MRC/CSO Social and Public Health Sciences Unit Consultation Response

Title of consultation

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

Name of the consulting body

HEALTH AND SPORT COMMITTEE, Scottish Parliament

Link to consultation

https://www.parliament.scot/parliamentarybusiness/CurrentCommittees/112415.aspx

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?

We have expertise in the area of social prescribing, and some of our published research could be drawn on to answer the specific questions posed by the consultation. There are various problems with the social prescribing model being rolled out, and we hoped to highlight some areas of concern.

Our consultation response

1. To what extent does social prescribing for physical activity and sport increase sustained participation in physical activity and sport for health and wellbeing?

We do not have specific expertise in social prescriptions for physical activity and sport, but regarding the general social prescribing research there is a clear lack of evidence about what works for whom; the effectiveness of social prescribing generally is not supported by evidence (Bickerdike 2017; Kilgarriff-Foster & O'Cathain 2015; Centre for Reviews and Dissemination 2015). There is some evidence that social prescribing may address low self-esteem and confidence; poor mental wellbeing and mood; and anxiety and depression; increasing sociability, communication skills and social connections; and increasing motivation for future goals with increased hope, optimism and meaning to life (Dayson and Bashir 2014; Barely et al 2012; Carnes et al 2017; Makin and Gask 2011; Todd et al 2017; Abbotts and Spence 2013). However, the quality of studies is generally limited, and the types of social prescribing intervention diverse.

Sorensen et al (2006) conducted a systematic review of exercise on prescription, with some positive results showing moderate improvement in physical activity at 6-12 months, but with the caveat that here were few high quality studies and the evidence was too limited to draw solid conclusions. Also, there was concern that the studies included self-selecting groups of patients taking up the interventions and GPs offering them. A rigorous randomised trial evaluation of the National Exercise Referral Scheme in Wales found positive impacts on physical activity and mental health (Murphy et al 2012). Process evaluation within this study found that running group sessions only for those referred helped to foster social support networks and that this was a key mechanism for maintaining changes in the longer term (Moore et al 2011). A further evaluation specific to physical activity explored the effectiveness of a primary care based programme of exercise on prescription among relatively inactive women over a two year period (Lawton, 2008). It provided some support for an exercise on prescription scheme (intensive individual support,

delivered by a primary care nurse, to engage in physical activity and achieve personal goals (Rose 2007)), with physical activity and quality of life improving in the intervention group. However, there were no significant differences between those receiving the intervention and controls for clinical outcomes, and importantly, falls and injuries increased in the intervention group (significantly compared to controls). It should be noted that this evidence is specific to the intense follow up and support of the intervention.

2. Who should decide whether a social prescription for physical activity is the most appropriate intervention, based on what criteria? (e.g. GP, other health professional, direct referral from Community Link Worker or self-referral)

Ultimately the individuals themselves should decide whether a social prescription for physical activity is the most appropriate intervention. People who are offered social prescriptions are likely to have numerous competing needs and they should be supported to prioritise the things that they are able to tackle with help of social prescriptions. This should be done in partnership with the health care providers involved in the patient's care. A review of studies found that where patients were recruited through their regular health or social care professional, e.g. GP, nurse, social worker, engagement with the social prescribing programme was more successful than when intervention staff recruited patients directly (Mossabir 2015). The existing trusting relationship between patient and health or social care provider was thought to be key to engaging patients.

3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?

As mentioned above, individuals may face issues that they feel are more important to address (although may be out of their control) and have their own priorities beyond sport and physical activity. Before addressing these 'bigger' issues individuals may not feel able to engage in sport and physical activity. It is therefore essential that individual patients are involved in developing social prescription plans alongside their health or social care provider and link worker (or equivalent).

The facilities or organisations for people to be 'prescribed' to, and resources or capacity of the resources in the local areas may not be available (Skivington 2018). This is an overlooked aspect of social prescription, whereby initiatives may start within primary care with insufficient partnership or collaboration with local community assets. An example of a successful physical activity and diet intervention, upon which social prescribing could draw, is Football Fans In Training—FFIT (Gray et al 2013, and associated papers). FFIT was developed in Scotland and delivered through professional sports clubs to support men lose weight, become more active, and eat more healthily. Success of this intervention is partly related to the fact that it has involved shared identity (of relationship with the team), social practice, and support throughout. FFIT has since been transferred to other settings and contexts, and for a wider range of participants (e.g. van Nassau et al 2016).

Relatedly, GPs are overwhelmed with work, particularly in areas where need is greatest (Mercer 2007). There is a danger that individuals are prescribed sports/physical activity so that 'something' is being given, but that effective referrals/communication links are not in place. The barriers to effective social prescribing to sport and physical activity are likely to be the same for social prescribing generally.

4. How should social prescribing for physical activity and sport initiatives be monitored and evaluated?

It is essential that social prescribing initiatives are evaluated, otherwise we will not be able to learn from the plethora of activities. Any evaluation should be planned from the outset (i.e., when

social prescribing interventions are designed) rather than from when after the initiative has been rolled out. All those involved in delivering, supporting, and receiving the social prescription should be consulted, i.e. including the individuals themselves and the organisations that the prescription refers them to (which is often left out of evaluation, Skivington 2018). It is important that social prescribing initiatives are done in partnership with local community organisations, rather than solely an initiative of the primary care health centre/surgery. There is a danger that GPs will refer to link workers or others but the infrastructure, services, or communication will not be in place for the referrals to be made and sustained. Therefore, an evaluation of the available resources that are needed at community level should be undertaken in the development of the social prescribing initiative, e.g. if initiatives are set up to refer individuals to physical activity or sports then these facilities have to be available at local level (and they have to have expertise, accommodations etc. to enable them to fulfil prescriptions for people who have additional needs). Perhaps the starting point should be to identify and evaluate community need before setting up a referral scheme for individuals.

The MRC/NIHR is due to publish updated guidance on 'Developing and Evaluating Complex Interventions' (Craig, 2008), which we at SPHSU are leading on. Many of the new recommendations, e.g. those related to involving stakeholders, developing programme theory, and considering taking a systems perspective (particularly when considering appropriate processes and outcomes) would be highly relevant to the evaluation of a social prescribing initiative. This guidance is likely to be available early 2020 though we would be happy to discuss further if requested.

References

Abbotts, J. & Spence, W. Art and wellbeing in a deprived Scottish community. J Public Ment Health. 2013; 12(2): 58–69.

Barley, E. A. Robinson, S. & Sikorski, J. Primary-care based participatory rehabilitation: users' views of a horticultural and arts project. Br J Gen Pract. 2012; 62: 127–134.

Blickem, C., Kennedy, A. & Vassilev, I. et al. Linking people with long-term health conditions to healthy community activities: development of Patient-Led Assessment for Network Support (PLANS). Health Expect. 2013; 16(3):e48–e59.

Carnes, D., Sohanpal, R. & Frostick, C. et al. The impact of a social prescribing service on patients in primary care: a mixed methods evaluation. BMC Health Serv Res. 2017; 17: 835.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I. and Petticrew, M., 2008. Developing and evaluating complex interventions: the new Medical Research Council guidance. Bmj, 337, p.a1655.

Dayson, C. & Bashir, N. The social and economic impact of the Rotherham Social Prescribing Pilot: Main evaluation report. Centre for Regional Economic and Social Research, Sheffield Hallam University. 2014. Available from: doi:10.1017/CBO9781107415324.004

Gray, C.M., Hunt, K., Mutrie, N., Anderson, A.S., Leishman, J., Dalgarno, L. and Wyke, S., 2013. Football Fans in Training: the development and optimization of an intervention delivered through professional sports clubs to help men lose weight, become more active and adopt healthier eating habits. BMC public health, 13(1), p.232.

Greenwood, N., Smith, R. & Akhtar, F. et al. A qualitative study of carers' experiences of dementia cafés: a place to feel supported and be yourself. BMC Geriatr. 2017; 17: 164.

Howarth, M. L., Mcquarrie, C. & Withnell, N. et al. The influence of therapeutic horticulture on social integration. J Public Ment Health. 2016; 15(3): 136–140.

Makin, S. & Gask, L. 'Getting back to normal': the added value of an art-based programme in promoting 'recovery' for common but chronic mental health problems. Chronic Illn. 2011; 8(1): 64–75.

Mercer, S.W. and Watt, G.C., 2007. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. The Annals of Family Medicine, 5(6), pp.503-510.

Moffatt, S., Steer, M. & Lawson, S. et al. Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. BMJ Open. 2017; 7: e015203.

Moore GF, Moore L, Murphy S. Facilitating adherence to physical activity: exercise professionals' experiences of the National Exercise Referral Scheme in Wales: a qualitative study. BMC Public Health. 2011;11:935. Published 2011 Dec 15. doi:10.1186/1471-2458-11-935

Morton, L., Ferguson, M. & Baty, F. Improving wellbeing and self-efficacy by social prescription. Public Health. 2015; 129: 286–289.

Murphy SM, Edwards RT, Williams N, et al. An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales, UK: a randomised controlled trial of a public health policy initiative. J Epidemiol Community Health 2012;66:745-753.

Rose SB, Lawton BA, Elley CR, Dowell AC, Fenton AJ. The Women's Lifestyle Study, 2-year randomized controlled trial of physical activity counselling in primary health care: rationale and study design. BMC Public Health2007;7:166.

Sorensen, J.B., Skovgaard, T. and Puggaard, L., 2006. Exercise on prescription in general practice: a systematic review. Scandinavian journal of primary health care, 24(2), pp.69-74.

Stickley, T., Hui, A. & Souter, G. et al. A community arts programme for older people: an evaluation. Mental Health and Social Inclusion. 2016; 20(1): 22–28.

Stickley, T. & Hui, A. Social prescribing through arts on prescription in a UK city: Participants' perspectives (Part 1). Public Health. 2012; 126: 574–579.

Stickley, T. & Eades, M. Arts on Prescription: a qualitative outcomes study. Public Health. 2013; 127: 727–734.

Todd, C., Camic, P. & M. Lockyer. et al. Museum-based programs for socially isolated older adults: Understanding what works. Health and Place. 2017; 48: 47–55.

van Nassau, F., van der Ploeg, H.P., Abrahamsen, F., Andersen, E., Anderson, A.S., Bosmans, J.E., Bunn, C., Chalmers, M., Clissmann, C., Gill, J.M. and Gray, C.M., 2016. Study protocol of European Fans in Training (EuroFIT): a four-country randomised controlled trial of a lifestyle program for men delivered in elite football clubs. BMC public health, 16(1), p.598.
Vogelpoel, N. & Jarrold, K. Social prescription and the role of participatory arts programmes for older people with sensory impairments. Journal Integr Care. 2014; 22(2): 39–50.

White, J. M. Social Prescribing: the Perspectives of Service Users, Providers and Prescribers. PhD [thesis]. Glasgow Caledonian University; 2012. Available from: http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos. 570733

When was the response submitted?
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