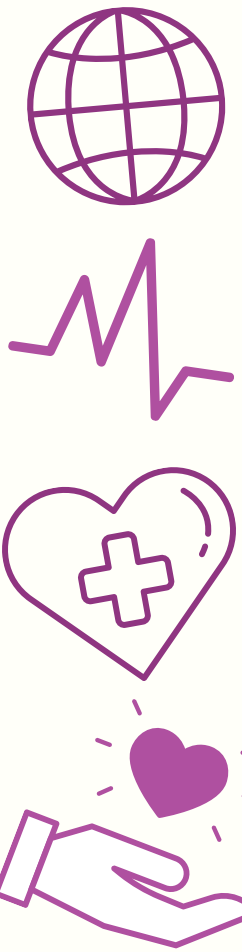
SOCIAL PRESCRIBING: THE HEALING POWER OF VOLUNTEERING?



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SOCIAL PRESCRIBING: THE HEALING POWER OF VOLUNTEERING?

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Introduction

The domain of mental wellbeing is receiving more and more attention in the healthcare profession, and it is commonly accepted that mental health, as well as social and environmental factors, are significant determinants of physical health. In recognising this symbiotic relationship, medical professionals are pursuing the development of more holistic approaches to improving the health of their patients. One such approach is that of "social prescribing".

Also known as "community referral", "linking" or "signposting", the phenomenon of social prescribing is expanding mainly in the United Kingdom but has been introduced in Ireland and the Netherlands. Originating in the Bromley-by-Bow Centre in London in the 1990s, social prescribing presents a means of tackling poor health without, or alongside, the prescription of pharmaceutical drugs. There is no widely agreed definition for social prescribing, however, the Social Prescribing Network developed a working definition at its 2016 conference, concluding that it can be understood as "enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and well-being"[1].

This paper will investigate the provision of social prescribing, focusing on the UK with particular emphasis on the prescription of voluntary activity to patients. The following section will lay out the current situation of social prescribing, including information on how it works, how it is funded, and what infrastructure is in place to support social prescribing in general. Section 3 will comprise an evaluation of the impact of social prescribing and volunteering on prescription, including a case study of volunteering prescriptions in Yorkshire. Finally, Section 4 will address the concerns going forward with social prescribing.

What is social prescribing?

As previously mentioned, social prescribing has its roots in a London community health centre and has been expanding across the UK since the 1990s. Interest in the mechanism particularly took off following the UK government's 2006 White Paper "Our health, our care, our say"[2] which highlighted the potential of the scheme. The NHS subsequently incorporated social prescribing into their health, well-being and prevention policies, outlined in the "NHS five year forward view"[3] in 2014 and the "General practice forward view" in 2016. As a result, schemes are currently running from the far South Western coast of England as far north as

1 Polley et al (2017), pp. 13.
2 Department of Health (2006).
3 NHS (2014).

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Aberdeenshire in Scotland. In the European context, social prescribing schemes can be found in Ireland and the Netherlands. But how do they work?

The scheme is usually aimed at those with a Long-Term Condition(s) as well as those who are dealing with mental health issues, social issues like debt affecting their well-being, and loneliness and isolation. The process begins with an appointment with the patient's local family doctor or healthcare practitioner, who then refers patients to social prescribing services. Alternatively, the family doctor can "signpost" patients towards these services, meaning they give patients practical information and recommendations for accessing certain services, but the patient will be responsible themselves for approaching the service for help. As well as family doctors, the Social Prescribing Network predicts that as social prescribing schemes become more widespread, other referring actors will become more active in referring patients[4], such as Adult Social Care professionals and third sector organisations like Macmillan Cancer Support.

The link worker is identified as a non-clinically trained individual who will consult with the patient following the initial referral. Despite being non-clinically trained, link workers must receive training on how to deliver social prescribing programmes, as well as undergoing background checks.

On the whole, link workers are based in the community within third sector organisations, such as volunteer centres, and have strong local knowledge of community groups and activities. In some social prescribing schemes, the link workers may be employed within the primary care organisation, such as the local doctor's surgery. The link worker and the patient work together to co-create a plan to address the issues, with the link worker using their local knowledge to direct patients towards appropriate organisations and activities.

The local groups that a patient can be referred to cover a broad spectrum of programmes and differs for each social prescribing scheme. They can range from physical activities such as sports clubs, to arts and crafts groups, to services that deal with specific social issues (debt or risk of homelessness, for example).

Certain programmes, such as the scheme in Blackburn, UK, focus on referring patients to voluntary activities. The patients in focus here struggle with mental health and substance misuse, and are referred to organisations such as charities, local libraries, and food banks to volunteer.

Some programmes can have a designated length, of weeks or months, whereas some programmes are open-ended and do not have a specific deadline. Often, the patients integrate into the receiving organisation and continue their activities beyond the prescription period, for example, one in three patients of the East Riding in Yorkshire exercise-on-referral scheme took out membership with their local sports centre[5].

4 Polley et al (2017), pp. 15.

5 Local Government Association (2016).

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As social prescribing schemes take on more patients and become more widespread across the country, there will be an increasing need for funding. Funding is required not only to employ and train link workers with the specific purpose of administering the social prescribing scheme, but also in order to facilitate the work of the community groups receiving social prescribing patients. In 2018, the UK Department for Health & Social Care[6] announced a £4.5 million funding boost specifically for social prescribing schemes across the country, and additional funding for social prescribing comes from the NHS (who employ and fund the link worker position), local councils and Clinical Commissioning Groups, as well as donations from charities and social investors.

Evaluation of the impact of Social Prescribing and Volunteering

The impacts of social prescribing have been widely noted and show signs of positive progression, although much of the data is anecdotal and datasets are not substantial.

Anecdotal evidence clearly suggests that social prescribing is beneficial for the patients. Many social prescribing schemes upload case studies providing patient feedback and many follow-up reports quote patients as part of the evidence base. Much of the patient feedback[7] includes reports of feeling less socially isolated, improved mental wellbeing and anxiety/stress coping mechanisms, crisis evasion, increased confidence, positivity and independence, improved health and fitness, and improved life skills.

A number of studies carried out concerning individual social prescribing schemes, such as those in Doncaster[8], Rotherham[9], Bristol[10], Newcastle[11], etc. find that social prescribing reduces pressure on healthcare services. It is reported that 20% of patients arrange appointments with their local doctor to address social issues rather than health issues[12]. The previously mentioned social prescribing schemes resulted in reduced appointments with local doctors as well as mental health doctors and patient attendance in Accident and Emergency departments in some cases. The social prescribing scheme run by Voluntary Action

6 Department for Health and Social Care (2018).

7 See Social Prescribing Cornwall (2019), Dayson and Bennett (2016), Dayson and Bashir (2014), Kimberlee et al. (2014), ERS (2013).

8 Dayson and Bennett (2016).

9 Dayson and Bashir (2014).

10 Kimberlee et al. (2014).

11 ERS (2013).

12 Torjesen (2016).

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LeicesterShire[13] reported savings equal to £4,500 for the local medical practice by reducing primary care appointments. They estimate that the scheme has the potential to save £97,381[14] annually for the local medical centre alone, reaching figures of £15m+ for the county's Clinical Commissioning Groups. An interest for further research could also include the savings made by reducing the prescriptions of pharmaceutical drugs, which can be costly. As well as economic benefits, the reduction in medical appointments also indicates an improvement in the health and wellbeing of the patients.

In Blackburn and Darwen[15], the social prescribing scheme saw the percentage of referrals who were active and who connected regularly with others increase substantially. This scheme places particular emphasis on using voluntary activities as part of its prescriptions, allowing patients to get out and about more and meet and socialise with other volunteers and service users. The percentage of patients who were active after 6 months rose from 67% to 100%, and those who connected with others weekly or more rose from 51% to 90%. Increased physical activity and increased social contact can of course be linked to increasing mental and physical health and wellbeing.

Where social prescribing schemes in general could save healthcare services time and money dealing with social issues, volunteering is also known to contribute greatly to economies. Employing voluntary activity in these schemes therefore benefits the patients, healthcare services and society as a whole. For example, where a patient is referred to volunteer in a library, such as within the Doncaster Social Prescribing scheme, the patient is then providing a service to the community and performing work that is valuable to an economy. In 2014, the Office for National Statistics reported that volunteering in the UK had an estimated worth of approximately £23 billion[16].

Concerns and limitations going forward

Given the relatively recent appearance of social prescribing practise, there are naturally certain limitations and concerns to consider going forward.

Firstly, it will take some time to gather clear and robust evidence regarding the impact of social prescribing. Research thus far has largely been carried out over short periods of time and the evidence base is usually rather small. Furthermore, much of the evidence is anecdotal and self-perceptive so is of course open to misreporting by patients, as well as only representing those

13 Voluntary Action LeicesterShire (2019), pp. 3
14 Ibid., pp. 12.
15 Community CVS (2019).
16 Office for National Statistics (2017).

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willing to engage and provide feedback. It would be helpful to standardise data on the outcomes of social prescribing; for example, the South Yorkshire Housing Association employ the Warwick-Edinburgh Mental Wellbeing Scale to evaluate the impact on the health and wellbeing of their patients. Finally, to gather truly robust evidence, it will be necessary for researchers to incorporate control groups into their studies. As schemes age, it will be easier to make clear and accurate conclusions.

Accountability is also a big question surrounding social prescribing. Whilst the programmes are designed to relieve the pressure on family doctors, there is a need for clarity on where the doctor's/link worker's/community group's responsibility ends. Doctors need to feel confident in referring the patients on to another service in order to fully engage with social prescribing schemes whilst link workers and community groups also need protections and backing to allow them to feel comfortable in their decision-making should anything go wrong. It is essential that there is monitoring of patients once they have left the direct care of doctors and into the hands of link workers and community groups. Whilst the root cause of health concerns may be linked directly to social issues, social prescribing may not always be sufficient in addressing such health concerns. If any tragic event were to happen, it is important to know where the buck stops and to recognise any failures within the scheme by developing robust monitoring and evaluation procedures.

This risk also necessitates sufficient training for link workers and a readiness of the receiving community groups, not only to protect themselves from liability but also to safeguard the patient. For the link workers, this means the continuous development of professional training and qualifications in the field specifically related to social prescribing. One suggestion is to develop an accreditation for link workers as a guarantee of their skillset and recognition of their commitment to continued learning. For the community groups, they must be ready to potentially receive a high volume of new participants. Training could prove equally important for community groups as for link workers, but also sustained funding could allow groups to buy additional resources, expand their premises, employ more staff, etc. and better accommodate social prescribing scheme patients.

Finally, whilst volunteering is sometimes prescribed by link workers to patients, it would be beneficial to increase the provision of voluntary activity within the social prescribing framework. As it stands, domains such as sports clubs, craft groups and advice centres dominate social prescribing schemes, yet the benefits of volunteering are widely accepted and significantly relevant to social prescribing. Not only benefitting the patients themselves, by improving health and wellbeing, but voluntary activity also brings benefits to society as a whole. Partner charities and social enterprises could make good use of an increased manpower to carry out their missions and voluntary work carried out by patients would contribute to the economy. Therefore, advocating for an increase in volunteering on prescription is recommended.

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Conclusion

From the literature and data considered within this paper, it is possible to conclude that volunteering on prescription, as part of a social prescribing scheme, is an efficient way of addressing health and well-being concerns. Social prescribing in general reduces the pressure on family doctors, by redistributing health concerns caused by predominantly social issues to non-clinical professionals who are equipped to deal with such concerns.

Volunteering on prescription not only improves the efficiency of healthcare resources, it is well-known that volunteering heavily contributes to society, not only in terms of social cohesion, but economically too. Although volunteering is not the most often-employed activity within the social prescribing framework, there is some evidence to suggest that it is highly beneficial to patients and the argument should be made to increase provision of volunteering as a social prescription.

However, the data considered in this paper was not exhaustive, and there is existing data that could supplement this. That said, there is still not enough data surrounding social prescribing, largely because it is a relatively recent phenomenon. As time goes on, it will be possible to gather evidence from larger samples and time periods, allowing for more robust data and well-informed policy decisions. As well as assessing the impacts on individual patients, further research is required in terms of economic and societal impacts, as well as at a governance level to develop successful policy and procedure.

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