Service



I am a Speech and Language Therapist working in an outpatient cognitive rehabilitation service. We are a psychology-led service, working in an interdisciplinary team. Our patient had a head injury three years ago, which had resulted in a very limited social life with little interaction with others because of his behaviour. He presented with cognitive-communication disorder, characterised by tangentiality, repetition, disinhibition (verbally & racially abusive), aggression, perseveration and reduced listener awareness. He was referred by his wife, who was struggling with his behaviour towards the family and his carers.

Our initial approach was around raising insight with reflection and experiential learning. However, although we did raise his insight in several areas (e.g. why he could not drive), it did not change his behaviour. He had 30 outbursts of anger in three months.

Our team found daily activities based on his values (responsible, faithful, trusted, respected, have health and wellbeing) and set up his week accordingly. Even though he was not always able to demonstrate his values, he still held them firmly. He said 'worth means having responsibility in life, that things you are doing in life are helpful':

- Monday and Friday – gym (health and wellbeing) 'to keep me fit and strong'
- Tuesday – volunteer at a garden charity (responsible, respected) 'helpful to others'
- Wednesday – visit museum in London (respected, trusted) 'I could take my family'
- Thursday – shopping and jobs for my wife and family (trusted) 'very helpful for my family'

This project took us six months to achieve and was challenging at times, due to his behaviour. Everyone in the team had to follow scripted language around his values e.g. 'would you help me by going to the shop, as I know I can trust you to get the right things?'. This felt unnatural, but helped remind him why we were prescribing these activities.

Each of the activities were carried out with diminishing support e.g. discussion and exploration, then planning the visit, then attending with him, then distant shadowing of the carer, then the patient and the carer attended the activity and reported back (by photographing the activity).

For more information, please [email Vicky](#).

Occupational Therapy-led Ways to Wellbeing Project, York

This occupational therapy led Ways to Wellbeing service has been running in York for 18 months offering a service to nine

GP practices across the city. The Occupational Therapist has a physical presence in five GP practices with particular pockets of deprivation. Referrals come from GP via System One to enable people to access support with:

- Emotional wellbeing
- Social networks
- Groups
- Volunteering
- Career support
- Peer dementia support

The service is not focussed on those in crisis but a preventative service aimed at people who frequently visit the GP. The Occupational Therapist uses a guided conversation approach to address people's needs in the 'here and now'. People are usually seen only once but up to six times in certain cases depending on their needs.

People referred to the team include: older isolated people and people with lower level mental health needs currently or in the past. As a result of the occupational therapy led intervention there has been a 30% reduction in GP appointments for these population groups. The occupational therapist has also recruited volunteers to support the service.

How do I start?

When talking to a person you may become aware that they have wider needs affecting their health and wellbeing (e.g. social isolation). Have a **'What matters to you?'** conversation to ascertain whether active signposting or social prescribing might help support them to meet these needs.

This **PHE blog** on brief advice, motivational interviewing and health coaching provides some ideas about starting conversations about health and contains links to training and other resources that might be helpful.



What services and groups are available in my local area?

It is likely that you are already linking with local services and have many connections already. However, if you are looking for additional services, here are some ideas:

- Talk to your AHP colleagues
- This [blog from PHE](#) highlights the types of local services and how to find them
- Investigate whether your area has a local directory or community asset map. This is likely to be held by your local council and/or voluntary, community and social enterprise (VCSE) councils
- Your local primary care network - contact your local GP surgery for more information about your network
- Talk to colleagues, in particular local link workers in your primary care network
- Some national organisations may have groups or services in your area: consider [Age UK](#), [Men in Sheds](#), [Mind](#), [Green Gyms](#), [Citizens Advice](#), [StreetGames](#)
- Consider services and groups for children and families that might be offered by local children's centres, leisure centres, local libraries, youth clubs and voluntary

organisations such as Scouts and Guides. Each local council will have a Local Offer website providing information about local provisions and opportunities available to all children including those with additional needs.

- Consider online or telephone services, such as **Step Change** for debt advice or **GamCare** for gambling support
- Consider local faith organisations and groups who work in the community
- As part of the NHS England online learning platform, there is a Social Prescribing Connector Schemes Database which contains some information about local groups. To join the platform, please **contact them**