
Article:
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Title: Exploring the components and impact of social prescribing

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Biographical details

Alexis Kilgarriff-Foster is a health service researcher at the University of Sheffield and has previous experience working in the voluntary and statutory sectors delivering health improvement initiatives. Her research interests include evaluating methods of supporting people with long term conditions and initiatives that address the wider determinants of health. She is also interested in researching how to measure the impact of non-clinical services.

Professor Alicia O'Cathain is the Director of the Health Service Research Section in the School of Health and Related Research at the University of Sheffield. She has experience in evaluating urgent care systems and services for long-term conditions. She is a mixed-methods specialist and has conducted methodological research on this topic.

Abstract:

Purpose: Social prescribing are short-term intermediary services that facilitate patients with psychosocial needs to engage in non-clinical support. However little is known about the components and potential impact of social prescribing.

Design/methodology/approach: A review was conducted to explore the evidence base on social prescribing including mapping its key components and potential impact. Database, internet and hand searching was utilised to identify relevant studies. Data extraction and narrative analysis was undertaken to explore the issues.

Findings: Twenty-four studies met the inclusion criteria. The studies were diverse in their methodologies and the services evaluated. Stakeholders such as general practitioners and patients perceived that social prescribing increased patients' mental well-being and decreased health service use. However the quantitative evidence supporting this was limited. The only randomised controlled trial showed a decrease in symptoms and increase in functional well-being at four months. The other non-controlled designs had large drop-out rates limiting their value in determining effectiveness.

Research limitations/implications: Further research is needed on the effectiveness and cost effectiveness of social prescribing using robust evaluative designs.

Originality/value: This is the first review of generic social prescribing services focusing on the general evidence base.

Keywords: Social prescribing, psychosocial needs, social support, community referral

Main Article

(1) Introduction

General Practitioners (GPs) report that over 20% of consultations involve dealing with patients' psychosocial needs (Zantinge et al., 2005). Psychosocial needs are emotional, social or psychological needs which may detrimentally affect a patient's health; for example, social isolation or low self-esteem. GPs can feel unable to manage these because of time constraints, a limited knowledge of available support and because referral to traditional psychological services may not be appropriate (Zantinge et al., 2005).

Policies such as 'Saving Lives: Our Healthier Nation' (Department of Health, 1999) advocate utilising community support structures to help manage psychosocial problems. In part, this is motivated by the need for the National Health Service (NHS) to develop alternatives to clinical primary care services because of increased demand and budgetary freezes (Curry et al., 2011). However it also reflects current strategies which encourage patients to develop self-management techniques such as good social support (Gallant, 2003). One such intervention is social prescribing, which helps patients to access non-clinical sources of support primarily, but not exclusively, within the community sector (South et al., 2008).

Whilst there are different models of social prescribing, this article focuses on generic supported referral schemes based in primary care, such as those in Sheffield and Bradford. Patients are usually referred by a health professional to meet for a limited number of appointments with a facilitator, often termed a social prescriber. They will identify and support the patient's engagement in non-clinical support that could meet their psychosocial needs (Keenaghan et al, 2012). For example, a patient who is socially isolated may be supported to engage in a lunch club. Social prescribing services are often based in General

Practices but delivered by community organisations. Social prescribing differs from services such as social work because it is an intermediary to facilitate the patient to access support rather than providing that support.

Reviews of specific initiatives such as exercise on prescription have found that services are beneficial. For example exercise levels increased by 10% amongst patients receiving an exercise on prescription service (Sørensen et al., 2006). However, there has been no comprehensive review of generic social prescribing services. Therefore the aim of this review was to map the evidence on generic social prescribing schemes and their potential impact.

(2) Methods

2.1 Review method

A review was conducted to identify the range of evidence on social prescribing. This involved the use of rigorous methods to identify and analyse relevant literature (Armstrong et al, 2011). Unlike systematic reviews, no formal quality appraisal of each study was undertaken because the aim was to map the overall evidence base.

2.2 Search strategy

There are no defined search terms for social prescribing, so a range was utilised in various combinations, including: ‘social prescribing’; ‘community referral’; ‘social support’; ‘psychosocial’; ‘social work’; ‘primary care’; ‘voluntary sector’; and ‘third sector’. Boolean operators and different truncations of the terms were utilised. These terms were used in a search of OVID SP, Open Grey, CINAHL, ASSIA, the Kings Foundation and Science

Citation Index Web of Knowledge. To capture grey literature, an internet search was conducted using Google. The search term 'social prescribing' was used because it was the most relevant term when performing the database search. Hand searching was undertaken of the following journals for 2011-2013: Primary Health Care Research and Development; British Journal of General Practice; Journal of Public Mental Health and Patient Education and Counseling. This time frame was chosen because earlier articles were likely to be referenced by later studies. The websites of relevant organisations were searched to identify potential literature. References of included studies were searched to identify other research.

2.3 Selection criteria

The search was limited to literature written in English and literature published between 1993 and 2013. Studies had to focus on primary care based social prescribing services which encompassed the description in the introduction. Primary research, evaluations, reviews and policy documents were included. Promotional information on specific services was excluded.

2.4 Data extraction

A data extraction form was developed to obtain consistent information about each study. Narrative synthesis was used to summarise the findings of the studies. The review was primarily conducted by AKF, in consultation with AOC.

(3) Results

The Google search identified several hundred thousand sources; only the first two hundred were searched because after that they were irrelevant. 2,201 potential studies were identified, with 1,959 rejected on title (Figure. 1). Ten studies could not be retrieved despite attempts to contact the authors. Thirty-two studies were rejected on their abstract. Of the 200 studies retrieved for review, six were duplicates and 170 were rejected. Twenty-four studies met the inclusion criteria.

3.1 Description of studies

The 24 included studies were diverse in terms of their methodology and the service evaluated (Table 1). All but one of the studies was published in the last ten years, highlighting that social prescribing is a relatively recent phenomenon. One study was based in Ireland, with the remainder from the United Kingdom. Seventeen were reports and seven were journal articles. There were three discussion articles: Brandling and House (2009), Brown et al. (2004), and NESTA (2013) and four reviews: Friedli et al. (2009), Friedli (2007), Keenaghan et al. (2012) and Johnson and Ross (2011). These sought to inform the development of a specific social prescribing service rather than for the purpose of evidence synthesis. The remaining 17 studies used a variety of primary research methods. Grant et al. (2000) was the only randomised controlled trial and cost-effectiveness analysis. Seven studies: Brandling et al. (2011), Friedli et al. (2012), Grayer et al. (2008), The Care Forum (2012), ERS (2013), Age UK (2012) and Dayson et al. (2013) considered effectiveness using a before and after design. Fourteen studies used qualitative methods including interviews and focus groups to describe a service and its perceived benefits and challenges.

3.2 Key components of social prescribing

3.2.1 Recipients

Several studies reported that social isolation and low mood due to life circumstances such as unemployment were the key reasons for referral to social prescribing (The Care Forum, 2013). Social prescribing was considered suitable for frequent attendees to health services or those with inexplicable symptoms (NESTA, 2013). Services had inclusive referral criteria (Brandling et al., 2011). The literature did not explore why a patient was referred to social prescribing rather than mental health services.

Patients using social prescribing services were largely female and over 40 years old. Some services were aimed at older patients (Age UK, 2012) but otherwise it was not clear why the clientele were older. Age UK (2012) found that referrals for black and ethnic minority patients were disproportionally low. Patients were from vulnerable groups: 37% of patients were unemployed/on long-term sick leave compared to the average of 5% in the area (The Care Forum, 2013).

3.2.2 Referral pathways

GPs and practice nurses were the main sources of referral (Woodall and South, 2005). Several services accepted self-referrals (South et al, 2008) or referrals from other sources including housing officers (Johnson and Ross, 2011). Referral pathways were often limited by service capacity (Brandling et al., 2011).

3.2.3 Referral rates

Studies described a range of referral rates including 5 and 52 per month which reflected differences in service size (The Care Forum, 2013 and NHS Tayside, 2011). There were concerns about engaging sufficient demand due to a lack of referrals (Brandling et al., 2011) and because some patients did not engage with social prescribing (Faulkner, 2004 and McMahon, 2013).

3.2.4 Appointments

Patients were usually seen within four weeks (Grayer et al., 2008). Non-engagement rates were higher amongst patients who waited longer for an assessment (The Care Forum, 2013). Qualitative research identified that operating from General Practices legitimised services in the eyes of patients and health professionals (Brandling and House, 2009). Patients initially had a 40 to 90 minute long appointment to enable the social prescriber to identify needs and appropriate activities (Brandling et al, 2011). Patients then had a small number of follow-up appointments; for example, the modal number in Grant et al. (2000) was two. Woodall and South (2005) found that some patients valued initially being accompanied to activities.

3.2.5 Prescriptions

Patients were mainly prescribed hobbies, volunteering opportunities or befriending services (Dayson et al., 2013), with 58% of patients engaging in an activity (Grayer et al., 2008).

3.2.6 Resources utilised in the provision of social prescribing

Social prescribers were usually employed by community organisations and were generic workers rather than having specific clinical qualifications (Keenaghan et al., 2012). There was little information on the running costs of these services. NHS Tayside (2011) estimated £27,300 annually per general practice, which provided support to six to eight patients a week. Services were often pilots or small scale, with unsecured funding (Johnson and Ross, 2011).

3.3 Evidence on the impact of social prescribing

3.3.1 Improvement in health and well-being

Whilst all of the studies discussed the benefits of social prescribing, only some were substantiated with empirical evidence. Through qualitative interviews, Woodall and South (2005) found that patients perceived that social prescribing increased their self-esteem and self-efficacy because it enabled them to access appropriate help and develop their support networks.

Eight studies used quantitative methods to explore changes in health and well-being. Grant et al. (2000) was the only randomised controlled trial and concluded that social prescribing has clinically important benefits in managing psychosocial needs compared to usual care. For example there was a statistically significant improvement in the Hospital Anxiety Scale at four months (Difference= -1.9, P value= .002). Five studies presented before and after data utilising a variety of outcome measures including the Warwick Edinburgh Mental Well Being Scale (WEMWBS) and General Health Questionnaire- 12 (Grayer et al., 2008, Brandling et al, 2011, Age UK, 2012, ERS, 2013 and The Care Forum, 2013). They found that, over a

range of time points up to a year, patients who received social prescribing experienced an improvement in their well-being, reduction in symptoms and met their goals. These results are available at: https://www.sheffield.ac.uk/scharr/sections/hsr/mcru/staff/foster.

The quality of the quantitative studies was not high; often the findings were based on small samples, with large drop-out rates. For example, in Brandling et al. (2011), only 7/33 patients completed the WEMWBS at 6-12 months. There was little consideration about whether any change was statistically or clinically significant.

3.3.2 Changes in health service use

Health professionals in qualitative interviews reported that social prescribing reduced demand on primary care services (Involve North East, 2013). Other studies found that 82% of patients decreased their number of health professional consultations (Popay et al., 2007) and there was a reduction in medical prescriptions (Age UK, 2012). However, Grant et al. (2000) reported little decease in primary care use.

3.3.3 Cost-effectiveness

Social prescribing is promoted as potentially cost saving (NHS Tayside, 2011). However, the only cost-effectiveness analysis found social prescribing to be on average £20 more expensive per patient compared with usual care over a four month period (Grant et al., 2000).

3.3.4 Feasibility and acceptability

Based on qualitative research, generally stakeholders viewed social prescribing as feasible and acceptable (Brandling and House, 2007 and Faulkner, 2004) and encompassing current policies on promoting self-management (Friedli, 2007). However the majority of referrals from social prescribing services were to community sector activities which raised capacity issues for some activities (Evans et al., 2013). Patients still faced practical barriers to engagement in activities such as cost or limited language skills (Johnson and Ross, 2011).

(4) Discussion and Conclusion

4.1 Discussion

The review identified that stakeholders viewed social prescribing as acceptable and feasible, perceiving it as improving patient well-being and reducing use of health services. But there was limited quantitative evidence of effectiveness and only one robust evaluative design. This gap needs to be addressed because decision makers are increasingly prioritising funding to services that can demonstrate impact (Devlin and Appleby, 2010). This could be done in both research and routine practice contexts by increasing the use of standardised outcome measures, for example the WEMWBS, and by considering whether any changes measured are clinically significant. Further cost-effectiveness studies, over a longer time frame are needed because Grant et al. (2000) had marginal findings.

4.1.2 Limitations of the review

No studies were identified from countries outside of the United Kingdom and Ireland. Whilst this could be a weakness of the search strategy, none of the included studies referenced relevant research from other countries. There is publication bias because ten studies could not be accessed despite attempts to contact the authors. To minimise the bias of the review primarily being conducted by one researcher, AKF regularly consulted with another researcher (AOC). There may be reporting bias because studies not finding an impact, may not have been published.

4.2 Conclusion and implications

This review identified a number of studies describing social prescribing and its potential impact. Stakeholders perceived that it improved patients' mental well-being and reduced service use. However, due to the lack of high quality studies of effectiveness, further effectiveness and cost-effectiveness studies are needed. There is current interest in developing social prescribing (Dayson et al, 2013) and this review may help to develop and evaluate these services. Stakeholders need to collaborate to address the evidence gap identified here. Without this, given the current financial and policy climate, it will be challenging for social prescribing to develop beyond locally based short-term funded services.

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Table 1- Description of the studies

Author	Year of Publication	Country	Literature type	Type of study	Focus
Age UK	2012	England	Report	Service evaluation	Acceptability and feasibility of a social prescribing scheme in practice and description of users
Brandling et al.	2011	England	Report	Mixed methods including qualitative and outcome measures	Acceptability and feasibility of a social prescribing scheme in practice and effectiveness of social prescribing using a before and after design
Brandling and House	2009	England	Journal article	Discussion article	Feasibility of social prescribing
Brandling and House	2007	England	Report	Qualitative study	Acceptability and feasibility of a social prescribing scheme in practice
Brown et al.	2004	England	Journal article	Discussion article	Feasibility of social prescribing
Dayson et al.	2013	England	Report	Mixed method	Acceptability and feasibility of a social prescribing scheme, Description of users and Effectiveness of social prescribing using a before and after design
ERS	2013	England	Report	Mixed method	Acceptability and feasibility of a social prescribing scheme in practice and description of users
Evans et al.	2011	England	Report	Mental well-being impact assessment	Acceptability and feasibility of a social prescribing scheme in practice
Faulkner	2004	England	Journal article	Qualitative	Acceptability and feasibility of a social prescribing scheme in practice
Friedli et al.	2012	Scotland	Report	Mixed methods	Acceptability and feasibility of a social prescribing scheme in practice, description of users and effectiveness of social prescribing using a before and after design
Friedli et al.	2009	England	Report	Literature review	Acceptability and feasibility of a social prescribing scheme in practice
Friedli	2007	Scotland	Report	Literature review	Acceptability and feasibility of a social prescribing scheme in practice
Grant et al.	2000	England	Journal article	Randomised controlled trial and economic evaluation	Effectiveness of social prescribing using an experimental design (Randomised Controlled Trial) and cost-effectiveness study
Grayer et al.	2008	England	Journal article	Before and after evaluation	Effectiveness of social prescribing using a before and after design
Involve North East	2013	England	Report	Mixed method	Acceptability and feasibility of a social prescribing scheme in practice

Johnson & Ross	2011	England	Report	Literature review	Acceptability and feasibility of a social prescribing scheme in practice
Keenaghan et al.	2012	Ireland	Report	Literature review	Acceptability and feasibility of a social prescribing scheme in practice
McMahon	2012	Scotland	Report	Service evaluation	Acceptability and feasibility of a social prescribing scheme in practice
NESTA	2013	England	Report	Discussion article	Feasibility of social prescribing
NHS Tayside	2011	Scotland	Report	Service evaluation	Acceptability and feasibility of a social prescribing scheme in practice and description of users
Popay et al.	2007	England	Journal article	Questionnaire	Feasibility of social prescribing
South et al.	2008	England	Journal article	Qualitative	Acceptability and feasibility of a social prescribing scheme in practice
The Care Forum	2012	England	Report	Service evaluation	Acceptability and feasibility of a social prescribing scheme in practice and description of users
Woodall & South	2005	England	Report	Mixed methods	Acceptability and feasibility of a social prescribing scheme in practice and description of users

Figure. 1- Study Selection Diagram