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Accessibility and use of social prescribing interventions by minority ethnic groups in the United Kingdom: a scoping review

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ABSTRACT

Objectives To map existing literature on the accessibility and use of social prescribing interventions/programmes by people from minority ethnic groups in the United Kingdom (UK).

Design A scoping review guided by the Joanna Briggs Institute methodology for scoping reviews.

Data sources Quantitative, qualitative, mixed methods and grey literature sources examining social prescribing among minority ethnic groups in the UK.

Eligibility criteria Included sources focused on adults from minority ethnic groups who had accessed, been referred to or attempted to access any social prescribing intervention in the UK.

Results A total of 17 papers were included. Common types of social prescribing included advice and information, arts and culture, nature-based activities and physical activity. Cultural relevance, tailored interventions, strong community links and link worker support facilitated engagement. Barriers included language issues, limited awareness, logistical challenges and cultural stigma. Demographic reporting was often inconsistent, with few studies specifying which services were accessed by different ethnic groups, limiting understanding of impact and equity.

Conclusions This review highlights gaps in social prescribing research, emphasising the need for better understanding of how culturally tailored approaches enhance use, accessibility and effectiveness. Better demographic reporting and more research into culturally relevant approaches are needed. This will support the development of inclusive, effective social prescribing services that address the needs of diverse populations.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Minority ethnic groups in the United Kingdom (UK) experience unequal access to social prescribing and face barriers including language, awareness and cultural relevance. Existing evidence is fragmented, with limited understanding of which social prescribing activities are used by different ethnic groups and how well services meet their needs.

WHAT THIS STUDY ADDS

⇒ This scoping review brings together existing evidence on the types of social prescribing accessed by minority ethnic groups in the UK and summarises reported health and well-being needs, barriers and facilitators to engagement. It also highlights substantial gaps in demographic reporting and limited detail on how different ethnic groups use services.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings underscore the need for culturally tailored approaches in social prescribing and for improved demographic data collection to support equitable service design. Policymakers and practitioners may use this evidence to strengthen inclusive social prescribing provision and address disparities in access and engagement.

INTRODUCTION

A long history of migration to the United Kingdom (UK) has resulted in a diverse population, with 26% belonging to Black, Asian, Mixed and other ethnic groups.[1] In this review, minority ethnic groups refer to UK-resident populations identifying with ethnic groups other than White British. These groups have varied experiences shaped by factors such as whether individuals are UK-born or not, length of residence in the UK, generational differences and differing migration histories.[2] Such factors can influence integration, the development of ethnic identities and interactions within British society, highlighting distinct needs and challenges across and within minority ethnic communities.[3 4] Multiple long-term health conditions such as cardiovascular disease, hypertension and diabetes are particularly high among some minority ethnic communities.[5 6] Many

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minority ethnic populations face higher levels of socioeconomic deprivation,[7] racial disparities[8] and health-related stigma around mental illness. Furthermore, access to digital health resources and health-related financial assistance greatly impact these groups.[9]

Social prescribing is an example of a complex multicomponent intervention that can help people to better manage factors affecting their health and well-being and may support individuals in navigating some social determinants of health such as social isolation or community connectedness.[10] The original focus of social prescribing was to help populations in deprived areas who were 'suffering complex physical and mental health problems, financial difficulties, social and emotional problems, substance abuse and chaotic lifestyles'.[11] Social prescribing, central to Universal Personalised Care,[12] is an approach that links people to community services that address practical, social and emotional needs affecting health and well-being. Link workers therefore act as the connection between healthcare professionals (HCPs) and individuals. Social prescribing may reduce demand on primary and secondary care and lower social care use, but current evidence for cost savings is limited and inconsistent.[13 14] It also supports patient autonomy and improves health outcomes through more integrated planning and delivery.[12]

Social prescribing models are localised and vary widely because of commissioning, funding, referral criteria and pathway, service providers (ie, voluntary and community sector organisations (VCSOs)) and the actual range of activities on offer.[15 16] Social prescribing specifically for minority ethnic groups includes health and well-being sessions, cultural activities and away days.[17] Across all populations, social prescribing activities include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.[18] Programmes and activities offered through social prescribing can subsequently improve people's health and well-being, promoting self-management.[19] Targeted social prescribing support is evidenced to benefit individuals experiencing mental health problems.[13]

In the UK, despite minority ethnic populations experiencing poorer health outcomes compared with the overall population, they are underserved in social prescribing and in health and care research,[20 21] and there is little evidence exploring why this is the case.[22 23] A systematic review that explored the perceptions of mental health services and support among Black and minority ethnic carers revealed a lack of awareness of culturally appropriate resources along with a lack of knowledge about the availability of mental health services.[24] Another review of social prescribing in the UK revealed an overall low-quality evidence-base surrounding use of social prescribing programmes among migrant populations (eg, refugees, asylum seekers and migrant workers). The review identified a need for social prescribing to be tailored to the individual needs of migrants (eg, language, gender, culture and trauma), as well as providing appropriate training for link workers on how to support migrants in addressing the wider determinants of health.[25] Others have suggested that while social prescribing programmes are not necessarily designed to address the structural inequalities and injustices within migrant communities, they can help migrants to forge the connections they need to enhance their health.[26]

Although existing reviews highlight gaps in social prescribing access and outcomes in the general population, no review has specifically mapped the types of social prescribing used by minority ethnic groups in the UK, the health and well-being needs these interventions address or the barriers and facilitators influencing engagement. This represents a significant evidence gap given that minority ethnic populations are consistently underserved within social prescribing pathways. There are challenges generating an evidence-base for social prescribing since services are provided differently in different areas, evaluated using differing outcomes, often with poor data access and linkage.[11] Ethnicity is frequently missing or inconsistently coded in social prescribing referral records, and a lack of standardised coding in primary care limits the ability to assess who is being referred, who declines and whether inequalities are being addressed.[23] Evaluations of social prescribing approaches tend to be localised but have evidenced the existence of targeted and tailored support provision for specific groups such as those with long-term conditions and people experiencing socioeconomic deprivation.[27] They have also shown benefits for those experiencing social isolation and mental health problems.[13 28–30] Some evaluations have reported potential improvements in mental well-being, social isolation and social connectedness; however, findings are mixed and often limited to small or localised studies.[17 29] Given the challenges in generating robust evidence on social prescribing, a scoping review was considered the most suitable method to capture the breadth and complexity of existing research.

Primary review question

RQ1: What types of social prescribing interventions, programmes, services or activities are accessed and/or used by people from minority ethnic groups in the UK?

Secondary review questions

- RQ2: What health and well-being concerns among people from minority ethnic groups are addressed through the social prescribing provision they access or use?
- RQ3: What barriers and facilitators influence minority ethnic groups' access and engagement with social prescribing?

METHOD

Design

This review was conducted following the Joanna Briggs Institute (JBI) methodology for scoping reviews.[31] The reporting was guided by the Preferred Reporting Items

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for Systematic Reviews and Meta-Analyses extension for Scoping Reviews checklist.[32]

Patient and public involvement

This scoping review was conducted without the involvement of a patient and public involvement (PPI) panel. While PPI is recognised as an important component of research and is included in other aspects of research linked to this review, it was not feasible or necessary for the scope of this particular review.

Eligibility criteria

Participants

The participants are adults (aged 18 years or older) from UK-resident minority ethnic groups who comprised part or all of the study sample and were directly accessing or using social prescribing services. For this review, minority ethnic groups were defined as populations identifying with ethnic groups other than White British, including racially minoritised groups (eg, Black, Asian and Mixed) and White minority groups (eg, Irish, Gypsy, Roma and Eastern European communities).[1] Studies were included only where participants were described as belonging to UK minority ethnic groups.

Concept

For this review, social prescribing is defined as 'connecting individuals with non-clinical support services within the community, enhancing their health and well-being, and fostering stronger community connections'.[33] Socially prescribed activities often fall into five main categories[34]:

- Advice and information (eg, social welfare, information about support services for specific needs/health conditions and help with housing issues or benefits).
- Arts and culture (eg, taking an art class, joining a singing group and music sessions).
- Heritage (eg, going on a heritage walk in a historic park and volunteering at a local museum).
- Natural environment (eg, food growing projects, creative activities in green spaces, such as drawing, and swimming outdoors in a group).
- Physical activity (eg, walking in nature, learning to dance and gardening).

As this review focuses on social prescribing in the UK, the National Academy for Social Prescribing (NASP) activity categories were used as a nationally recognised and policy-relevant starting point for describing the types of activities offered within UK practice.

Studies with any study design (eg, randomised controlled trials, quasi-experimental, case studies or qualitative methods) and resources (eg, service evaluations, policy or guidance documents) were included where:

- Minority ethnic groups were the focus, were mentioned within the participant sample or were among those engaging with social prescribing (targeted or general). Studies do not need to consist solely of minority ethnic groups. UK social prescribing models, including interventions, services, programmes, pilots and community-based activities, were described as part of a social prescribing pathway.

Context

This review focuses on social prescribing delivered through primary care and community-based provision that may or may not be culturally tailored. Primary care is a key referral route for social prescribing, and VCSOs also deliver and refer to these services. Other referral routes (eg, HCPs and self-referral) were considered. The review includes UK-based studies.

The eligibility criteria were developed to identify studies likely to contribute evidence to the review questions, including the types of social prescribing accessed, the health or well-being needs linked to referral or use and any reported experiences of access or engagement that indicate barriers or facilitators.

Data sources

Sources included in this review were primary research studies, policy reports, guidance documents, theses and dissertations, pre-prints and websites of UK-based organisations, entities and policy/research think tanks. Quantitative, qualitative and mixed methods research was included. Non-English language studies, review articles (eg, systematic/scoping/evidence reviews) and sources published prior to 2006 were excluded. We selected 2006 as the cut-off date as this was the year the Department of Health advocated in a White paper for the introduction of social prescribing for people with long-term health conditions.[35 36]

Search strategy

We used a combination of keywords and Medical Subject Headings terms adapted for the various databases, which were run in July 2024 (see online supplemental material 1) in MEDLINE, EMBASE, Scopus, Web of Science, PsycInfo and the Cochrane Library. Grey literature searches (see online supplemental material 2) were conducted between January and February 2025 using Google keyword searching and hand searching of websites. Reference lists of all included sources were checked for additional sources.

Data screening

Search results were collated and uploaded into EndNote, and duplicates were removed. De-duplicated references were imported into Rayyan for screening.[37] Titles and abstracts were screened independently by two reviewers (AW, MS) for assessment against the inclusion criteria. Each reviewer then carried out a random 20% review of each other's screening. Potentially relevant sources were retrieved in full. The full texts of selected citations were assessed in detail against the inclusion criteria by one reviewer (AW), with a second reviewer (MS) independently checking 20% for consistency. Discrepancies were discussed between AW and MS to meet an agreement.

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Table 1 Categorisation and summary of social prescribing used by minority ethnic groups

Category	Summary of social prescribing used by minority ethnic groups
Advice and information (inc. emotional and psychological support)	► Counselling in a non-clinical setting for Turkish, Kurdish and Cypriot Turkish women and Black, Asian, Minority Ethnic and refugee women,[55] counselling and psychotherapy services offered in different languages—Spanish and (Brazilian) Portuguese.[55] ► Peer advocacy for Black and minority ethnic women providing emotional and practical support.[17 46] ► One-to-one support in multiple languages (eg, well-being Friends Service).[47]
Arts and culture (inc. social and cultural engagement activities)	► Arts-based and creative activities for ethnic minorities/diverse carers.[47] ► Ballroom dancing for the Chinese Vietnamese community.[52] ► Health and well-being sessions for Black and minority ethnic carers.[17 46] ► Lunch club for Bangladeshi communities.[55] ► Cultural activities and away days for Black and minority ethnic carers.[17 46] ► Life story and memory-sharing sessions for older Asian men (eg, Yemeni and Pakistani).[17 46]
Physical activity	► Yoga and fitness classes for Somali, Kurdish and Middle Eastern women,[55] exercise sessions for Asian men (eg, Yemeni and Pakistani).[46] ► Walking groups and Nordic walking for diabetes prevention (South Asian, Caribbean, African and other ethnic minority communities),[53] walking group for refugees and asylum seekers from ethnically diverse communities.[56] ► 'Ping pong' (table tennis) and badminton for the Chinese Vietnamese community.[52]
Natural environment	► Gardening, allotment and food-growing projects (British South Asian and British Asian groups,[51] Bangladeshi communities,[55] refugees and asylum seekers from ethnically diverse communities[56]). ► Diversity focused nature-based activities.[47] ► Conservation activities (eg, within nature reserves) for refugees and asylum seekers from ethnically diverse communities.[56]
Heritage	► Preservation and heritage activities.[47]

Data extraction

Data were extracted by AW using a data extraction tool developed in Microsoft Excel. The tool was tested on two sources initially to ensure all relevant information was being collected. Extracted data included year of publication, study location, participant demographics (including age, gender and ethnicity) and key findings in relation to the review questions. Information relating to referral routes or delivery settings was noted where reported, and where relevant, this was incorporated into the descriptions of social prescribing interventions and activities in table 1, although this was not included as a formal extraction variable. For all three review questions, data were extracted on (a) the types of social prescribing interventions, programmes, services or activities described; (b) any author-reported health or well-being needs, aims or user characteristics linked to referral or use and (c) any experiences, perceptions or contextual factors influencing access or engagement, including barriers and facilitators. No assumptions were made about the purpose of interventions where this was not explicitly reported. Different study types contributed to different review questions: descriptive and service-level reports informed the mapping of social prescribing activities (RQ1), while evaluation and qualitative studies contributed evidence on health and well-being needs (RQ2) and barriers and facilitators to engagement (RQ3). Descriptions of social prescribing activities were informed by the Template for Intervention Description and Replication checklist.[38] As outlined in scoping review guidance, a quality assessment of included articles was not conducted.[39]

Synthesis

Key findings were synthesised using a descriptive narrative summary structured around the review objectives, review questions and using the principles of thematic analysis and tabulation.[40] The principles of codebook thematic analysis[41] were applied to develop prominent themes across the sources. The process involved systematically categorising data by AW to help organise and summarise the data against the topics contained within the review questions. These codes and developing themes were discussed by three authors (AW, ND, MA).

RESULTS

Study inclusion

The search strategy resulted in 17 papers being included in this review. The initial database search resulted in the identification of 13 234 records. Following de-duplication, title and abstract screening and the full-text screening five studies were included. The grey literature searches resulted in the inclusion of 12 papers (see figure 1).

Characteristics of included studies

The characteristics of the included studies are summarised in online supplemental material 3. The review includes studies using a range of mixed-methods (n=10), qualitative (n=4) and quantitative (n=3) designs. While

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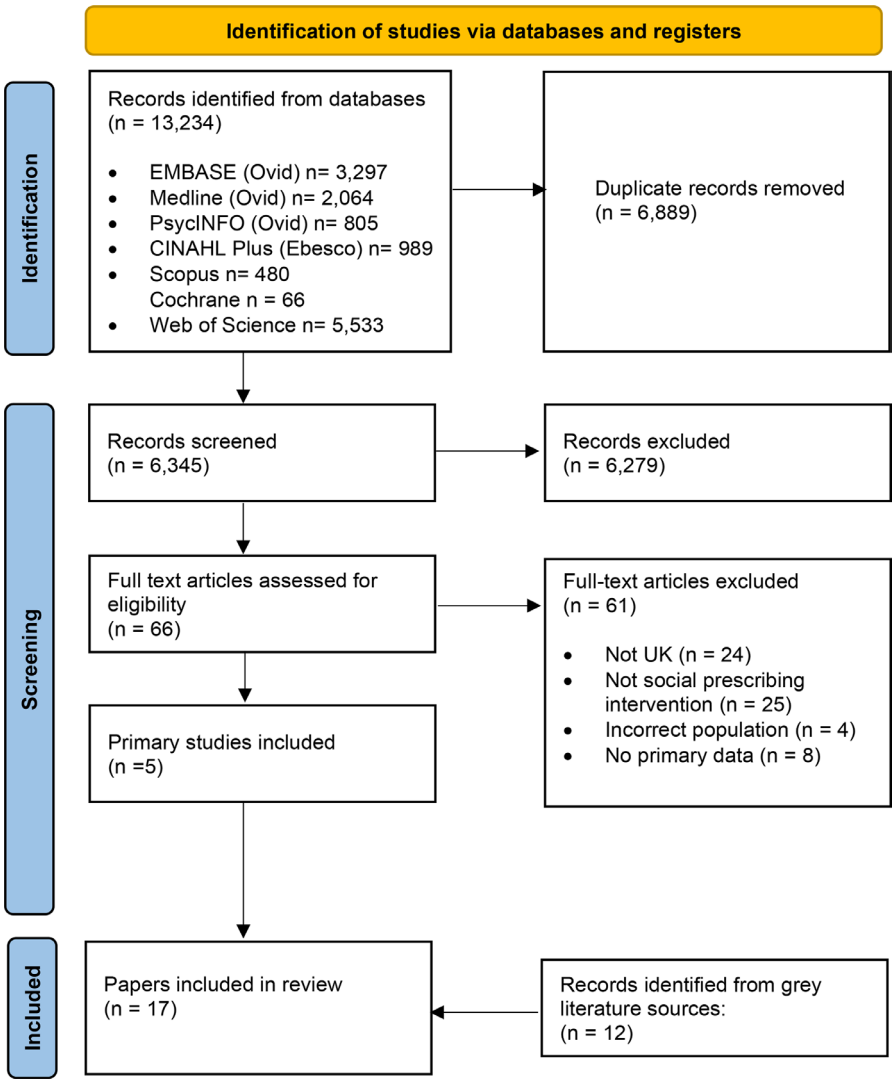

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) study selection flowchart. Adapted from Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines. Shows the number of studies screened, excluded and included at each stage.

all studies acknowledged the involvement of minority ethnic groups, most did not provide a breakdown of which services or interventions were accessed by these individuals. Several studies[17 29 42–47] reported broad demographic categories (eg, 'Non-White' or 'Black and Minority Ethnic participants') without further detail, making it difficult to assess how specific minority ethnic groups engaged with social prescribing. Among these, some[48–50] reported that individuals from minority ethnic backgrounds constituted the majority of their study participants, while others[42 51 52] noted a high proportion (>40%) but with White/White British individuals remaining the predominant group. The remaining studies either reported low representation of minority ethnic groups (<5%–21%)[17 29 43 44 46 53] or did not provide a breakdown of participant demographics by ethnicity.[45 47 54 55] Only one study[56] focused exclusively on minority ethnic groups, stating that all participants identified 'as migrants from ethnically diverse communities'. Notably, this study did not report on participant demographics relating to age, gender or specific ethnic background of the migrant population, beyond stating they were a group of refugees and asylum seekers. Age and gender were frequently not reported or not reported in detail, sometimes due to restrictions to projects' data collection and analysis or inconsistent reporting.[17 29 42–44 46–48 54–56] Some studies acknowledged that their findings only represented a subset of participants due to inconsistent data collection across organisations.

Types of social prescribing interventions accessed

The most accessed types of social prescribing among minority ethnic groups have been categorised using the earlier list provided by the NASP.[34] As some activities did not neatly align with NASP's broad groupings, additional descriptors are included in table 1 to reflect cultural or contextual nuances relevant to minority ethnic groups. Insufficient data on the descriptions of activities (see online supplemental material 3) also mean that some examples may fall across more than one category (eg,

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'health and well-being sessions' can include art classes, gardening clubs and cooking classes). Table 1 provides a summary of the types of social prescribing interventions and programmes that were accessed and used by people from minority ethnic groups in the UK. These examples encompass a diverse range of activities, delivered primarily by VCSOs, often in collaboration with the primary care and local councils.

The findings suggest a relatively even distribution across all categories, apart from 'Heritage' as presented in table 1. The most accessed services and activities tended to be those that are culturally tailored or specifically designed for distinct ethnic communities, rather than generic services. Notably, all examples of social prescribing identified in this review as being accessed by minority ethnic users incorporated a cultural or diversity element, with the exception of the preservation and heritage activities documented in one study.[47] However, due to the inconsistencies in reporting demographic data, linking the ethnicity of participants to the specific social prescribing activities or programmes accessed was not always possible.[17 46 54 55] Additionally, while some papers[43–45 48] referenced social prescribing services that would fall under 'Advice and Information' through providing welfare support (eg, debt management, benefits, housing and employment assistance), there were no specific reports of these services being accessed by minority ethnic groups.

Studies did not typically report on service attendance or frequency of participation, with two studies[29 54] specifically highlighting a difficulty in collecting this data, further restricting insights into the effectiveness and relevance of social prescribing for diverse populations. One study[45] found that individuals with complex needs remained engaged with social prescribing for up to 2 years, suggesting that longer term interventions may be necessary to support sustained involvement. However, the same study did not provide a clear breakdown of the ethnicity of interview participants or specify how many were from diverse backgrounds, instead using the broad label 'Black and Minority Ethnic participants' to describe service users. Since most studies (n=13) did not report a breakdown of ethnic data, it is not possible to determine whether a particular type of social prescribing intervention was preferred by users from minority ethnic groups in the UK.

Health and well-being concerns addressed by social prescribing interventions

Social prescribing interventions addressed a range of physical health conditions, particularly long-term and multiple long-term conditions, diabetes and mental health concerns. However, there is limited data from all but one of the included sources[56] identifying which recorded health conditions were specific to service users from minority ethnic groups. The paper which focused exclusively on a minority ethnic population reported that social prescribing users frequently experienced mental health concerns, particularly psychological distress and trauma.

More broadly across all populations, for individuals with long-term and multiple long-term conditions, social prescribing interventions to support health commonly included physical activity programmes, weight management and healthy eating initiatives and general health and well-being sessions.[17 29 43–47 53 55] The *Ways to Wellness* programme[29 45] was specifically designed to support individuals with cardiovascular disease, hypertension, respiratory illnesses (such as asthma and chronic obstructive pulmonary disease (COPD)), chronic kidney disease and multiple long-term conditions. Diabetes prevention and management were key areas of focus for ten of the included papers.[17 29 42–45 48 52 53 55] Social prescribing interventions designed to address or support with diabetes included walking groups, such as Nordic walking,[53] alongside lifestyle-focused activities that promoted exercise,[17 42 48 55] healthy eating and weight management.[29 44 45 48] While dementia was identified as a health concern that was supported through social prescribing activities,[17 46 55] no dementia-specific interventions were reported in the reviewed literature.

Mental health concerns, particularly anxiety and depression, were frequently stated as being addressed through social prescribing.[17 29 42 44–47 49 50 52–54 56] Interventions that social prescribing enabled access to included talking therapies,[49] peer support groups[17 46] and arts-based activities[29 45 47 50 53] aimed at improving emotional well-being. In addition to the mental health concerns outlined above, four studies[29 42 47 52] reported that mental health problems specifically associated with social isolation and loneliness were addressed through social prescribing activities.

Barriers and facilitators influencing the accessibility and engagement of minority ethnic groups with social prescribing interventions

Facilitators

The role of social prescribing link workers acted as a facilitator for minority ethnic patients' engagement in services, assisting with access and maintaining attendance,[44] as well as reports that participants experienced improved mental well-being, particularly when they were able to engage with activities over time.[50] Face-to-face support over multiple occasions indicated a higher level of support,[49] and link worker-led interventions offered greater potential for culturally sensitive programmes to address chronic health conditions.[44 50]

The cultural relevance of activities was highlighted as important for acceptability and sustained engagement with social prescribing.[55] As such, mental well-being was expected to improve where community participation or engagement is sustained over time.[50] Key facilitators to access and engagement included same-gender classes, language-specific support and opportunities to connect with others from similar backgrounds, fostering comfort, belonging and sustained participation.[48 51 52 55] Two

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studies,[48 55] which included participants from Bangladeshi, Black British, Somali, Kurdish, Middle Eastern and Eritrean backgrounds, highlighted that taking a personalised, holistic approach that considered specific characteristics (eg, cultural background and gender), priorities and needs was key to improving accessibility and engagement with social prescribing. To overcome challenges around continued use of social prescribing services among some minority ethnic groups, gender-specific activities, sessions or same-sex classes were needed.[45 55]

Access to nature-based activities that combined culturally sensitive approaches was shown as being particularly effective for minority ethnic groups,[51 56] with activities delivered through local community groups such as gardening and food-growing helping them reconnect with familiar practices and specific Green Social Prescribing programmes. In addition, strong partnerships between healthcare providers and local voluntary, community and faith groups helped make social prescribing more accessible to minority ethnic groups,[48 56] while inclusive and collaborative approaches supported the tailoring of interventions to different needs.[51] There may also be benefits to offering 'pre-engagement' in the form of confidence building and providing reminders the day prior to sessions to assist with future engagement.[47]

Barriers

Despite positive outcomes, several barriers have been highlighted. Practical challenges, including travel difficulties, logistical issues and inaccessible referral thresholds and barriers to social engagement, were said to prevent participation but this was reported broadly and not necessarily in relation to minority ethnic service users.[42] Language barriers, lack of awareness and limited culturally appropriate activities were identified as barriers and obstacles for minority ethnic groups accessing social prescribing.[45 53–56]

Some participants from Central and Eastern European communities reported that they had never seen local advertising for social prescribing.[54] The same study highlighted that men from these backgrounds were reluctant to engage due to cultural stigma around seeking support and that there was a high level of unmet needs around mental health among Polish and Lithuanian communities. In relation to Green Social Prescribing, one study[51] noted that increasing the diversity of service users requires addressing perceptions that nature-based activities are primarily associated with certain cultures or demographics. These perceptions, combined with inconsistent recording of ethnicity and variations in referral practices, contribute to lower engagement among ethnic and cultural minority groups. The same study reported that area-specific deprivation hindered access to green spaces as well as a lack of cultural focus when delivering nature-based activities. Proactive support among service providers was needed to enable access to social prescribing and to overcome barriers relating to service users' ability to reach out to services.[48]

DISCUSSION

Summary

This scoping review aimed to map the use of social prescribing interventions by minority ethnic communities in the UK, the types of interventions accessed and the barriers and facilitators influencing participation and engagement. However, many included studies had inconsistent or incomplete reporting of participant demographics and social prescribing usage among minority ethnic groups. Inconsistencies in the approach to capturing ethnicity points to the ongoing challenges with accurate demographic monitoring, as found in a recent review by the Race Equality Foundation.[57] There was also a lack of comprehensive monitoring and follow-up data, limiting insight into the long-term impact of interventions. The experiences of individuals who declined referrals or dropped out early were often not captured, restricting understanding of engagement barriers. This limits the ability to determine the extent to which social prescribing meets the needs of diverse populations.

While the review did not focus solely on social prescribing interventions that were culturally tailored, it reflects broader literature which suggests the benefits of targeted social prescribing support,[58 59] especially for enhancing engagement and outcomes among diverse groups.[60 61] The findings suggest that when culturally tailored services are available, minority ethnic communities tend to engage more with social prescribing interventions that meet their cultural needs. However, minority ethnic social prescribing users are also shown to be accessing a variety of support ranging from those focused on specific health and well-being needs to services focused on physical activity, nature-based initiatives and social engagement activities. This is important given the prevalence of certain long-term conditions (eg, diabetes) and higher levels of social isolation and mental health problems among some minority ethnic groups.[5 6 13] The findings indicate that while the *types* of activities offered may not deter use, increasing engagement and accessibility requires these activities to be culturally tailored, for example, offering same-gender classes or language-specific support. Other facilitators included strong community partnerships and effective engagement through social prescribing link workers who played a key role in access. Barriers included language difficulties, low awareness, logistical challenges, cultural stigma and limited culturally appropriate activities, particularly in Green Social Prescribing. These findings align with wider literature that emphasise the importance of culturally relevant support[29 60] and cultural competence training for HCPs and social prescribers to promote equity in care.[10 19 62]

Strengths and limitations

This review incorporated a rigorous search strategy that encompassed peer-reviewed studies and grey literature, ensuring a broad and comprehensive evidence base. Following the JBI methodology, this review has also taken

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a structured and methodological approach enhancing its reliability. The focus on diversity and inclusion highlights the experiences of minority ethnic communities, an area that remains underexplored in social prescribing research.[63] This review makes a unique contribution by synthesising the types of social prescribing accessed by minority ethnic communities in the UK and the specific health needs, barriers and facilitators reported in this population. Existing reviews have tended to focus on social prescribing in the general population or on narrower groups, such as migrants or carers.

A key limitation is the incomplete and inconsistent reporting of participant demographics, particularly concerning ethnicity, age and gender. Additionally, information on socioeconomic status and migration-related factors, such as length of time in the UK or generational status, is lacking yet these may influence engagement with social prescribing and the need for culturally relevant support. In particular, the use of broad demographic categories such as 'Non-White' or 'Black and Minority Ethnic participants' makes it difficult to assess variations in engagement across different ethnic groups. The lack of evidence on service use patterns over time and frequency of engagement with social prescribing also means there are gaps in understanding the extent to which social prescribing meets the needs of minority ethnic communities. This review focused on service users rather than social prescribing staff, and although link worker characteristics were beyond the eligibility criteria, their ethnic background may be an important factor in the delivery of culturally tailored support, with potential relevance for service users' trust and engagement.

Few studies explicitly consider how systemic factors like racism might influence access to and experiences of social prescribing. While this review cannot draw firm conclusions, wider public health research recognises racism as a contributor to health inequalities that may affect engagement with health and social care services.[64 65] This represents an important gap for future research to address in order to promote equity in social prescribing.[10]

Implications for research, policy and practice

This review highlights critical gaps in the existing literature and provides clear directions for future research. The findings offer valuable insights for policymakers, healthcare providers and community organisations in designing more inclusive and culturally responsive social prescribing interventions.

To better understand the nuances of service user engagement, research must prioritise capturing detailed demographic data, particularly ethnic background. Improved reporting on how specific ethnic groups engage with social prescribing will help identify the demand for culturally tailored interventions, as well as barriers to access and reasons for disengagement. This evidence is essential for securing funding to develop such services. Policymakers should encourage standardised data collection in social prescribing services to monitor participation and outcomes more effectively.

Funding of social prescribing should support culturally responsive interventions, including language-specific services, same-gender classes and tailored activities. Policymakers can further support voluntary and community-led organisations within ethnically diverse communities through the provision of ringfenced funding to deliver culturally relevant and inclusive social prescribing interventions. Stronger collaboration between health and care providers and the voluntary and community sector should also be promoted to improve accessibility. Additionally, investing in meaningful cultural competency training for all staff, and a multilingual workforce of link workers, is vital to ensuring a diverse workforce is at the heart of delivering social prescribing services for diverse populations.

CONCLUSIONS

This review highlights that cultural relevance is a key driver of engagement with social prescribing among minority ethnic communities. However, a deeper and more nuanced understanding of how these interventions meet the specific needs of diverse populations remains limited. Social prescribing users are not a homogeneous group, and interventions must reflect this diversity to be truly effective. Future research must prioritise consistent and detailed reporting, especially regarding protected characteristics such as ethnic background. Without robust data, it is difficult to assess who is being reached, who is being left out and what forms of support are most effective. Improved data collection and standardised reporting are vital for designing culturally appropriate and inclusive services. Policymakers and researchers must work together to evaluate whether social prescribing aligns with health equity principles.

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