The Social Psychology of Social Prescribing

Seminar 1: Unpacking the relationships between social groups and health

Plenary Session Report

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Executive Summary

Social Prescribing (SP) is a new method of health service delivery that aims to respond to a number of urgent challenges facing health and social care services, including an ageing population, changing patient expectations, and a policy decision to include the voluntary sector in the formal provision of health services. It aims to tackle the social needs of vulnerable populations by linking at-risk individuals to local community support. Greater social integration should lead to health benefits for the individual, the community, and ultimately, broader society. However, as a new service, SP faces a number of challenges. There is a need to appropriately measure outcomes at each targeted level as well as articulate the processes through which such programmes can produce health benefits for society's most vulnerable groups.

The first aim of the *Social Psychology of Social Prescribing* seminar series is to disseminate social psychology's evidence base concerning the relationships between individuals, groups and health. This evidence can directly address the gaps highlighted above. The second aim is to promote discussion and collaboration between academics and those commissioning, providing, and using SP services. This document provides a record of the afternoon plenary session that took place at the first seminar held at Nottingham Trent University in June 2018. Attendees (comprising academics and those directly involved in developing and/or providing SP services) participated in small group discussions regarding the challenges facing SP service providers and the populations they serve. Notes from each group were collated and key points were extracted in relation to each of the main topic areas discussed. The topics and key points were as follows:

Who should be offered SP services?

- Ideally all those who could benefit. However, given the current financial climate it may be necessary to prioritise those most in need (especially members of groups disproportionately affected by adverse social circumstances and/or who traditionally have low health service engagement).

- Greater effort needs to be made to ensure SP services are reaching out to, and viewed as accessible by, those most in need.

What are the 'active ingredients' of SP?

- SP should take a holistic approach and be client-centred.

- The 'social prescription' should be one that is meaningful to the client – especially when linking clients to community or activity groups.

- SP services should be community-centred, that is, tailored to the needs of the groups and communities that use them.

- Groups receiving SP referrals should be cohesive and members should have a sense of connection with each other and the wider group.

- Trust should be present at all stages of the SP process (i.e., between client and GP/initial referrer, link worker (where relevant), and any groups they are connected to through the SP service)

- SP requires engaged, skilled workers and there should be a shared understanding of its purpose across all those involved at each stage.

What are the key challenges faced by SP stakeholders?

- Unrealistic expectations on the part of funders regarding the outcomes that can be achieved in relatively short timescales.

- Medicalization of social issues

- Developing sustainable services in the context of short-term funding and under-investment in the voluntary sector.

- Providing high-quality services in the light of a lack of standardised SP provision, lack of clarity on the training needs of key staff, and widespread misunderstanding of the purpose of SP.

- Ensuring all sectors of the community are involved in the SP service development process.

- Providing access to SP services for all (including those in remote locations and those without access to reliable transport)

What can the research community do for SP stakeholders?

- Communicate research findings in an appropriate, accessible format.

- Generate evidence to support claims of cost-savings and social return on investment.

- Provide advice to small organisations on how to secure funding and demonstrate service efficacy.

- Provide an evaluation toolkit comprising a set of measures (including social metrics) applicable across contexts

- Conduct robust, critical research that focuses on ascertaining how, why, and for whom SP works.

In summary, the discussion provided valuable insights from those involved at the front-line of SP service delivery. This discussion points the way forward for the seminar series which continues until mid-2019 and also represents the beginning of fruitful collaborations between social psychologists and all those involved in the commissioning, provision, and use of SP services.

The Social Psychology of Social Prescribing: An Introduction to the BPS Seminar Series

Social Prescribing (SP) aims to tackle the social needs of vulnerable populations by linking at risk individuals presenting to primary care with local community support. It is seen as a response to a number of urgent challenges facing national health and social care services including an ageing population, changing patient expectations, and a policy decision to include the voluntary sector in the formal provision of health services. It is anticipated that it will lead to health benefits at the level of the individual, community, and ultimately, broader society. As with any new initiative, SP faces a number of challenges. First, there is a limited evidence base supporting its effectiveness. Second, the community and voluntary sector is seeking guidance as to the delivery and evaluation of sustainable services. Third, service commissioners and local authorities need evidence of cost as well as health benefits. Thus, while SP has the potential to produce important health benefits, there is a need to appropriately measure outcomes at each targeted level as well as articulate the processes through which such programmes can produce health benefits for society's most vulnerable groups.

Social psychology's evidence base concerning the relationships between individuals, groups, and health can directly address the gaps highlighted by those commissioning and providing SP services. Articulating the health implications of group memberships and their associated social identities forms part of a rapidly developing paradigm in social psychology known as the *Social Cure* (Haslam, Jetten, Cruwys, Dingle, & Haslam, 2018). This paradigm (within which the work of the seminar series team is contained), can provide the evidence base linking the medical, community and policy audiences. For GPs, it can provide the hard, robust evidence as to the effect of SP on measurable health outcomes and scientifically establish the mediators of its effects. For the community sector, it can demonstrate the group dynamics underpinning initial involvement, service delivery, participant engagement,

volunteering, and sustainability. For policy makers and commissioners, it can demonstrate reduced burden on health and social care services and increased independent living. Despite this wealth of knowledge, social psychology is not currently informing discussions concerning the development of SP initiatives.

The *Social Psychology of Social Prescribing* seminar series aims to promote knowledge exchange and collaboration by bringing together social psychologists and SP commissioners, general practitioners and allied health professionals, and the community and voluntary services sector across the UK. The seminar series comprises three day-long meetings which are free to attend and are open to all SP stakeholders. Events have a strong focus on networking and stakeholder engagement and include plenary sessions where attendees can respond to academic discussions and share their experiences of commissioning, providing, and using SP services. Plenary session discussions will be written up in report form to serve as a record of that event and to inform future events and broader debates around SP more generally. This document provides an overview of the discussions that took place at the first seminar held at Nottingham Trent University in June 2018. We begin by providing an overview of the seminar aims before detailing the key issues raised by attendees relating to their experiences providing SP services.

Seminar 1: Unpacking the relationship between social groups and health

There were 52 attendees in total representing 27 external organisations involved in the commissioning and/or provision of SP services alongside academics from 7 universities. The aims of this first seminar were as follows:

- Outline how Social Psychology's existing evidence base on the relationship between social isolation, group memberships, and health can address the knowledge gaps identified by those commissioning and delivering social prescribing services

- Consider how to promote engagement with social prescribing services among communities and individuals that are at greatest risk of social isolation and marginalisation

- Discuss the challenges facing organisations involved in social prescribing and the populations they serve

The morning session comprised academic talks and a research showcase session. The talks introduced social psychology's evidence base concerning the ways in which group memberships enhance individual health and well-being as well as the social prescribing research currently being undertaken at Nottingham Trent University. Two keynote talks were delivered. First, Sarah Collis (CEO Self Help UK) outlined the important link between self-help groups and social prescribing to illustrate how such groups can enhance the health and self-care of their members. The second keynote, delivered by Professor Catherine Haslam (University of Queensland) introduced *Groups 4 Health*, a world-leading, evidence-based social psychological intervention that tackles loneliness by developing participants' knowledge and skills to increase their social connections. The research showcase session highlighted the Social Cure research undertaken at NTU.[1]

The afternoon session was devoted to small group discussions that centred on the following key questions:

- Who should be offered SP services?

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[1] Slides and posters from the morning sessions are available on the seminar series website (https://spsocpres.wixsite.com/spsocpres)

- What are the 'active ingredients' of SP?

- What are the key challenges faced by SP stakeholders?

- What can the research community do for SP stakeholders?

Attendees discussed these questions in groups of between six and eight people. Groups were facilitated by two members of the seminar series team (one moderated the discussion while the second team member took notes). Following the event, discussion notes from each group were collated and key points were extracted. These are reported next in relation to each of the topic areas discussed.

Who should be offered SP services?

There was a clear desire that SP should retain a preventative focus in offering a non-medical solution to address health issues. Offering SP services to anyone who would benefit from it, would inevitably open this service to wide range of people but have the advantage that it would be seen as a 'mainstream' service. There was a concern that targeting specific groups or particular issues such as loneliness might confer a stigma on the service and discourage engagement. However, in the current climate of reduced budgets and funding cuts, it was questioned whether SP services could realistically be provided to all who need it with the suggestion that perhaps **those who are most in need should be prioritised**. This would include members of groups that are disproportionately affected by adverse social circumstances and/or who traditionally do not engage with health services.

There are likely to be **service access disparities**. First, people's tendency to talk to GPs about their issues in medical terms combined with limited appointment times could mean that **those who would benefit from SP are not being referred**. Second, it was felt that there may be group-based differences in referrals due to unconscious biases on the part of referrers. Relatedly, those groups who are less likely to access other health services might

also be less likely to access SP services. One possible way forward could be to tailor SP interventions to specific groups (or ensure existing activities are inclusive to all in the community) and consider building relationships with key figures in those groups to encourage wider community service access and initial engagement.

Alongside access issues, there are also challenges surrounding continued engagement of those who are particularly vulnerable with SP services. Attendees reported difficulties in encouraging and supporting those experiencing high levels of social isolation to join group activities. Furthermore, those who have the most difficulty engaging are also most likely to lose the service as a result of poor attendance at appointments. In sum, while there was a clear consensus regarding who should be offered SP services, it was agreed that greater effort needed to be made to ensure services were reaching out to, and viewed as accessible by, those most in need.

What are the active ingredients of SP?

While there is currently limited knowledge on how or why SP might work, attendees felt that SP services should comprise several key elements:

(1) Services should **take a holistic approach and be client-centred**. Link workers (or equivalent) should work with beneficiaries to co-produce a solution that best meets their individual circumstances. Attendees felt that the power differential between clients and practitioners at each stage of the SP process needs to be acknowledged. Thus, the relationship with clients should reflect a partnership rather than the link worker or community connector occupying the position of expert. SP services should go **beyond sign-posting** – the aim should be to empower clients to take charge of their health. The 'social prescription' should be one that is **meaningful** to clients, especially where this involves linking them to groups.

(2) Taking a purely individualistic focus is unlikely to be sufficient. SP services must be **community-centred**, that is, tailored to the needs of the groups and communities that use them. Those in the community should feel a **sense of ownership** over their community assets. Organisations working at a national level have much to offer in this area, as long as services are delivered locally in accordance with community needs.

(3) To be effective, community groups receiving SP referrals need to be **cohesive** with members feeling a **sense of connection** with each other and the wider group. Group **sustainability** and continuity over time is essential to long-term success.

(4) **Trust** needs to be present at all stages of the SP process (between the client and their GP / initial referrer, their link worker (if relevant), and any groups they are connected to through the SP service). Without a sense of trust, it is unlikely that clients will engage with the SP process or the social prescription itself. All those involved need to have some element of **credibility, be engaged, and appropriately skilled**. Referrers and service providers should share a **common understanding of SP**, its benefits, and its limitations.

What are the key challenges faced by SP stakeholders?

The challenges identified primarily relate to the key barriers faced by those providing SP services (reflecting the roles of seminar attendees). The following six key challenges were identified:

(1) **Unrealistic expectations** on the part of funders about the outcomes that can be achieved in relatively short timescales (which are often tied to budget cycles). There was a fear that SP is being "over-hyped". Attendees felt that the service flexibility needed for success (in terms of time and meeting individual needs) is not facilitated by the current funding system which does not allow services to grow and develop in such a way as to deliver the transformative

change required of them. SP providers felt in a constant battle to meet changing and /or unclear goals, which they viewed as being fuelled by wide-spread misunderstanding of SP and variation in outcomes expected by different commissioning groups. There was a sense of pervasive over-monitoring both of services and service beneficiaries. This was thought to be particularly detrimental to smaller organisations who lack the resources to comprehensively evidence what they are doing and consequently, lose funding.

(2) **Medicalization of social issues**. While attendees felt the GP referral route was a good place for this type of service provision to start, GPs should not remain the only source of referral. Some organisations involved with SP do not work with medical professionals but nonetheless are in a good position to identify, and help, vulnerable individuals, given their links to local communities and assets. Attendees felt that GPs were in a position of some power and could either promote or stop SP services from progressing. Not having a clinical lead buy-in to SP could mean that SP services would not be used. Relatedly, attendees felt that SP was acting as a "sticking plaster" that maintained existing health inequalities by shifting focus to the individual rather than tackling wider systemic issues. This would require the involvement of other statutory services such as housing, social welfare, transport, etc.

(3) **Sustainability** of services is hindered by short-term funding for short-term initiatives. This fuels a feeling of insecurity in both service staff and beneficiaries and can negatively impact on the services' ability to build trust with clients and the local community in which they operate. Attendees were concerned about the adverse effects of the withdrawal of support from vulnerable individuals when initiatives have to end due to lack of funding. Smaller organisations find it increasingly difficult to survive and secure funding in an increasingly competitive environment. SP provision requires resources (both human and financial) in order to deliver the expected outcomes. Running community groups, activities,

and other services that rely heavily on the input of volunteers is not cost-free. These require significant investment to recruit and retain volunteers in order to achieve promised outcomes.

(4) **Quality assurance** of SP services can be undermined by a lack of standardised provision, lack of clarity on the training needs of key staff (such as link workers and community connectors), and misunderstanding of the purpose of SP. Attendees raised concerned about inappropriate referrals to their services from GPs. These typically related to individuals in crisis whose needs would be best served elsewhere in the health system. However, attendees were reflective about their own work and queried whether this problem is also happening with SP services. It was suggested that external pressures to show service effectiveness in short timeframes might lead some to focus on engaged clients that are responding well to the social prescription. Such a focus, however is unlikely to ultimately show that SP schemes can change health outcomes for the most vulnerable members of society.

(5) It was felt there needed to be greater **stakeholder involvement** in the design and planning of SP services. Reflecting on their practice, attendees wondered if there were assumptions being made regarding the needs of people from vulnerable groups. While co-production does occur in many areas, it was felt that steps should be taken to ensure this is not tokenistic and that all stakeholders are involved from the beginning. It was felt that at times these meetings might not be representative of all those who would use SP services and that there can be a failure to check assumptions with representatives from groups/communities that providers are trying to engage with. Relatedly, there is also a need to clearly identify and work with community-based groups and other organisations (often successful ones), that are already operating in the community and avoid duplication or disruption of existing community assets.

(6) Finally, there were **practical challenges** associated with service provision. For example, it might not be seen as cost effective to provide services in remote locations. There are also difficulties for some populations accessing transportation to 'prescribed' activities.

What can the research community do for SP stakeholders?

The final topic for discussion focused on the research needs of those providing SP services and what role, if any, universities should play in this area. A distinction was made between evaluation needs and wider research needs.

(1) Evidence pertaining to the efficacy of SP services serves a number of purposes. For example, it can be provided to GPs and commissioning groups to persuade them of the value of a particular initiative. However, it can also be communicated to beneficiaries to sustain engagement or the wider public to promote awareness (or even self-referral). Consequently, **research findings should be communicated in an appropriate, accessible format**. The type of findings communicated should be tailored to the audience as different stakeholders value different outcomes. With regard to funders, however there is a pressing need to provide evidence to support claims of **cost savings** and social return on investment.

(2) Regarding **evaluation**, it was felt that these projects are often difficult to cost into initiatives funded by small budgets. It was suggested that universities could provide advice to smaller organisations on how to obtain funding or how to present their in-house data to illustrate the effectiveness of their initiatives. It would also be useful to produce an SP evaluation toolkit that contains a standard set of outcome measures applicable across contexts to be used in an evaluation. Such a toolkit should include social metrics as it was felt that these are typically not included in current evaluations (e.g. collective behaviour, social justice, etc.).

(3) Alongside evaluation-focused research which attendees felt is primarily descriptive, there is the need for more **critical research** focusing on ascertaining how, why, and for whom SP works. Research should also investigate group-based differences in outcomes and service access, the impact of differing conceptualisations of SP amongst referrers, service providers and commissioners, and finally, the wider societal impact of SP services (moving away from the current individualistic focus). Conducting the **robust research** needed to answer these questions is almost impossible within evaluation timeframes and requires a large-scale approach rather than focusing on smaller initiatives. Attendees felt that SP research requires more sophisticated designs including longitudinal studies and should be mixed-methods in nature. Attendees placed high value on qualitative data. There were mixed views regarding the use of (Randomised Controlled Trials) RCTs in SP research. It was felt such studies can be difficult to conduct in this context but are thought to be needed to convince medical professionals of the value of SP.

Conclusion

In sum, the small group discussions from this first seminar provided valuable insights from those involved at the front-line of SP service delivery. In an uncertain funding context, it was proposed that while all can benefit from SP, those most in need should be prioritised. Further research is needed to establish the efficacy of SP and to understand how, why, and for whom it works. Nonetheless, there was a consensus on the key characteristics of successful SP schemes, specifically that services are client-centred, that they link individuals with groups and community supports that are meaningful to them, and that SP services are themselves tailored to meet the needs of the communities that will use them. There were a number of urgent challenges currently faced by those providing SP services relating to developing and operating a new form of health service delivery in a climate of austerity. The need to build trust between SP providers, beneficiaries and the wider community is undermined by short

term funding streams which are not conducive to providing sustainable services as well competing understandings of the purpose of SP. Finally, a key challenge for the future is to ensure SP services are truly inclusive and accessible to all sectors of the community.

References

Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, S.A. (2018). *The new psychology of health: Unlocking the social cure.* London: Routledge.