Social prescribing for patients of secondary mental health services: emotional, psychological and social wellbeing outcomes

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Chris Dayson, Jo Painter and Ellen Bennett

Abstract

Purpose – *This paper aims to identify the well-being outcomes of a social prescribing model set within a secondary mental health service recovery pathway and understand the key characteristics of a social prescribing referral for producing these outcomes.*

Design/methodology/approach – *A qualitative case study of one mental health social prescribing service with three nested case studies of social prescribing providers. Semi-structured interviews were undertaken with commissioners, providers and patients (n = 20) and analysed thematically.*

Findings – *Social prescribing makes a positive contribution to emotional, psychological and social well-being for patients of secondary mental health services. A key enabling mechanism of the social prescribing model was the supportive discharge pathway which provided opportunities for sustained engagement in community activities, including participation in peer-to-peer support networks and volunteering.*

Research limitations/implications – *More in-depth research is required to fully understand when, for whom and in what circumstances social prescribing is effective for patients of secondary mental health services.*

Practical implications – *A supported social prescribing referral, embedded within a recovery focussed secondary mental health service pathway, offers a valuable accompaniment to traditional approaches. Current social prescribing policy is focussed on increasing the number of link workers in primary care, but this study highlights the importance models embedded within secondary care and of funding VCSE organisations to receive referrals and provide pathways for long-term engagement, enabling positive outcomes to be sustained.*

Originality/value – *Social prescribing is widely advocated in policy and practice but there are few examples of social prescribing models having been developed in secondary mental health services, and no published academic studies that everybody are aware of.*

Keywords *Mental health, Well-being, Social prescribing, Secondary mental health services*

Paper type *Research paper*

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Introduction

In the National Health Service (NHS) in England social prescribing has been promoted to enable healthcare practitioners to refer patients to link workers who help them identify and access non-clinical activities provided by voluntary, community and social enterprise organisations (VCSEs) at a community level (NHS England, 2019). This approach aims to harness community assets to encourage self-care and address long-term health and psychological conditions and accompanying social issues (Moffatt *et al.*, 2017). Most social prescribing in England occurs in primary care (Carnes *et al.*, 2017) and evaluations of these

services identify benefits for patients with low-level mental health conditions such as anxiety or mild depression (Kilgarriff-Foster and O'Cathain, 2015). This primary care evidence suggests that social prescribing could be extended to secondary mental health services (Friedli and Watson, 2004) as a treatment option available to Community Mental Health Teams(CMHTs) supporting people with more serious mental health conditions that cannot be treated in primary care settings.

The need to demonstrate how social prescribing can be embedded within secondary mental health services is important for, whilst philosophies of care have moved away from a model of paternalism and disability (Pilgrim and McCranie, 2013) services themselves have struggled to transcend traditional paradigms and fully embrace a recovery-based philosophy of care (Burns-Lynch *et al.*, 2016). Thus, it is unclear how the care and treatment options available to CMHTs enable them to prioritise patients' self-determination, emotional resilience and quality of life (Pilgrim and McCranie, 2013) and many mental health interventions remain pathogenic in focus. That services still seek to diagnose and focus treatment on perceived deficits associated with illness (Barker and Buchanan-Barker, 2011) is not necessarily inappropriate, but in recovery terms it is arguably inadequate. Provencher and Keyes (2011) argue that full recovery, when defined from the viewpoint of patients experiencing mental ill-health, requires a salutogenic focus alongside pathological considerations. Salutogenesis in this context means enhancing positive mental health and quality of life so that patients are able to flourish emotionally, psychologically and socially (Table I).

The salutogenic potential of social prescribing has been highlighted by a number of studies in primary care. In their review of 24 published social prescribing studies Kilgarriff-Foster and O'Cathain, (2015) identified well-being benefits associated with social prescribing such as increased self-esteem and self-efficacy through development of support networks, and reduction in symptoms of mental ill-health such as anxiety. This is supported by more recent

Table I The factors and dimensions of mental health as flourishing

Factors	*Dimensions*
Hedonia (emotional well-being)	1. Positive affect: cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
	2. Avowed quality of life: mostly or highly satisfied with life overall, or in domains of life
Positive psychological functioning (psychological well-being)	3. Self-acceptance: holds positive attitudes towards self, acknowledges, likes most parts of personality
	4. Personal growth: seeks challenge, has insight into own potential, feels a sense of continued development
	5. Purpose in life: finds own life has a direction and meaning
	6. Environmental mastery: exercises ability to select, manage and mould personal environs to suit needs
	7. Autonomy: is guided by own, socially accepted standards and values
	8. Positive relations with others: has, or can form, warm, trusting personal relationships
Positive social functioning (social well-being)	9. Social acceptance: holds positive attitudes towards, acknowledges, and is accepting of human differences
	10. Social actualisation: believes people, groups and society have potential and can evolve or grow positively
	11. Social contribution: sees own daily activities as useful to and valued by society and others
	12. Social coherence: interest in society and social life, and finds them meaningful and somewhat intelligible
	13. Social integration: a sense of belonging to, and comfort and support from, a community

Source: Provencher and Keyes (2011)

studies of social prescribing, which point to the positive contribution community-based interventions make to emotional, social and psychological components of well-being such as involvement in work, volunteering and social groups (Dayson, 2017); positive social interaction with health professionals (Bertotti *et al.*, 2018); and opportunities to meet and socialise in the community which reduce social isolation and help improve confidence, self-esteem and mental well-being (Moffatt *et al.*, 2017; Kellezi *et al.*, 2019). These studies also suggest that low mental well-being is one of the most common reasons for referral to a social prescribing service.

A social prescribing model for secondary mental health services

In spite of evidence identifying the mental health benefits of social prescribing and the rise to prominence of the recovery ethos (Pilgrim and McCranie, 2013), current NHS England policy is focussed on embedding social prescribing in primary care (NHS England, 2019) and does not propose extending its reach to secondary care settings. Whilst CMHTs in some areas are able to refer patients to existing primary care-based schemes, the extent to which this is happening is unclear, and it is arguable that social prescribing services offering a 'lighter' model of provision (Kimberlee, 2015) would not be able to provide the level of support required by secondary mental health patients. Many of these patients are vulnerable and socially excluded and may require intensive support to access community-based groups and activities.

The Rotherham Social Prescribing Mental Health Service was established on this premise in April 2015. The NHS Clinical Commissioning Group recognised that their existing primary care-based social prescribing service was unable to handle referrals from CMHTs and that a new 'holistic' service (Kimberlee, 2015), tailored to the needs of secondary mental health services and their patients, was required to augment existing treatment pathways.

The service helps patients tailor packages of support and enables them to access services and peer-led activities in the community. It is delivered in partnership between Rotherham, Doncaster and South Humber Foundation Trust (RDASH) and a consortium of 18 local VCSEs led by Voluntary Action Rotherham (VAR). Funding was provided for social prescribing link workers (employed by VAR) alongside grant funding for the activities provided by the other 17 VCSEs.

A six-month pathway was developed in consultation with the CMHT to support the transition from secondary mental health services to community-based activities. It enables CMHTs and social prescribing link advisors to work together alongside a patient for a period of ten weeks to ensure they are ready to engage with community-based activities. CMHTs stay involved in the patient's care for up to six months during which time it is established whether or not the patient can be discharged from secondary mental health services. It is a guideline that is applied flexibly so that individuals' engagement can be tailored to their personal circumstances.

This research article uses the Rotherham Social Prescribing Mental Health Service as a case study through which to explore the benefits of social prescribing for patients of secondary mental health services. It addresses the following questions:

Q1. What are the well-being outcomes of a social prescribing referral for secondary mental health patients?

Q2. What are the most important characteristics of a social prescribing referral in producing these outcomes?

It makes an important contribution because, to our knowledge, there are no previous published academic studies focussing on social prescribing in a secondary mental health setting.

Methodology

The study used a nested case study design (Yin, 2003). The Rotherham Social Prescribing Service for Mental Health provided the overall case, with three VCSEs providing social prescribing activities nested cases within it. In all, 20 semi-structured interviews were undertaken (Table II). All participants had been informed about the purpose of the study, issued with a participation information sheet and agreed to participate prior to interview. A member of the research team confirmed that participants understood the purpose of the evaluation before signed consent to participate was obtained.

Interviews were digitally recorded and transcribed verbatim. Transcripts were anonymised and collated for data management and thematic analysis according to the structure of the topic guide. Following a re-reading of each transcript by two members of the research team to ensure inter-coder reliability, a coding framework was developed iteratively based on a process of induction and deduction (Langley, 1999) through which common themes and sub-themes were generated (Table III).

An additional phase of analysis was then undertaken to support the production of this article, with the initial themes and sub-themes compared against the factors and dimensions of mental health as flourishing set out by Provencher and Keyes (2011) (Table I), followed by a re-reading and re-coding of relevant data under those themes and dimensions.

Table II Overview of interviews undertaken

		No. of interviews		
Interviewee	*Case level*	*Nested case 1*	*Nested case 2*	*Nested case 3*
Commissioner	2			
Service provider (VAR/RDaSH)	3			
Service provider (VCSE)		2	2	2
Patient accessing social prescribing		3	3	3

Table III Themes and Sub-themes identified in the data

Theme	*Sub-theme*
Key features of social prescribing service delivery	Adaptability
	Person-centred
	Relaxed service-environment
	Support to access VCSE provision
	Distinct from traditional mental health service "therapies"
The social prescribing model and processes	Time taken to develop and embed the service
	Sustaining patient involvement in prescribed activities
	Timing of the referral in relation to personal circumstance
	The range of VCSE activities available
	The flexibility of VCSE grants
	Local service context
Benefits/outcomes for patients	A way to get out of the house
	Providing something to look forward to
	Developing skills and new interests
	Preventing isolation
	Developing confidence
	Becoming happy
	Building positive social networks beyond mental health services
	Increasing the likelihood of discharge

Results

A number of outcomes for secondary mental health service patients were identified through our nested case studies that demonstrate how social prescribing contributes to the factors and dimensions associated with mental health as flourishing (Provencher and Keyes, 2011).

Emotional well-being

Patients reported being happier when engaging in socially prescribed activities and emphasised the importance of these in enabling them to view life with a *positive effect*.

> You can tell by my demeanour at the moment: I'm happy. I've not always been like that. (Patient 005)

Patients also demonstrated improvements in their *avowed quality of life*, for example several reported that participating in social prescribing activities had left them more satisfied with their life than during the period before they engaged with the service.

> I can certainly say that every time I've been to the group, I've left the group in a happier state than when I arrived. (Patient 003)

Psychological well-being

Although many patients recounted feeling anxious at the start of their engagement with social prescribing, they also reflected on the importance of having something planned in the week which they looked forward to and knew they would enjoy.

> I've really enjoyed coming here and doing the little bits of what we've done[. . .] it's not only that, it's also the meeting people, and being able to talk to people, and just having something that says 'get out of the house and get down there for 11 o'clock. And it's something interesting. (Patient 007)

This was important as it gave service users a sense of *purpose in life* that had previously been absent.

> It gives me something to look forward to. I'm here and doing something rather than sat in the house getting more depressed. (Patient 003)

Patients reflected on the importance of having an activity which provided them with opportunities for *personal growth*, particularly when this was linked to a new interest through which skills could be developed and put to use.

> [. . .] the great thing that this place has done is being able to make your brain fire, and allow you to think, both about the subject, but more importantly around it, and how you feel about stuff, and how other people react to it [. . .] and a friendly fairly informal relationship. It's the facilitating of that kind of friendliness or freedom to be ourselves that makes the difference. (Patient 007)

Social prescribing activities had also been an important factor in developing people's confidence, leading to *self-acceptance*, as the following example retold by a service provider illustrates.

> There's one chap[. . .] he wouldn't use the telephone, he just won't go out and do anything [. . .] He's now had a telephone put in at the side of his lounge chair, he answers the phone to me now. And he's now part of this other group that have got this little thing going where they all bounce ideas off each other [. . .] He's come out of his shell, he's got a bit of confidence, he's mixing with other people. (Service provider 001)

A number of patients reflected on how the activities they attended provided them with a "lifeline" and had enabled them to cope with extremely challenging life experiences. Importantly, it had provided a way for people to make friends and develop support

networks that were *autonomous* from mental health services. This autonomy and ability to overcome adversity reflects the way in which social prescribing enabled *environmental mastery*. Some patients had sustained their involvement in voluntary activity beyond the initial social prescribing referral period, including becoming volunteers supporting the delivery of activities for new cohorts of patients. In one example, a group of patients were in the process of setting-up a group through which they could continue to attend the main activity alongside participation in additional activities independent from the service provider.

> The other (patients) that are now finishing wanting to start a group and wanting to go forward and do something for themselves but with us as part of it. (Service Provider 002)

In another case, the VCSE organisation had set-up another activity session for those who had finished their referral period, but patients were asked to donate towards the cost of this session. One volunteer reflected on the progression they had made from receiving a service through to volunteer, and their aspirations for the future.

> This is a brilliant way of getting back into work, I had a very bad experience with my last job, and this was a very good way of getting used to working again [. . .] one day I'll have to move onto something that comes with a wage, which will be very sad because I'd love to stay here. (Service Volunteer 001)

The activities provided through social prescribing, and the ability to extend these beyond the scope of the initial prescription, were crucial in enabling patients to develop *positive relations with others.* Group activities had enabled relationships between patients to develop, and informal peer support to be established.

> Especially with the older (patients) it's, 'oh what medication are you on? Oh I tried that and [. . .]' it's sharing stories, not only the current situation, but a lot of them, it's what they've done in the past, where they've worked, people they've worked with, countries they've lived in. You know, it's amazing, you see a person walk through the door who physically might be uncomfortable even walking, but you get them sat down, and the atmosphere just changes, and they start totally opening up about what they've done. (Service Provider 002)

Patients reflected on the significance of learning from each other's experiences and supporting each other. The informal nature of the activities contributed to this.

> A lot of people with our kind of issues become insular, but one of the whole points of [social prescribing] is to get you out and to meet people, so as far as we're concerned, to have that group outside the structure of anything is everything to us, and that in a way is the ultimate outcome. (Patient 001 – also a volunteer)

Social well-being

As many of the examples discussed above demonstrate, social prescribing played an important role in enabling patients to develop their *social contribution, coherence and integration*. Essentially, it provided them with a meaningful reason to 'get out of the house' and provided them with a focus for their time.

> It made a big difference to me because it got me out during the day. (Patient 009)

A volunteer, who had also been a service user, reflected on the importance of the service in providing this motivation.

> It makes a huge difference to us when, you know, you have actually got something to get out of bed for in the morning. (Patient 001 – also a volunteer)

A common theme amongst patients was the extent of the isolation they felt in their lives beyond the social prescribing service and reflected on the service being a vital aspect of their lives.

> It's not necessarily one-to-one therapy, it's that point of getting out your door, getting into a group, it's socialising, it brings something different, more into your life. (Patient 006)

Discussion

This article has explored a model of social prescribing within secondary mental health services and presented findings about the well-being outcomes for patients within a salutogenic frame of mental health as flourishing (Provencher and Keyes, 2011). Previous research has identified well-being benefits for patients experiencing poor mental health (Kilgarriff-Foster and O'Cathain, 2015; Dayson, 2017; Bertotti *et al.*, 2018; Moffatt *et al.*, 2017) in receipt of a social prescribing referral from primary care without explicitly framing these in salutogenic terms. The opportunity to engage in meaningful community-based activities that support social contact and reduce isolation are highlighted as particularly important drivers of outcome change for patients.

Our data suggest very similar findings for patients within secondary mental health services and reveal some of the explanatory mechanisms behind a series of salutogenic outcomes associated with emotional, psychological and social well-being (Provencher and Keyes, 2011) for individuals engaged with community mental health services. In terms of *emotional well-being*, patients consistently reported positive affect and improvements in their avowed quality of life: they were happier and more satisfied with their life than they had been previously and attributed this change to their social prescription. In terms of *psychological well-being*, patients and providers identified the sense of purpose that engagement in a socially prescribed activity brought to an individual's life, including how developing a new interest, sustained over the longer term provided opportunities for personal growth, built self-confidence and self-acceptance and afforded opportunities to develop their environmental mastery and autonomy independent from statutory provision. In terms of *social well-being*, social prescribing enabled social integration for previously isolated patients for whom 'getting out of the house' had previously been a challenge. This contributed to a greater sense of social contribution and coherence than had been possible previously. Although a large proportion of our evidence is presented under *psychological well-being* this reflects the emphasis given to these factors by the research participants. Whilst we have used this framework to organise our findings participants did not necessarily make such clear distinctions between the three components, which overlap and are interlinked.

A key mechanism within the social prescribing service was the supportive model of transition from secondary mental health services to community-based peer-led support, and provision and development of opportunities for engagement with prescribed activities beyond the lifetime of the original prescription. This model helped patients build their confidence and reduce reliance and dependence on service provision; enabled them to become enthused by an activity; and provided opportunities to retain and enhance their involvement, including through participation in peer-to-peer support networks and by becoming volunteers supporting subsequent cohorts. Overall, the model provides a platform for outcomes to be sustained over the longer term and enables VSCEs to support this developmental approach through grant funding that is provided through the main service contract.

Although we present a positive picture of the benefits of social prescribing for secondary mental health service patients it is important to caveat these with a note of caution. Whilst social prescribing appears to work for a large proportion of patients, in this study only 78 per cent of patients who were referred to social prescribing took-up a community-based activity and only 54 per of patients were fully discharged from secondary mental health services at end of the six month pathway. This suggests that social prescribing will not be all appropriate for all patients of secondary mental health services and will depend on their

personal circumstances and willingness to engage with a new model of care. Similarly, it suggests that the six-month discharge pathway needs to be applied flexibly. Whilst some patients will be ready for discharge after six months, others will not and may require further support from CMHTs alongside their social prescription.

Limitations

The generalisability of our findings is limited by relatively small sample of mental health patients included in the study (n = 9) which meant that variations in terms of intervention, length of engagement, mental health condition and demographic characteristics have not been be explored. To address these limitations further longitudinal mixed-methods research is required to fully understand when, for whom and in what circumstances social prescribing is effective for patients of community mental health services.

Conclusion

This article has highlighted the potential for a social prescribing referral to contribute to emotional, psychological and social well-being outcomes for patients of secondary mental health services, building on existing evidence about the well-being benefits of primary care-based models of social prescribing. It has also demonstrated the importance of providing financial and developmental support to frontline VCSEs to enable these outcomes to be achieved and sustained. However, current social prescribing policy and investment in England (NHS England, 2019) is focussed on increasing the number of link workers embedded within primary care, with a view to increasing referrals, and there is limited guidance about how social prescribing can be extended to include referral pathways and associated models of support for patients of secondary mental health services. Furthermore, the current NHS England, model does not provide funding to enhance frontline VCSE provision and there is concern about whether or not VSCEs will have sufficient resources to meet this increasing demand. We suggest that without a broadening of social prescribing policy to support its embedding in secondary mental health services, or additional resources for VCSEs to support this process, it seems unlikely that the benefits of social prescribing for patients with mental health conditions will be fully realised in the near future.

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