Social Prescribing and Complexity Theory: A Systematic Literature Review

Executive summary

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One of the key aims of this systematic review was to develop a greater understanding of the context under which social prescribing operates by mapping the terms' pragmatic use, despite the typology of the service. This study utilised search results from nine databases, manual searches via Google (19/04/2019), scanning the reference lists of retrieved articles for related documents (23/04/2019) and manual searches for full articles based on identified protocols.

The databases accessed were as follows (accessed between 15/04/2019 - 17/04/2019):

. PubMED
. Applied Social Sciences Index and Abstracts (ASSIA)
. Cumulative Index to Nursing and Allied Health Literature (CINAHL)
. MEDLINE
. Cochrane Database of Systematic Reviews and NHS Economic Evaluation Database
. Directory of Open Access Journals (DOAJ)
. Science Direct
. Social Care Institute for Excellence (SCIE)
. Psychology Database – PROQUEST

Search terms included: Social Prescribing, Community Referral*, Arts on Prescription, Community Coordination, Non-Medical Referral*, Social Referral*, Social Prescription.

Unlike other reviews of social prescribing literature this search did not exclude studies held outside of the UK, however was inclusive of only those written in English and published after January 2016, to coincide with the inclusion criteria of the previous systematic review published in 2017 (Bickerdike et al., 2017). In order to meet eligibility for this review each publication had to include primary research or an evaluation of a social prescribing programme(s) and as such systematic or non-systematic reviews were excluded. There were no limitations for inclusion placed on either the design or sampling criteria of studies.

This study utilises a lumping (Squires et al., 2013) method of selection, where inclusion is structured around a pragmatic definition as opposed to a theoretical definition of an intervention. Therefore, the primary criteria for inclusion in that each publication must recognise and refer to the programme being examined as social prescribing, as opposed to a definition such as those provided by the Social Prescribing Network (2019b) and Wales Social Prescribing Network (2019a). By relying on the original author's classification/description, we aimed to mitigate some of the potential screening bias which could occur as a result of the ambiguity amongst common definitions of social prescribing (2008, Squires et al., 2013), particularly those definitions which exclusively recognise statutory based services.

As expected, findings demonstrate a wide variety of projects with little uniformity in the demographic of clients or staff members involved. Furthermore, interventions demonstrate a diverse range of activities and length of operation, which varies from the short term (6 weeks) to the long-term (2 years). Despite these differences, there are however two constants running through all the studies:

1. *Interventions are non-medical in nature* – despite their health and wellbeing connotations none of the services were specifically delivering medical interventions
2. *Interventions are delivered by a third party* – whilst there was variation between the type and number of organisations involved in each project, all of the studies reported the use of third-party delivery rather than in-house interventions.

It is possible to extrapolate a definition from these constants, which defines social prescribing as a process of *individuals being referred/self-referring to non-medical interventions run by a third-party organisation in order to contribute to their general health and wellbeing.* This definition is similar to that provided by both the Social Prescribing Network (England) (2019b) and that provided by Primary Care One Wales (Broomhead, 2018), suggesting that these are somewhat representative of general practice.

Beyond this however, no singular definition would encompass each study included. Whether difference is apparent at an individual level, in the day-to-day practice of link workers (Whitelaw et al., 2017, Wildman et al., 2019), or at an organisational scale (Baker and Irving, 2016, Sumner et al., 2019), with whole services being dedicated to singular interventions (Todd et al., 2017); the freedom to meet the needs of clients and to self-organise afforded to many of the services, renders further definition particularly challenging. Whilst a definition full of regulation and specificity is not necessarily vital, as the unique nature of services are perceived as being highly beneficial (Kimberlee, 2013, Polley and et, 2017), further discussion about the use of the term social prescribing and the classification of services could be of benefit, as misunderstandings from clients and staff of how services operate are still reported (Pescheny et al., 2018, Kimberlee, 2016). This is especially prescient when considering third-sector services, which have been excluded in previous studies. In practice it would seem that both statutory and third sector services are equally varied and as such a new definition encompassing both is plausible and potentially useful for the inclusion criteria.

Results also demonstrate that whilst there exists expansion in the implementation of social prescribing, the evidence for its benefits remain largely inconclusive. The quantitative reports included, although demonstrating an improvement in detail and sample size (Bickerdike et al., 2017), continued to consistently capture small increases or, in the case of all studies utilising a control group, no statistical significance between client outcomes. Whilst in contrast qualitative reports were predominantly positive from the entire range of stakeholders interviewed. This disconnect between the two sets of data requires further investigation, that would rely on an increase in the rigour of studies as well as the transparency in reporting.

The vast majority of the studies included were focused on whether the services ‘worked’ and not ‘how’ they worked. Social prescribing models are heterogeneous in design and delivery. Predominantly located at the interface of healthcare and community services, they are likely to be shaped by the interplay of multiple stakeholders. This indicates inherent complexity within social prescribing models, which cannot be effectively evaluated with a simple cause and effect lens.

References

2008. AHRQ Methods for Effective Health Care. *Methods Guide for Effectiveness and Comparative Effectiveness Reviews.* Rockville (MD): Agency for Healthcare Research and Quality (US).

2019a. *The All Wales Social Prescribing Research Network (WSPRN)* [Online]. Wales Council For Voluntary Action. Available: https://www.wcva.org.uk/what-we-do/the-social-services-and-wellbeing-(wales)-act-the-role-of-the-sector/wales-social-prescribing-research-network [Accessed 04/02/2019 2019].

2019b. *What is Social Prescribing?* [Online]. The Social Prescribing Network. Available: https://www.socialprescribingnetwork.com [Accessed 15/04/2019 2019].

BAKER, K. & IRVING, A. 2016. Co-producing Approaches to the Management of Dementia through Social Prescribing. *Social Policy and Administration,* 50**,** 379-397.

BICKERDIKE, L., BOOTH, A., WILSON, P. M., FARLEY, K. & WRIGHT, K. 2017. Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open,* 7.

BROOMHEAD, D. P. 2018. *A realist evaluation of NHS managers' experiences of managing staff poor performance.* D.Prof., Sheffield Hallam University (United Kingdom).

KIMBERLEE, R. 2016. What is the value of social prescribing? *Advances in Social Sciences Research Journal,* 3.

KIMBERLEE, R. H. 2013. *Developing a social prescribing approach for Bristol,* Bristol, University of the West of England.

PESCHENY, J., RANDHAWA, G. & PAPPAS, Y. 2018. Patient uptake and adherence to social prescribing: a qualitative study. *BJGP Open,* 2**,** bjgpopen18X101598-bjgpopen18X101598.

POLLEY, M. & ET, A. 2017. *Making sense of social prescribing,* London, University of Westminster.

SQUIRES, J. E., VALENTINE, J. C. & GRIMSHAW, J. M. 2013. Systematic reviews of complex interventions: framing the review question. *Journal of Clinical Epidemiology,* 66**,** 1215-1222.

SUMNER, R. C., CRONE, D. M., BAKER, C., HUGHES, S., LOUGHREN, E. A. & JAMES, D. V. B. 2019. Factors associated with attendance, engagement and wellbeing change in an arts on prescription intervention. *Journal Of Public Health (Oxford, England).*

TODD, C., CAMIC, P. M., LOCKYER, B., THOMSON, L. J. M. & CHATTERJEE, H. J. 2017. Museum-based programs for socially isolated older adults: Understanding what works. *Health & Place,* 48**,** 47-55.

WHITELAW, S., THIRLWALL, C., MORRISON, A., OSBORNE, J., TATTUM, L. & WALKER, S. 2017. Developing and implementing a social prescribing initiative in primary care: insights into the possibility of normalisation and sustainability from a UK case study. *Primary Health Care Research & Development,* 18**,** 112-121.

WILDMAN, J. M., MOFFATT, S., PENN, L., O'BRIEN, N., STEER, M. & HILL, C. 2019. Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & Social Care In The Community*.