Social prescribing

The latest hot topic is Social Prescribing but what is it and how should it function? Social prescribing in primary care involves health professionals referring patients to non-clinical forms of intervention, with the intention of enhancing the patient's health and wellbeing (Polley et al 2017). You may question whether community nurses have been referring and introducing their patients to community groups already, so is this really innovative or are general practitioners just realising the benefits of these type of referrals? Is it just the formalising of 'social prescribing' by giving permission to healthcare professionals by whom to refer their patients to groups within their communities that is new?

Social Prescribing is based on the assumption that not all patients' needs require treatment with drugs or other medical interventions but there is recognition that a patient would benefit if their social, emotional and practical needs were met. Therefore if social prescription is practiced well, not only will the individual benefit, it is assumed costs within national health systems will be reduced. For example, costs may be avoided if mental health patients avoid the use of anti-depressant drugs or engagement with psychotherapists (Morton et al 2014). Such referrals may even improve the health and wellbeing of the primary care team members by freeing up their capacity to see more patients that may benefit from medical interventions.

A case in point is illustrated through the use of the 'green prescription' as a socially prescribed intervention for a range of population groups. These nature-based approaches include innovative person centred interventions such as 'ecotherapy' or 'therapeutic horticulture' (TH) to influence an individuals recovery (Howarth et al., 2016). Typically, individuals can be supported in activities ranging from sowing seeds to creating raised beds for growing vegetables. 'Green prescriptions' form part of a growing Nature, Health and Wellbeing sector which involves national organizations such as the RHS, Green Gym, Social Farms & Gardens and Thrive as some of the key leads within the recently formed' Green Care Coalition'. Supported by research (Howarth et al 2018), the Nature, Health & Wellbeing Sector actively promote therapeutic horticulture as a socially prescribed intervention for people with mild to moderate mental health problems as a way to reduce social isolation, improve wellbeing and reduce the stigma associated with mental health. Interest in the impact of nature on health and wellbeing is echoed outside of the traditional health and social care environment; with DEFRA supporting the introduction of social prescribing in its 25 year plan (2018) as a way to influence children and young people to access and use green spaces to improve wellbeing. Equally, the aforementioned national organizations have also been working to develop Green Care initiatives through working with communities to promote asset based approaches that

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promote wellbeing and support community resilience. These nature based opportunities signal a unique approach to personalization that embeds salutogenic approaches within a social prescribing framework. The use of community assets and natural approaches has resulted in a steady increase in the number of third sector organizations providing nature based interventions as part of a social prescription. However, the sustainability of social prescribing is challenging , as many providers herald from the third sector…..

However, there will inevitably be costs to voluntary, community and social enterprise sectors supporting patients within communities, so will there be extra financial support for this sector? Schemes have been funded in the past through local commissioning groups, local authority funding, public health funds, grants and trust funds (Polley et al 2017. There has recently finances assigned to various projects across England through the Health and Wellbeing fund 2018 (Gov UK).

The four countries of the United Kingdom (UK) are not the only countries interested in the development of social prescribing. Recently I ran a workshop to develop research priorities for rural family doctors in Crete and the number one priority as agreed by members of 16 countries was 'Socialising for health prevention'. There has in fact been a long history within the World Health Organisation (European Office WHO) to try to address social inequalities in health (WHO), realising that whilst there is a diversity of populations across Europe there are commonalities in the causes of ill health. However, current systems do not function for a healthy society, but as they are socially produced they can be modified to create change. Therefore there is a need to take into account that the current system is unfair and therefore creates inequalities as not everybody can access facilities including information. Consequently, there is a need not to underestimate the importance of social factors and their benefit on health (Haslam et al 2017). Through engaging with the social factors that impact on health and wellbeing, we can work together across boundaries to address this global issue.

Social prescribing presents in different formats in the United Kingdom (UK) and elsewhere in Europe taking into account cultural difference and health systems. These present in different models of social prescription resulting in a diversity of approaches. This complexity was described by Kimberlee (2015) who identified four key models of social prescribing as: 'sign posting' – where an individual is literally directed to a suitable service; 'lite', which many readers may have read about – such as 'weight watchers' on prescription for tacking obesity; 'medium' – where a link worker, wellbeing champion or equivalent has a meaningful conversation with an individual to determine

the relevant service – through to 'holistic', in which GP's, local authorities, and the third sector communicate and offer a range of socially prescribed services using integrated services and approaches. The most formal of these (medium & holistic) is to employ a link worker, whose role is to engage with people, bridge the gap between health care providers and the wide range of services provided by social and third sector organisations (Polley et al., 2017). The link worker needs a range of skills to be able to work independently and support people who may be experiencing an acute crisis. There is currently a long list of titles given to people in this new and emerging role such as health advisor, community navigator, health broker and social enterprise advisor.

So who are the best people to take on this new role? It has to be considered how this can be done safely and supported. It required the setting up referral systems taking into account the new General Data Protection Regulation (GDPR) (ICO 2018), safeguarding and financial responsibility. The link worker may refer an individual to various groups according to their needs and that they feel they have the capacity to engage in at the stage and acceptance of their condition (Polley et al., 2017). For example, an obese individual with resulting diabetes could benefit from learning about their condition from a diabetes specialist group, which could also motivate them to lose weight or they could be advised to go to a weight reducing group (PCO 2017). Interestingly, in some parts of Australia, qualified nurses have been employed as link workers because of their ability to assess a persons needs and then create a social prescription that will support the individual to achieve their desired goals. Hence, there is a need to support link workers to ensure that they have the skills, capacity and capability to assess and prescribe a social intervention.

There is another model where the general practitioner or other health professionals within the team may advise the patient on opportunities for non-clinical support. Have we as community nurses and health visitors referred patients to organisations such as Home-Start UK a voluntary organization who support families with young children or local Parents and Tots groups. Social prescribing is making us think wider about the advantages to individuals and families for instance going rambling together with local routes being provided by local organization demonstrating local plants and wildlife, going to the museum where there is no cost but activities for the children to learn and being engaged. For the older person there are equally a range of activities that they could pursue. However, not everybody has the confidence to attend a group and actually needs to be referred, maybe introduced, accompanied to attend and made to feel welcome especially if it is an aspect of their condition. Engaging with older people using social prescribing is significant because it is estimated that the health impact of social isolation is equivalent to smoking 15 cigarettes per day and as our population begins to live longer, there is a risk that more people will become trapped in

their own homes. Could, social prescribing to a 'knit & natter' group, or gardening club be a potential antidote to the increasing challenges presented by an aging population?

There is also in this social prescribing initiative a certain amount of trust/hope that the patient will listen and engage with the non-clinical agency for their benefit. Subsequently there is a need for some sort of feedback mechanism at different levels. Should it be at patient level, organisational or a 'trip adviser' for community groups? Should we as nurses consider if our attitude and practices are paternalistic towards patients? Perhaps instead we should be giving patients the knowledge and prescribing for them access to the opportunities and community groups that exist to enable patients to take control of their own health and wellbeing? Will that make a difference to the health of patients in your community and how will you know?

Interestingly, the concept of 'prescribing' seems at odds with the person centred salutogenic philosophy proffered by social prescription, and could appear to favour the pathogenic model. Hence, there are some who argue that social prescribing is not a helpful terminology as it reinforces a model of health and wellbeing where there is a dependency on professionals without taking into account the impact that self-referral for self-management and community support has on the individual (WG 2017).

This may be overcome in part, perhaps, if a co-production model is used in the development of social prescribing. Through co-production service users are active in the design, implementation and reporting of activity relating to the development of new services and through all stages of research. Service users are invaluable in this respect as they voice the actual needs of people with certain health and social care issues, carer's and their families. Instead of the paternalistic model of 'we know best', or the traditional model of 'we have always done it this way' co-production for future service provision will hopefully ensure the provision of services fit for purpose that meet the needs of the service users (Boyle and Harris 2009) and not overlook the social economy of family and neighbourhood. Consequently using a co-production model for the development of social prescribing could be beneficial. Importantly there needs to be respect and trust within the system at all levels. Unfortunately public services have been constrained by targets, deliverables, management, standards and software which has led to undermining relationships between professionals and the public.

These issues need to be addressed as the concept of social prescribing has the potential to benefit not only individuals, but communities may benefit by people getting to know and support each other. In the Shetland Islands, for example, permission has been given by the health board for GPs to

prescribe rambling and bird watching for people with chronic and debilitating illnesses. These walks have been designed by the Royal Society for the Protection of Birds (PSPB) (The Guardian 2018), linking up organisations within communities. I was surprised to see that this very article had been picked up and rewritten for the children's weekly newspaper 'The Week- junior' informing children across the UK of this initiative in the Shetland Islands. It would be wonderful to know the impact and the views of the children reading this article.

It is acknowledged that people with mild/ moderate mental health problems benefit from social prescription and this can be as a result of being prescribed to attend: arts and crafts groups, environmental activities, such as the aforementioned therapeutic horticulture, leisure, stress management, and cultural activities within their communities. These initiatives of engagement and learning within groups have the potential to improve participants feeling of wellbeing, pride in their achievements. They also create opportunity to develop transferable skills, motivation to undertake more activities, aspirations for the future and more importantly a reduction in anxiety and depression (Stickley and Hui 2012; Morton et al 2015). There would be great benefit within communities for the primary health care teams to know what groups, activities can be accessed and if certain concessions are available or can be negotiated. There is also a decision making process to be agreed within the primary health care team regarding the categories of patients that can be and cannot be referred to certain social organisations. Also to be considered is the emerging use of information technology - if you what to know an answer 'google' the question.

Technology has a lot to answer for as it has impacted on the population with the development of television where most people at least sat together to watch programmes and perhaps discuss what they have watched in the home or in the workplace. Now many people sit in their own room and only communicate through their computer using so called 'social media'. People even go out together but do not communicate with each other as they are preoccupied with their mobile telephone. It has been reported that the lack of face to face communication and use of the mobile phone leads to greater loneliness (Jin &Park 2013). More face to face communication can break the cycle of what has been described as the Problematic Use of the Mobile Phone (PUMP) (Kim et al 2015). How many of you notice young parents are not talking to their children as they are on their phones? You, like me, have seen pictures of young people at a café not speaking or engaging with each other as they are on their phones and it is presented as a joke, but is it? Should we have times and places when the use of mobile phones are banned?

The internet can have both constructive and negative impact on young people. On one hand it can provide access to support groups, but it can also exert a negative influence by normalising self-harm, potentially discouraging disclosure or seeking professional help (Daine et al Plos One). The internet has also created communication channels that can be misused by 'cyber-bully' peers; both of these negative influences have been found to correlate with increased risk of self-harm, suicidal ideation, and depression. So there is a need for people to use their mobile phones wisely. Therefore should we be encouraging people especially young people in our communities to socialise more and leave their mobile phones on silent or have rules on their use, especially at meal times. There is the thought that through social prescription an individual may meet new people, learn new activities, improve their health and have fun instead as often happens sitting at home alone. So instead of becoming isolated and socially inept, to use technology wisely to their own advantage and communication instead of being controlled by this technology.

Recently in the UK the health and social care secretary for England, Matt Hancock suggested at the Conservative Party Conference in Birmingham that helping people before their condition deteriorated through interventions such as the use of social prescribing rather relying on drugs and medical procedures when they hit crisis was "common sense". This may be logical in thought but will it work in practice especially when scaling up the process? Dame Donna Kinnair, The Acting Chief Executive and General Secretary of the Royal College of Nursing of the United Kingdom was reported to have responded that he had not addressed staffing levels and vacancies and nurses were needed for preventative services vital to keeping people healthier for longer. They may argue on the political stage but there is need for evidence of which is the most effective means of enabling people in our communities to take responsibility for their own health. An individual may need help in choosing the right direction due to simply lack of knowledge or lack of confidence. We need to consider that if patients were able to join groups to prevent ill health whether it would free up nurses as well as general practitioners time to see the patients who really need their help in a reasonable time frame.

So what happens if clinicians have given their patient a social prescription and it has no impact or the patient is not compliant, are they then accountable for the outcome? What if the referral is totally inappropriate - is the provider or community group accountable? What if the patient is a recurrent attender with non-specific symptoms, who keeps making appointments to see their GP? Where does the accountability lie? It has to be acknowledged that all eventualities of risk cannot be covered. The reader may consider that there is a need for robust evidence that social prescribing and social prescribing programmes have a long term impact on the health and wellbeing of

participants and that be shown to be cost effective (Bickerdike et al 2017). Recent developments by NHSE to develop a national social prescribing outcomes framework is nearly complete – could such a framework provide a methodological framework to help establish such an evidence base?

Higher Education Academic Institutions also have their role to play, both in terms of research – and teaching & learning, especially as the new NMC standards for pre-registration are operationalized in nursing curriculums across the UK. Surely this is an ideal time to redress the imbalance between the pathogenic and salutogenic approaches so that through embedding social prescribing within the curriculum? Could we foresee placements outside of the NHS working with the third sector to support social prescription? Nurses are arguably well placed to seize the opportunities that social prescribing affords. We represent a significant part of the NHS workforce and we have a long track record in supporting self-help groups and sign-posting patients and carers to these and similar community based resources. We have a long tradition as public health advocates and indeed many nurses have helped community groups become established using to co-construction methods. Nurses should be seeking out local opportunities for social prescribing and take an active role in shaping these agendas and designing evaluations that assess effectiveness and impact. Indeed, there may be opportunities for collaboration internationally to develop a programme of research in this area.

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