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Social Prescribing for an Aging Population

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ABSTRACT

As the human population is moving toward a demographic of aging individuals, increased levels of stress will be placed on the current health care system. "… As people live longer, there is a tendency for the onset of disease to occur closer to the end of life" (p. 441) and the incidence of mental health illnesses is prevalent in older adults. Currently, the medical model is dominant in the health care system and aims to cure any issue(s) without considerations in the cause or source. Social prescribing/social prescription enables physicians and health care professionals to refer individuals to non-clinical services, such as art and music, to provide holistic care or a response to the current health care system. This paper will provide an overview of the concept of social prescribing, offer examples in the current practices of social prescription, and describe the role of social prescription in older adults and their caregivers.

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Introduction

Have you received a social prescription from a health care professional for the treatment of your health and wellness concerns: either alone or in combination with your current medical prescription? Social prescription(s) is a relatively new concept that is important to the holistic approach to health care (Bergland, 2017; Kings Fund, 2017). With the major advancements in technology and the availability of resources in everyday life, people expect an instant gratification and solution to their health and wellness issues.

During a visit to a physician, the patient describes various symptoms related to their health and wellness. The physician is often prompted and encouraged by the patient to prescribe a drug that may or may not treat the actual disease or underlying symptoms. Further, physicians can be taxed with large patient caseloads and patients are eager for a prompt recovery. Finding the source of symptom manifestation is a challenging task that takes time, involves substantial medical tests, changes in the patient's lifestyle and habits, and/or a combination of different medications or devices. Unfortunately, "settling for a short-term medical fix may be pragmatic but can easily become a conspiracy of silence,

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which confirms the underlying sense of defeat" (Brandling & House, 2009, p. 454). In other words, a prescription drug can provide immediate health care to a certain threshold, whereas in other times, it is simply a band-aid to the problem. "For all that can be accomplished using modern medicine, healthcare professionals still face enormous challenges in treating patients to the point where can say they feel 'well'" (O'Neil, 2018).

Patients can take years in the topical treatment to their symptoms and they may never find its source or alleviate these issues; which poses the effectiveness of drug prescriptions as the ideal treatment. "Drugs can only do so much, especially when a person is experiencing social isolation, loneliness, low income, barriers to employment or other issues that can further impact their quality of living" (O'Neil, 2018). Although there is a steady and growing number of persons that seek out natural, alternative or complementary therapies to manage their health and wellness (with a physician), very few patients have received a formal written social prescription from a health care professional.

Crimmins and Beltrán-Sánchez (2010) affirm with the above statement, proclaiming that the growth in the population of older adults results in the increased need for a holistic approach to health care that considers wellbeing in a physical, social and psychological context. While there is a progression in older adults being more exposed to holistic practices – such as music therapy, recreation therapy, art therapy, acupuncture, and naturopathy – these services are not readily available and its investment can prohibit persons with low incomes due to limited government subsidy and private insurance. These therapies should serve as the primary resources to an aging population. As longer life expectancy has been attributed to outcomes of the engagement in cultural and artistic experiences (as well as socioeconomic status variables like age, education, sex, income, social network, smoking, physical activity, and long-term disease) (Bygren, Konlaan, & Johansson, 1996), social prescribing has a more meaningful stance in the long term.

Health care is costly for individuals and society at large: especially medications, procedures, medical specialists, and therapies. Health care costs have reached peak heights. Many countries are not prepared for the exponential growth in older adults, which account for a significant proportion of health care expenditures (Emergo, 2016). According to Emergo (2016), health care spending increased to an average of 63% around the world between 2004 and 2014, per capita. To address these concerns, the Social Prescribing Network (SPN) was created in the United Kingdom. In expansion with Ireland and Scotland, SPN aims to promote a more holistic approach and minimize financial concerns in health care (Social Prescribing Network, 2018a). "Social prescribing is one such model and is being widely promoted as a way of making general practice (GP) more sustainable" (Bickerdike, Booth, Wilson, Farley, & Wright, 2017). This health referral is not primarily to the care of older adults, but individuals across the lifespan.

In this paper, information will be provided on the following topics: the concept of social prescription; the social prescribing network; the empirical link between health, wellness and social prescribing; the history of social prescribing; and the research that examines the efficacy of social prescription. Examples will explore social prescriptions for older adults and caregivers, and the current practice of social prescription in the community.

What is social prescribing/social prescription?

According to The Kings Fund (2017), social prescribing or social prescription enables physicians and primary health care professionals to refer patients to a broad range of non-clinical services that can be maintained with existing treatments (Bickerdike et al., 2017). Social prescribing advocates that health is a result of a combination of economic, environmental and social factors, and offers a more holistic approach to health care (The Kings Fund, 2017). It offers a variety of potential solutions to a general health practitioner that can be shared with patients in their treatment process.

The social prescribing network (SPN)

The SPN is a group that consists of academics, researchers, health care professionals, social prescribing practitioners, community and volunteer sector representatives, patients, and funders (Social Prescribing Network, 2018a) that primarily serves in the United Kingdom, Ireland, and Scotland. The purpose of this network is to work collaboratively within the group to share the best practices and knowledge of social prescription, while advocating its significance at both local and national levels (Social Prescribing Network, 2018a). The SPN supports social prescription schemes, research, evaluation, conferences and collaborations in this field (Social Prescribing Network, 2018b).

Health, wellness, and social prescribing

The terms "health" and "wellness" derive from fields of psychology and medical science such as health promotion, nursing, rehabilitation medicine, internal medicine, nutrition and exercise science (Wolever, Jordan, Lawson, & Moore, 2016). According to the World Health Organization (1946), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The maintenance of health is determined by the patient's social, economic, and physical circumstances, as well as their lifestyle (Canadian Nurses Association, 2019). On the other hand, wellness is the conscious, self-directive awareness that encourages an individual to choose a more successful existence (Stoewen, 2015). It is crucial for health practitioners to understand the current health and wellness states of the patient to have their assessments lead to

recovery. Social prescription may be a viable community resource that can ameliorate the overburdened health care system, while emphasizing the holistic approach through rich conversations between the health practitioner and the patient.

Research that focused on the effectiveness of social prescription in the patient's health and wellness has been narrow, but beneficiary in related studies. For example, Kivela, Elo, Kyngas, and Kaariainen (2014) found significant positive results in health coaching on patients with chronic diseases, as they experienced better control in weight management, increased exercise and improved physical and mental wellbeing. The coaches recommended services like referrals by a health care professional, which suggest social prescription as a meaningful contribution to health and wellness. Also, Morton, Ferguson, and Baty (2015) measured social prescription and well-being through a course of activities: meditation, painting, photography, jewelry, arts/crafts, and pottery. Results found decreased levels of anxiety, depression, and significant improvements in self-efficacy and well-being; however, it was not clear whether these results were affected by the patient's concurrent intake of antidepressants (Morton et al., 2015). Hence, the effectiveness of social prescription in health and wellness is potentially evident but is limited in research and surrounded by confounding variables.

From the holistic perspective of social prescription in health and wellness, Martino, Pegg, and Frates (2017) found that social interactions initiated the empowerment of health and wellness in patients with diabetes, cancer, cardiovascular disease, and psychological health. Recommendations for a proposed connection prescription include good relationships with friends and family, as well as awareness for health professionals (such as physicians) to incorporate these lifestyle changes with patients during their annual or wellness visits (Martino et al., 2017). Further, Carnes et al. (2017) discovered that patients were satisfied with the social prescription referrals during their visits with the general health practitioners, as these recommendations created a lasting impression and awareness about the topic. Thus, these studies emphasize the holistic approach of social prescription as a viable health care solution.

History of social prescribing

Social prescribing or social prescription started in the United Kingdom during the 1990s, where exercise and the arts were the common referrals for patients (Whitelaw et al., 2017). By the twenty-first century, social prescription transitioned into a more comprehensive stance that encompassed a vast range of activities, meaning, and discoveries. This included: creating 'up-stream interventions' with the health practitioner (Whitelaw et al., 2017); promoting 'health and well-being' (Kilgarriff-Foster & O'Cathain, 2015); encouraging 'self-management' (Chatterjee, Camic, Lockyer, & Thomson, 2017; Morton et al.,

2015); and considering vulnerable persons with socioeconomic issues (Moffatt, Steer, Lawson, Penn, & O'Brien, 2017). Today, social prescribing is administered in many countries such as Canada, the United States, Sweden, Norway, and Denmark (Jensen, Stickley, Torrissen, & Stigmar, 2016).

Social prescription is determined by various models/schemes of implementation that are based on the referred activities by health care professionals (Pescheny, Pappas, & Randhawa, 2018). Thomson, Camic, and Chatterjee (2015) explain the models of social prescribing through community programs in the United Kingdom:

- *Arts on Prescription* support patients with mental and physical health issues with creative and participatory workshops in the arts (e.g. music, dance, visual arts, poetry). The model aims to encourage people to experience self-expression, self-esteem, and social contact.
- *Books on Prescription/Bibliotherapy* focus on the psychological health of a patient through self-help books borrowed at a library or as a self-referral. Reading books have shown to reduce stress and the effects of dementia in older individuals.
- *Education on Prescription* revisits formal learning opportunities in educational establishments or nonprofit organizations, allowing a patient to improve their socioeconomic status, resilience, self-esteem, and self-efficacy.
- *Exercise Referral/Exercise on Prescription* involves referees to attend their physical health by supported exercise (e.g. dance, cycling, swimming), while meeting new people improve their quality of sleep and structure their daily life. These referrals are made available for patients with depression or as a self-referral.
- *Green Gyms/Ecotherapy* is a cost-effective activity that emphasizes nature (e.g. walking in parks) as a valued consideration to self-esteem and positive mood for those with mild-to-moderate mental health conditions.
- *Healthy Living Initiatives* prescribe community nurses or health professionals to visit disadvantaged communities to promote health education (e.g. smoking cessation, healthy eating). This may inspire members of the community to develop new skills, participate in social circles, and pursue new health-related activities.
- *Signposting/Information Referral* uses contact information (e.g. websites, telephone numbers) on posters to guide patients in accessing material about health and welfare (e.g. housing, finance, care services).
- *Supported Referral* offers patients with a mental health service, where the facilitator discusses strategies to overcome barriers and provide moral support to the patient.
- *Time Banks* involve a patient to engage in volunteering activities and document their hours through a time broker. Volunteering commitment is discussed with the practitioner.

Due to the public awareness of social prescribing in recent years, there has been an increased demand for government action and policy support. For example, in 2000, art and cultural activity in the public health system was acknowledged by the Swedish Government, resulting in sponsored initiatives with the Swedish Arts Council (Jensen et al., 2016). This emerged into several permanent community programs like the Kultur för äldre/Arts for the Elderly, and "Arts and Culture" as rehabilitation for patients with pain and mental health issues (Jensen et al., 2016). These government-sponsored programs suggest an analysis of the efficacy and research to support social prescription as an essential health referral.

The efficacy of social prescribing supported by research

Researchers have conducted systematized reviews of social prescribing to understand its benefits at the individual, community, and national level. For instance, Chatterjee et al. (2017) evaluated non-clinical community interventions in the United Kingdom in a review of social prescribing schemes published from 2000 to 2015. Results showed that the largest number of studies analyzed "Arts on Prescription", where data was gathered through interviews, focus groups, questionnaires, and surveys. This result provides justification for the history of arts referrals in social prescription and the use of qualitative methods in understanding the personalized experience. Further, the review generated no results for "Books on Prescription", "Education on Prescription", "Healthy Living", and "Time Bank" models for the patient, which suggest that certain schemes may be inefficient in supporting individual goals (Chatterjee et al., 2017).

At a community level, Chatterjee and colleagues found many effective schemes for disadvantaged populations, such as physical activity, healthy eating, mental well-being, and arts and culture. Kilgarriff-Foster and O'Cathain (2015) believed that social prescription builds community cohesion in patients with mental health issues and persons with long-term conditions. Hence, Chatterjee et al. (2017) reinforced that social prescribing is effective for persons living in vulnerable conditions, as they can gain access to resources unavailable to them. In addition, Chatterjee et al. (2017) discovered that social prescription could be administered by other health professionals such as nurse practitioners, physiotherapists, and pharmacists. This is attributed to the United Kingdom and their understanding of the overcapacity of general health care in the nation.

Bickerdike et al. (2017) took a similar approach by evaluating studies of social prescription programs in the United Kingdom published from 2000 to 2016. Researchers found that the quality of the literature in this search was unclear or possessed a high risk of bias, as many studies had a small sample size (under 100 participants), no criteria for the study population, and the lack of control before and after the recommendation for social prescription

(Bickerdike et al., 2017). Despite these findings, the literature showed improvements in the following areas: health and wellbeing; patient satisfaction to the programs; as well as mental and physical health (Bickerdike et al., 2017). Unfortunately, many patients resulted in prescription drugs even with social prescription, general health practitioners had limited knowledge about social prescription, and government funding was expensive (Bickerdike et al., 2017). These results imply that social prescription is limited by poor design. Positive conclusions of these studies are descriptive and narrative in nature, which demonstrate the individual experience of the service; however, the results are clinically insignificant (Bickerdike et al., 2017). Prospective pathways should consider rigorous conduct, transparent reporting, and comparative design in the research on social prescription. Further, Lamont et al. (2016) recommend researchers to consider the following questions in the evaluation of social prescribing programs:

- *Why* are researchers interested in social prescription and what is the current stance of the published evidence?
- *Who* are the stakeholders and users of social prescription?
- *How* are the study designs in social prescribing programs influence the potential for bias?
- *What* are the key measurements and data in social prescription? Does it consider the activity, costs, and outcomes of the service?
- *When* is the data collected and how does timing influence the results?

Hence, social prescribing possesses different levels of effectiveness on the individual, community, and nation. Although social prescription has shown prominence for persons in vulnerable communities, it is important to discover the transition of social prescribing in health care to evaluate its significance. As well, social prescription has demonstrated inadequacy and support in literature, as researchers unsuccessfully asked the right questions to ensure quality results. Potential analysis should consider the stakeholders, study design, key measurements, and timing of social prescription before embarking in the research.

Does a social suggestion have the same impact as a social prescription?

According to Brandling and House (2009), a social suggestion that is provided by a health care professional may be received by the patient as a casual recommendation rather than a prescription for treatment. Social suggestions offer vague advice for patients to pursue certain activities instead of relying on a prescription for engagement (Mishori, 2018). For example, a practitioner may articulate: "I suggest you consider joining a choir to help you socialize with others" as a formality to the patient to pursue these activities on their own.

Social prescription provides guidelines for the patient to engage in the activity at a specific location and time frame (Mishori, 2018). Relating to the example above, a patient may be prescribed "Join the Community choir at location X, and attend the weekly rehearsals which are 1 hour in length for 6 months." Thus, it is imperative to differentiate between social suggestion and social prescription, as inaccurate referrals by a health care professional can lead to detrimental results.

Dayson and Bennett (2016) interpreted interviews of staff and clients to discover the impact between social suggestion and social prescription in the Doncaster Social Prescribing Service. Personalization was significant in social prescribing, as referees wanted the service to be administered face-to-face in their own home for better rapport and trust (Dayson & Bennett, 2016). Health practitioners affirm this statement, describing that the evaluation of the patient widened to the coping mechanisms in the home and their willingness to comply after the social prescription (Crawford, Roger, & Candlin, 2017). Although a social prescription is often administered in a health care environment, social suggestions can be casually mentioned in a space outside these parameters, which may decrease the individual experience. Despite these results, human beings are complex with multiple issues, which may involve a social prescription of one or more activities (Dayson & Bennett, 2016).

In social suggestion, a patient's ability to participate in an activity without a prescription demonstrates their determination and risk-taking behavior, as he/she can potentially experience withdrawal by community members (St. Clair et al., 2017). Alternatively, social prescription initiates a guaranteed support system that is targeted and accommodated by daily changes. For instance, interviewees talked about the dynamic housing situation in Doncaster, which offered various welfare services, benefits, and housing situations that were advantageous to the patient (Dayson & Bennett, 2016).

Hence, social suggestion does not have the same impact as social prescription. The value of social prescriptions is specific to the needs of the patient based on the desired connection with the health practitioner, immediate targets/goals, and changes in the immediate environment.

Examples of two social prescriptions for older adults

The following are two examples of social prescriptions written by a patient's physician.

Case example: Jane, 87-year-old female who lives alone

Jane is an 87-year-old female who lives alone in a large urban setting. Her husband passed away 2 years ago. She is diagnosed with depression, osteoporosis, and osteoarthritis. She has been managing well on her prescriptions for these conditions. At her last doctor visit, Jane discloses to her physician

that many of her friends have recently passed away, resulting in a feeling of loneliness and social isolation from her companions whom she used to walk with at the mall and speak daily. Her physician is concerned that Jane has progressed into further isolation. He engages in an active discussion with Jane about her past hobbies, interests, and circle of friends. He discovers that Jane enjoyed singing with her husband on Sunday afternoons, reminiscing her husband accompanying on the piano. Jane's physician recommends a community choir in Jane's demographic area, where free transportation is made available for members to attend the weekly sessions. He writes Jane a formal prescription to participate in the community choir once a week for 3 months. He provides her with the contact information of the choir and asked his office coordinator to follow up the procedure by sending the recommendation to the choir with Jane's consent in attendance. He books a 3-month post-follow-up appointment with Jane to discuss the results.

Case example 2: Silvio, 81-year-old male living in a rural setting

Silvio is an 81-year-old Italian male widow and immigrant in Canada. Shortly after his wife died, Silvio was sponsored by his daughter to immigrate to Canada at 70-years-old. He resided with his daughter until she was diagnosed with dementia and moved to a long-term care facility. Silvio is living in a rural area and has no friends or social interaction opportunities. He relies on a volunteer to visit his daughter once a week. Silvio is in relatively good health with no major diagnoses. On his previous visit to the family doctor for a urinary tract infection, Silvio speaks about his daughter. His physician is concerned that Silvio is very isolated and recommends a potential referral to a senior community center in the area. Silvio is skeptical and comments that he does not know how to make new friends. The physician writes a formal prescription for Silvio to participate in boccie and card games at the community center once a week. With Silvio's consent, the physician asked his office administrator to contact the community center for volunteer transportation for Silvio. The physician schedules a 3-month follow-up appointment to discuss the progression with Silvio.

Where is social prescribing actually happening in a formalized manner?

Social prescription as a formal service has been gaining momentum and featured in various news and social media as a wellness phenomenon. For example, from January to December 2019, the Royal Ontario Museum's Community Access Network (ROMCAN) in Toronto, Canada created a pilot project that offered free admission to the world culture and natural history museum for up to four persons living in vulnerable conditions (e.g. students, newcomers, seniors at

risk) (O'Neil, 2018). Administered by an affiliated health care professional approved by ROMCAN, 5,000 passes were dedicated to this program and extended to clients currently enrolled with community partners, such as the Rexdale Community Healthcare Center (O'Neil, 2018). ROMCAN aimed to promote public awareness about the accessibility of community resources to improve health and wellbeing, as well as encourage social inclusion via three pillars: access, representation, and participation (O'Neil, 2018). Future publication of the impact of social prescription in ROMCAN is unknown. It is interesting to consider these results as a means to change the current perception of social prescription.

In an artistic perspective of social prescription, a new initiative launched by the British Health Secretary could potentially permit physicians to "prescribe therapeutic art- or hobby-based treatments for ailments ranging from dementia to psychosis, lung conditions and mental health issues" (Solly, 2018). For instance, stroke survivors were connected to the Royal Philharmonic Orchestra to play instruments, conduct musicians, and prepare for performances. Most of the participants reported improved physical and mental health symptoms after the experience (Solly, 2018). In addition, increased concentration and communication skills were developed in persons with early signs of psychosis during the engagement of prescribed dance lessons, which suggest social prescription in the arts as a key resource to health and wellbeing (Crawford, 2018). As well, hospitals in Gloucestershire have socially prescribed patients with lung conditions to singing lessons to improve their breathing technique and physical endurance, further implying the importance of social prescription in the arts (Solly, 2018). Although the formalized *Arts on Prescription* programs in the United Kingdom connect with various art forms, the Secretary aspires the health care system to focus on preventative and perspiration methods for the patient, rather than the intake of over-the-counter medication as a solution to recovery (Solly, 2018). Thus, social prescription for the arts may accomplish this health care goal with more public awareness and social connectedness about this service.

Social prescribing for caregivers of older adults

Caregivers for older adults have resulted from the epidemiological changes of the aging population, overburdened acute-health care system, and sudden family dynamics (Gillespie, Mullan, & Harrison, 2014). Many individuals who become caregivers are family members who forfeit their paid occupations to take on these challenging unpaid roles to foster persons or kin with physical, cognitive, or chronic life-threatening conditions (Ploeg & Markle-Reid, 2018). Although caregiving is rewarding, these individuals are overwhelmed with the new role and can acquire symptoms such as poor mental

wellbeing and physical health, as well as increased levels of stress, anxiety, and doubt (Ploeg & Markle-Reid, 2018).

Social prescriptions for caregivers may alleviate the symptoms of caregiving. For example, Ploeg and Markle-Reid (2018) evaluated the impact of various internet-based interventions on the mental health of caregivers like Thomson et al. (2015)'s *Signposting/Information Referral*. Results showed caregivers experienced decreased levels of depression and stress and stated that "information and/or education with or without professional support" as the most effective online resource available to them (Ploeg & Markle-Reid, 2018). While the internet intervention was not prescribed by a health professional, caregivers provided recommendations to increase support on online resources. This included easier navigation on websites; personalized information about the local community; and connection with other caregivers (Ploeg & Markle-Reid, 2018). These findings imply that accessibility and personalization are priority to the social prescription for caregivers of older adults in par with patients with vulnerable conditions.

Another social prescription that may be effective for caregivers of older adults is the personal time to reconnect with their loved ones that require care through bonding activities. Camic, Baker, and Tischler (2016) analyzed the engagement of viewing and making visual art activities between persons with dementia and their caregivers. Both participants shared that the art gallery was a valued space that intellectually stimulated their curiosities and the art activities offered social inclusion beyond the diagnosis of dementia (Camic et al., 2016). These themes suggest that caregivers receive a break from everyday care, peer support from other caregivers, and a chance to develop a positive relationship with their loved ones, which were recommendations on their new role (Ploeg & Markle-Reid, 2018). Also, changed perceptions of dementia allowed the older adults to be socially competent and interactive, which may be reasoned by the cognitive processes required for the art activities (Camic, Tischler, & Pearman, 2014).

Hence, considerations of social prescription should be extended to individuals involved in caring persons with vulnerable conditions, as caregiving comes with costs to their health and finances. In Nova Scotia, Canada, the Caregiver Benefit Program aims to subside a monthly allowance to address the needs of caregiving, including transportation and appointment costs (Ploeg & Markle-Reid, 2018). Social prescription may be included into this financial support as a means to accomplish the duties as a caregiver.

Conclusions and take away message

Social prescription is an innovative initiative that is progressively integrated into the current health care practice and management of older adults and their caregivers. While social prescribing has demonstrated positive symptoms in the patient's health and wellness (Morton et al., 2015), awareness of community

resources and the personalized experience (Dayson & Bennett, 2016), as well as formalized pilot projects (O'Neil, 2018; Solly, 2018), researchers should consider a rigorous research design to ensure the validity of these results (Bickerdike et al., 2017). Future analysis should acknowledge social prescription beyond the patient referral (such as informal caregivers) and evaluate specific demographic areas to ensure the promotion of social prescribing models/implementation (Jensen et al., 2016). It is important to engage in conversations about social prescription as a means to build momentum about this cost-effective health care process and include new activities into the referral system.

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