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## **New Horizons in Supporting Older People's Health and Wellbeing: Is Social Prescribing a Way Forward?**

### **Abstract:**

Older people's health and care needs are changing. Increasing numbers live with the combined effects of age-related chronic illness or disability, social isolation and/or poor mental health. Social prescribing has potential to benefit older people by helping those with social, emotional or practical needs to access relevant services and resources within the local community. However, researchers have highlighted limitations with the existing evidence-base, while clinicians express concerns about the quality of onward referral services, liability and upfront investment required. The current article provides a critical review of evidence on social prescribing, drawing on the RE-AIM Framework (Glasgow et al., 1999) to identify questions that will need to be addressed in order to inform both the design and delivery of services and the evolving research agenda around social prescribing. We emphasise the need for researchers and planners to work together to develop a more robust evidence-base, advancing understanding of the impacts of social prescribing (on individuals, services and communities), factors associated with variation in outcomes and strategies needed to implement effective and sustainable programmes. We also call on policymakers to recognise the need for investment in allied initiatives to address barriers to engagement in social prescribing programmes, provide targeted support for carers and improve access to older adult mental health services. We conclude that social prescribing has potential to support older people's health and wellbeing, but this potential will only be realised through strategic alignment of research, local level implementation and national policy and investment.

## **Introduction**

The aim of this review is to consider the potential role of social prescribing in supporting older people's health and wellbeing. We begin by summarising sociodemographic trends relevant to understanding older people's changing health and care needs. The concept of social prescribing is then considered, from both a policy and research perspective, as we examine how it is implemented in practice and to what extent services are underpinned by evidence. Implications for the design and delivery of services and the research agenda around social prescribing are discussed.

## **Background**

It is estimated that the world's population aged 60 years and older will reach 2 billion by 2050, an increase from 900 million in 2015 [1]. Population aging is associated with increasingly complex health care needs – as people age, there is a trend towards declining physical and mental capacity and rising prevalence of chronic conditions such as osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression, and dementia. People are also more likely to experience several conditions at the same time [1]. Healthcare needs among older people are characterised by considerable variability, with some 80 year olds having physical and mental capacities similar to many 20 year olds and others experiencing significant declines at much younger ages [1].

Research further highlights rising levels of social isolation and loneliness among older people. Prevalence of isolation is around 13-15% among those aged 65 or over [2], higher for those aged 80 or over and much higher in deprived inner-city/ inaccessible rural areas [3]. Paradoxically, as a result of feeling trapped at home many older people find it difficult to

make connections that could reduce their sense of isolation [4]. Surveys have consistently revealed that 6-13% of older people report they are often or always lonely [5,6]. Loneliness, especially persistent loneliness, is associated with increased vulnerability to mental health problems, particularly depression and risk of suicide [7].

The concept of resilience has been used to understand risk and protective factors associated with individual variability in health and wellbeing among older people. Wild et al. [8] view resilience as the product of a number of separate but linked areas: psychological, mobility, financial, environmental, physical, social and cultural. An individual may be resilient in one area (e.g. income), but not another (e.g. physical health); this balance may vary over time and in response to changing circumstances. The Age UK report *Improving Later Life* [9] conceptualises resilience as having three legs: wealth, health, and social networks and support. The report acknowledges that resilience is broader than an individual trait and that the system around the older person - family, universal services, the environment and care services - plays a key role in facilitating and supporting resilience. The Age Concern and Mental Health Foundation inquiry into *Mental Health and Wellbeing in Later Life* [10] highlighted five key foci for policy and public investment: maintaining relationships; participation in meaningful activity; physical health; discrimination; and addressing poverty.

### **What is Social Prescribing?**

Social prescribing involves the referral of patients with social, emotional or practical needs to non-clinical services and community-based resources. While this practice is not new, it has become more formalised in recent years, as health care systems (most notably, the UK National Health Service) have increasingly invested in social prescribing programmes or schemes (also called community referral or linking schemes). These typically involve the use of non-clinically trained link workers (also called connectors, health advisers, coordinators,

care navigators, or community navigators) to assess patients' support needs and help them engage with relevant services and activities [11,12]. These may include for example, benefits, housing or employment advice, bereavement support, health behaviour change programmes, or opportunities for arts, creative, or nature-based activities (e.g. community gardening, or green exercise initiatives). In 2017, there were more than 100 social prescribing schemes running in the UK [13] and a recent survey found that nearly a third of family doctors in the UK were using social prescribing [14]. There is also growing interest in this approach beyond the UK context, with examples of related initiatives in Ireland [15], the Netherlands [16], Scandinavia [17], the US [18], Canada [19] and Australia [20].

### **How Does Social Prescribing Fit with Health and Social Care Policy?**

Increasing investment in social prescribing in the UK reflects the national policy agenda. Social prescribing is recommended one of '10 High Impact Actions' to increase capacity in general practice and reduce physician workload [21]. The NHS Long Term Plan [22] includes a commitment to increase access to social prescribing across England as part of a personalised care model. This includes ensuring that over 1,000 trained link workers are in place by the end of 2020/2021. The Health and Wellbeing Fund is investing £4.5 million in 23 social prescribing projects across England to extend existing schemes or establish new ones. The aim is to improve patients' quality of life, health and wellbeing and reduce demand on health services [23].

Social prescribing initiatives are also highlighted in a 2017 report of the UK Government's All Party Parliamentary Group on Arts Health and Wellbeing [24]. Benefits cited include: strengthening preventative strategies to maintain health for all; helping frail and older people stay healthy and independent; enabling patients to take a more active role in their own health; improving recovery from illness; enhancing mental health and social care; mitigating social

isolation and loneliness, strengthening local services and promoting more cohesive communities; enabling more cost-effective use of healthcare resources; relieving pressure on primary care and increasing health and social care staff wellbeing.

Prescribing nature-based health promotion activities and ‘green care’ services is consistent with the Natural Environment White Paper *The Natural Choice: securing the value of nature* which identifies a need to strengthen the connection between people and nature [25]. A commissioned report by Natural England [26] concluded that there is strong evidence of the efficacy of nature-based interventions and these are welcomed by patients and clinicians.

The development of social prescribing initiatives beyond the UK context reflects similar policy drivers. Alderwick et al. [18] emphasise that although the UK and US have very different healthcare systems, a variety of policy initiatives in both countries, such as accountable care organisations and other value-based payment models, have created opportunities for approaches such as social prescribing to be developed within the healthcare system - models that reward outcomes of care, rather than just provision of services also offer incentives for providers to address psychosocial factors that impact health. Keenaghan et al. [15] report that development of social prescribing in Ireland is underpinned by policy emphasis on the importance of a comprehensive community level response for people with mental health difficulties, including non-medical interventions at primary care level. In the Netherlands, Canada and Australia, social prescribing is similarly viewed as a means of offering patients a wider range of options, reducing reliance on medical interventions and more effectively targeting social factors influencing health and wellbeing [16,19,20]. In Scandinavian countries (particularly in Sweden), policy emphasis on the importance of arts and culture for health is an important driver underpinning development of social prescribing programmes [17].

## **How is Social Prescribing Implemented in Practice?**

Most social prescribing programmes have developed in response to local need rather than being systematically planned, resulting in a variety of practice [12, 27]. Referrals are commonly made by family doctors, although some programmes accept referrals from allied health professionals, nurse specialists or consultants (particularly for cancer patients). Link workers may be based in medical centres, or community settings and there is significant variability in link worker skills, knowledge and training [12, 27]. A variety of mechanisms exist for targeting and identifying patients 'in need' of social prescribing. In some areas, a risk stratification model is used to identify patients based on their level of clinical need, while others rely on less formal needs assessments and clinician discretion [28].

Social prescribing programmes are highly heterogeneous in terms of both the target patient group and the services offered (which often include small voluntary, or community groups operating at a local level) [27]. For example, the Bromley-by-Bow Centre in London, England, one of the oldest social prescribing schemes, helps patients to engage in services and activities ranging from gardening to housing and benefits advice. The scheme is available to patients aged 18 or over, registered with participating practices. A parallel example in the US is Health Leads, a non-profit organisation that trains and supervises volunteers to help patients identify support needs (including employment, housing, legal and other needs) and navigate relevant community-based resources - patients are screened during regular clinic visits [18].

Other schemes target specific groups, including older people, people with mental health needs, learning disabilities, diabetes, obesity or chronic pain. These adopt a variety of models, including Arts on Prescription Programmes (which refer patients to arts in the community, including museums, galleries and libraries), Books on Prescription

(Bibliotherapy), Education on Prescription and Exercise on Prescription (Exercise Referral) [15, 17, 29].

### **What Evidence is there that Social Prescribing is Effective?**

Despite widespread enthusiasm for social prescribing, evidence of effectiveness is limited. A systematic review [27] identified that most evaluations are small scale and hampered by poor design and reporting. Missing information made it difficult to assess who received what, for what duration, with what effect and at what cost. The reviewers concluded that ‘there is an urgent need to improve the ways by which schemes are evaluated’ (p15).

Researchers have further highlighted problems with assumptions underlying social prescribing [30], including that voluntary and community services can be readily incorporated into formal care pathways. There is often no direct funding for the services/activities patients are offered via social prescribing and these may lack specific inclusion criteria, or accreditation requirements for the service provider. Consequently, clinicians have expressed concerns about the quality of services and their liability when referring patients to social prescribing schemes [14, 26]. Also, while social prescribing initiatives may reduce primary care workloads over the longer term, physicians have questioned the level of upfront investment and workload required to implement these properly at the start [14]. In the UK, the Royal College of General Practitioners has argued that for social prescribing to effectively link patients with local services, funding and support is required to enable these to be accessible and sustainable [14]. Alderwick et al. [18] report that in both the UK and US, efforts to incorporate social supports under alternative payment models and allow funding to ‘follow the patient’ could present new opportunities for integrated care delivery.



Researchers have additionally noted the impact of cuts to other services, such as reductions in mental health services resulting in inappropriate referrals to social prescribing programmes, requiring link workers to provide support beyond their skills and training [31]. Alderwick et al [18] highlight that in both the UK and US, social services are under major financial strain, often struggling to meet community needs. In England, there have been significant cuts to welfare benefits and local services since 2010, as well as the reversal of policies aimed at reducing health inequalities. Consequently, increased referral to community services may have unintended consequences, placing services under greater strain and/or increasing patients' frustration if resources are not available to meet their needs [18]. Focusing on the needs of socially isolated older people, a recent commentary in the British Medical Journal questioned whether social prescribing programmes are really what people want, or if funding would be better directed to sustaining local infrastructure such as bus services, libraries and public spaces, providing 'natural' opportunities for social activity and engagement [32].

Assumptions underlying social prescribing are highlighted in Figure 1.

**Figure 1. Some of the assumptions underlying social prescribing** (from Hamilton-West et al. [30])

Assumption 1. *Social prescribing is effective* – there is sufficient high-quality research evidence to judge impacts on patient outcomes, health service costs and physician workload.

Assumption 2. *Social prescribing services are being implemented in ways that allow for evaluation* - there is a clear underlying logic model and robust monitoring of inputs and outcomes (for patients, referrers and onward referral services).

Assumption 3. *Social prescribing is what patients want* – patients have been involved in its development, and users' experiences have been explored via qualitative research.

Assumption 4. *Social prescribing is what referrers want* – SP services have been developed in collaboration with referring health professionals and referrers’ experiences have been explored via qualitative research.

Assumption 5. *Social prescribing works for onward referral services* – small, community groups (often relying on volunteers) are willing and able to accept referrals and respond to people’s needs - and this is sustainable over the longer term.

Assumption 6. *We know what skills, competencies and resources link workers need in order to be person-centred and effective, and to manage risk appropriately.*

Assumption 7: *There is a close match between services available in the local area and the needs of patients attending primary care* – health professionals can be confident that an individual’s needs will be met via referral to social prescribing.

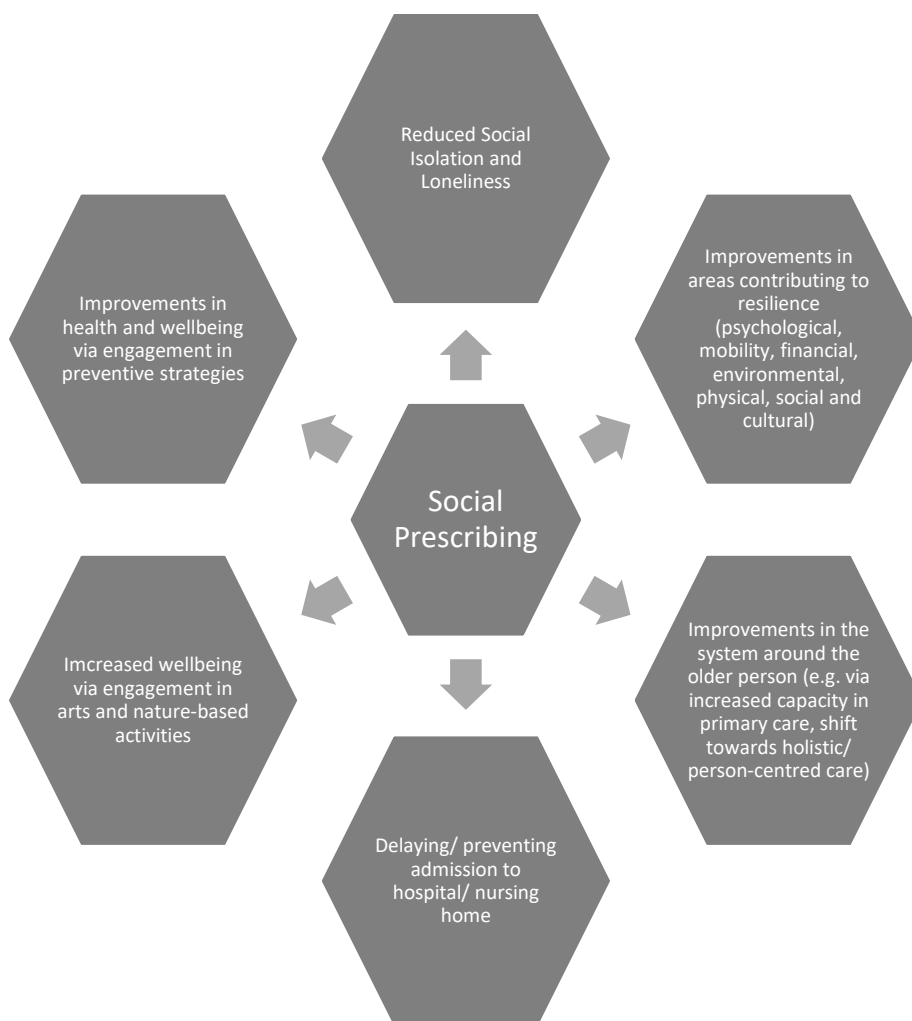
### **How Might Social Prescribing Benefit Older People?**

There are few controlled studies examining social prescribing for older people. However, research has demonstrated positive impacts of engagement in gardening, nature-based activities, museum-based activities and creative arts among older people, including benefits for wellbeing, health and social isolation [33-35]. Service evaluations of social prescribing pilot projects targeting older people experiencing social isolation and mild-to-moderate mental health problems report benefits including increased self-esteem, improved mental wellbeing, reduced loneliness and reduced health service use [36-37]. A realist evaluation of a large social prescribing pilot project in London, England revealed that (predominantly older and social isolated) patients accessed a wide range of services and activities, including lunch clubs, walking groups, psychological counselling, gardening, and bereavement support. Empathetic support from social prescribing coordinators with a detailed knowledge of local

services was a key mechanism enabling patients to act upon improving their own health and wellbeing [36].

Potential benefits of social prescribing for older people highlighted in policy documents and evaluations of local services are illustrated in Figure 2. Further research will be needed to develop a robust evidence-base in relation to each of these.

**Figure 2. Potential Benefits of Social Prescribing for Older People**



## **Implications for Social Prescribing Researchers and Planners**

To ensure that future design and implementation of social prescribing services is underpinned by evidence, researchers and planners will need to work together more closely, enabling programmes to be developed with a clear underlying logic model, describing the programme aims and assumptions, inputs (staff and resources), outputs (activities and participants) and outcomes (short, medium and long-term), as well as hypothesised relationships between these. The target group(s) also need defining. To allow for meaningful evaluation, planners must ensure that expected outcomes are plausible, measurable (on the basis of available data) and can be reliably attributed to the intervention [38].

Further research is required to advance understanding of the strategies needed to implement social prescribing programmes at scale across diverse settings [38, 39]. Baker and Irving [40] suggest that successful implementation of social prescribing depends on the ability of multiple organizations, operating in different institutional fields and with different codes of practice, to co-produce a treatment and care regime through collaboration with one another and with patients. This is a complex ask. Focusing on a pilot programme in the North East of England targeted at older people with early onset dementia and depression, they illustrate some of the difficulties social prescribing programmes face navigating the institutional logistics, norms and values underpinning effective collaboration.

The RE-AIM evaluation model [41] provides a useful framework for examining programmes across a number of key dimensions (**R**each, **E**fficacy, **A**doption, **I**mplementation and **M**aintenance), which operate at multiple levels (e.g. individual, setting, organization, community) and interact to determine the public health or population-based impact of a programme. Priority questions for future research linked to these dimensions are proposed in Table 1.

**Table 1. Priority Questions for SP Research Relating to REAIM Framework**

**Dimensions**

Reach	What proportion of the target population (e.g. older people with complex health and care needs) participate in social prescribing programmes when offered and why? To what extent is there a close match between activities/services offered and the needs and priorities of the target population? Which criteria determine whether referral to social prescribing is appropriate and what are the determinants of participation in activities offered? Are there potential barriers to participation (e.g. relating to chronic illness, disability, dementia/cognitive impairment, poor mental health, reduced mobility, poverty, discrimination, lack of transport)? If so, how could these be addressed?
Efficacy	Does social prescribing impact on outcomes relevant to the target population (e.g. those illustrated in Fig 2)? Are there any unanticipated negative outcomes for patients, staff (including referring clinicians, link workers and activity providers), or services (including primary and secondary care, social care, mental health, community and voluntary services)? If so, how could these be addressed? What knowledge, skills and competencies do staff (referring clinicians, link workers, activity providers) need to provide effective support for older people with complex health and care needs?
Adoption	What proportion of relevant settings (e.g. medical practices) deliver/engage in social prescribing programmes? What barriers are there to implementation (e.g. relating to institutional logistics, norms and

	<p>values, clinician concerns about quality of onward referral services, liability and upfront investment required) and how could these be addressed? Are there other services/professionals (e.g. mental health, social care, or emergency services) that could refer to social prescribing? What are the potential barriers and enablers to involving these organisations? What types of organisations accept referrals via social prescribing and why? What are the potential barriers and enablers for activity providers?</p>
Implementation	<p>To what extent are social prescribing programmes implemented as intended? Is there a clear underlying theory and logic model that is understood by all stakeholders (e.g. referring clinicians, link workers, activity providers)? Is this supported by appropriate staff training and supervision? Are there barriers preventing effective implementation at the individual, setting, or organisational levels? If so, how could these be addressed?</p>
Maintenance	<p>To what extent are social prescribing programmes sustained over time? What strategies are needed to maintain service quality and ensure staff knowledge, skills and competencies remain to date? Are there barriers to maintenance at the individual, setting, or organisational levels (e.g. relating to changes in: service user needs and priorities, service commissioning/funding, or onward referral services)? If so, how could these be addressed?</p>

## Discussion

Older people's health and care needs are changing, as increasing numbers live with the combined effects of longstanding illness or disability, social isolation, loneliness and/or poor mental health. Social prescribing claims the potential to improve health and wellbeing by enabling those with social, emotional or practical needs to access relevant services and resources within the local community. It may also have the potential to improve the 'system' around the older person, by increasing capacity in primary care, delaying/preventing admission to hospital or nursing home and enabling a shift towards more holistic, person-centred care. However, this potential is currently limited by a lack of robust evidence on either the impacts of social prescribing or the strategies necessary to implement effective and sustainable programmes.

In this article, we propose a number of priority questions for future research, emphasising the need for social prescribing researchers and planners to work together more closely to ensure that the design and delivery of services is underpinned by robust evidence. Work to develop a standardized reporting template<sup>1</sup> will also be important for improving the quality and completeness of social prescribing evaluation reporting and enhancing replication. However, some of the issues discussed extend beyond the remit of researchers and healthcare planners. For example, although it could be argued that social prescribing addresses some of the key areas for policy and public investment outlined in the Age Concern and Mental Health Foundation inquiry into Mental Health and Wellbeing in later life [10] (e.g. maintaining relationships, participation in meaningful activity, physical health), others seem less likely to be impacted by SP (e.g. poverty and discrimination). These factors could also make it more difficult for people to engage in social prescribing programmes. Hence, if social prescribing

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<sup>1</sup> <http://www.equator-network.org/library/reporting-guidelines-under-development/reporting-guidelines-under-development-for-observational-studies/#94>

is implemented at scale without initiatives to address poverty and discrimination among older people, those at greatest risk of poor mental and physical health could be left behind. A related issue, is the lack of direct funding for onward referral services. If these are not funded as part of the implementation of social prescribing programmes, it is likely that either they will need to charge patients or the referral pathway will fail. The cost may be prohibitive for some patients and contribute to widening socioeconomic inequalities in health and wellbeing, a problem that may be compounded by lack of investment in public transport and community services and cuts to health and social care services.

When considering the potential for social prescribing to provide a way forward for developing innovative support for older people, it is useful to differentiate between different levels of preventive activity. In relation to mental health, Goldie et al. [42] draw a distinction between *primary prevention* (intervening before a mental health problem arises – e.g. by reducing social isolation and loneliness), *secondary prevention* (identifying early signs of poor mental health and preventing more serious problems – e.g. via support for dementia carers with depression/ anxiety symptoms) and *tertiary prevention* (ensuring access to services and support for established mental health problems). It seems likely that social prescribing mainly operates at the level of primary prevention. To tackle the health and wellbeing challenges facing older people, investment in social prescribing programmes needs to be complemented by investment in universally available/publicly funded secondary and tertiary prevention, such as carer support groups and older people's mental health services.

## **Conclusions**

We conclude that social prescribing has potential to support older people's health and wellbeing and address difficulties at an early stage. However, this potential will only be realised if researchers and commissioners work together to address the questions highlighted



here and if policy and investment is targeted towards enabling older people to access preventive services at primary, secondary and tertiary levels.

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