# Social Prescribing, Health, and Well-being

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social prescribing | public health | isolation | loneliness | well-being | connectedness | systematic review

## 1. Overview

Social prescribing programmes (SP) are person-centred coaching schemes meant to help participants improve individual circumstances, thereby to reduce demand on health and social care. SP could be an innovative means to improve preventive and public health in the pursuit of universal financially sustainable healthcare. Given its potential, our systematic review assesses type, content, and quality of evidence available regarding SP effectiveness at the individual, system, and community levels. We examine the impact of SP on addressing loneliness, social isolation, well-being, and connectedness, as well as related concepts, which are not yet considered jointly in one study. Following PRISMA, we search: EBSCOHost (CINAHL Complete; eBook Collection; E-Journals; MEDLINE Full Text; Open Dissertations; PsycARTICLES; PsycINFO); Web of Science Core Collection; and UK National Institute for Health and Care Excellence. Excluding systematic reviews and articles without impact evaluations, we review 51 studies. Several studies do not distinguish between core concepts and/or provide information on the measures used to assess outcomes; exactly one peer-reviewed study presents a randomised controlled trial. If we wish to know the potential of social prescribing to lead to universal financially sustainable healthcare, we urge researchers and practitioners to standardise definitions and metrics, and to explore conceptual linkages between social prescribing and system/community outcomes.

## 2. Background

The United Nations Sustainable Development Goals (UN SDGs) include a focus on “ensuring healthy lives and promoting well-being for all at all ages” [1]. As part of the pursuit of universal health coverage and sustainable health financing, some countries have begun to focus on well-being as a target. Because well-being is closely associated with physical, mental, and public health outcomes, efforts to support well-being are seen as potential avenues for preventing physical health problems, lowering the risk of public health emergencies, reducing the overall cost of healthcare, and promoting public health.

Practitioners, policy makers, and researchers around the world have been calling for an innovative and fundamental change in healthcare systems as a means to encourage well-being, reduce loneliness and isolation, and improve connectedness among individuals. One increasingly popular approach to addressing loneliness and social isolation, and to improving individual health and well-being and community connectedness, is social prescribing [2]. Social prescribing is a community-based, person-centred, holistic health coaching scheme, which supports individuals to better understand their needs and take action to improve their health and well-being [3][4]. It empowers individuals to identify their own needs and find solutions in a way that is meant to give individuals choice and control over their mental and physical health, improve public health and well-being, and enhance value for money [5]. The growing interest in social prescribing has led to calls for researchers and programme managers to evidence the impact and articulate the ways in which social prescribing models are expected to work [6].

To answer this call for evidence and the call for research into innovative preventive services that promote health, we conduct and present a systematic review of evaluations of social prescribing programmes that are designed to cause reductions in loneliness and social isolation and improvements in well-being and connectedness. We focus on the quality and content of studies that address mechanisms and outcomes of social prescribing initiatives to provide insight into the extent to which person-centred care delivery models can address new challenges in promoting health with innovative approaches to preventive healthcare services.

## 2.1. Key Outcomes

Loneliness, a subjective, unwelcome feeling of lack or loss of companionship, occurs when there is a mismatch between the quantity and quality of social relationships that a person has, and those that a person wants [7][8]. While loneliness is likely to be experienced by most people at some point in their lifetime, it is the chronic condition of loneliness that has garnered attention in social sciences, and in various government, community, and voluntary sector organisations. This interest is driven by reports that link persistent feelings of loneliness to a variety of physical and mental health issues and early mortality risks [8][9]. It is believed that loneliness is contributing to an increase in usage of public health and social care services [10]. Given the potential loneliness-related impacts, the United Kingdom (UK) government has recognised loneliness as a threat to public health and is addressing the issue via a Loneliness Strategy, appointing a Minister of Loneliness, and numerous resources to combat loneliness [11][12]. Around the globe, governments are seeking solutions to address loneliness and social isolation [13].

Social isolation, an objective, quantifiable measure of the number and the quality of contacts that one has, is another global issue that influences health and well-being [14]. While related to loneliness, social isolation is a distinct phenomenon; socially isolated individuals do not necessarily experience loneliness, and lonely individuals do not necessarily have less social contact with others [15]. Both phenomena are linked to depression, a mental health condition that impacts physical health, well-being, and ways in which one adjusts and recovers from difficult life experiences [15]. As such, these phenomena present an opportunity for innovative health solutions to address. Initiatives that aim to improve satisfaction with one's social network and the support that the network offers may be able to motivate people to engage in meaningful and productive activities with others, give them a sense of purpose, and help improve overall well-being.

Well-being is a personal or subjective feeling about one's life, and is a combination of a personal sense of satisfaction with life, a sense that what we do in life is worthwhile, and how happy and anxious we are [16]. These four aspects of well-being are commonly included in national and international surveys. The concept and measures of well-being can be expanded to include functional aspects (feelings of autonomy), vitality (sleeping and eating habits), and feelings about the community in which one lives [17]. The complex nature of well-being presents challenges for studies that seek to link well-being to various dimensions of health [16] because the components of health and well-being are often co-determined [18] and related to one's active participation in social, economic, and political life [19]. Given the complexities of this relationship, governments are increasingly recognising the need to address health *and* well-being as essential for preventing deteriorations in physical, mental, and public health [19] [20].

Connectedness is another outcome of interest with respect to public and preventive health. In their 2018 report, New Zealand's Ministry of Social Development named connectedness as a key driver of well-being and resilience [21]. While there is no generally accepted definition of connectedness, it can be described as an experience of belonging and relating to others [21][22]. Many preventive health programmes and social prescribing initiatives focus on improving connectedness, though a lack of conceptual clarity, which we present below, presents challenges to assessing levels of connectedness and potential changes therein. Measures of connectedness range from counting an individual's group activity attendance and perceived group support [23] to assessing an individual's sense of acceptance [24], belonging, or identity [25], and to consideration of connectedness in terms of its relation to loneliness and social isolation [26]. In addition to these conceptual challenges, we also lack a theoretical explanation as to precisely why and how social connectedness enhances health [27].

## 2.2. Effects at Multiple Levels

Together, these four concepts represent a potential target for preventive health initiatives on multiple levels. Individuals experiencing higher levels of well-being are both less likely to become ill and more likely to be able to continue their own economic activity and help others during a public health emergency [28]. This means higher levels of well-being should be associated with the ability to weather pandemics, such as that driven by COVID-19, and to bounce back from the shocks associated with such a pandemic. People who are socially connected to their communities, and communities of people with high levels of social connection, should be better at communicating quickly and more able to work together during times of stress and uncertainty [29]. People who have the low levels of trust in others that often accompany loneliness will have a harder time accepting the advice or help of others, even people tasked with managing crises by providing guidance [30]. Initiatives that address these issues, then, should help prevent worse health outcomes and public health crises later.

Reducing loneliness and isolation and increasing trust and connectedness are positive individual-level changes that programmes such as social prescribing are meant to bring about for participants. Such programmes are also, however, meant to spark positive changes at the system and community levels, meaning evaluations of programme effectiveness should include these levels as well [3][31][32]. The argument is that improvements in individual-level health and well-being will help individuals gain confidence, retain memory, and even remain

autonomous longer, meaning they are less likely to need long-term health or residential care [10][33]. As people feel better about themselves and their lives, they are also less likely to call on medical services for non-physical needs, such as loneliness and depression. Medical and social services should experience more targeted and, ultimately, reduced demand.

Further, people who are more connected to their communities and more trusting of others should contribute to overall community connectedness, thus enhancing a community's social capital. With higher levels of connectedness, people should be more likely to help each other in times of need, to establish networks that trade favours, and to generally be healthier for longer [33]. Communities that are more connected are therefore argued to be more economically productive, to be less likely to need social and public services, and to have lower crime rates [33]. At the individual, system, and community levels, interventions like social prescribing are meant to prevent crises and promote health.

## 2.3. The Need for Evidence

Although connections between these types of programmes and preventive health are plausible, we know very little about the impact of initiatives such as social prescribing that are seeking to address them. Social prescribing has been present in the UK since the 1970s [24] and is a key means with which the UK Government aims to support 2.5 million people by 2023/24 to manage their own health, improve their well-being, and reduce both pressure and spending on health and social care services [34]. Some estimate that 20% of the general practice (GP) appointments in the UK are related to social issues [35], while this estimate is closer to 30% in the Netherlands [36]. Given the existing evidence and the budgetary constraints that many services face, social prescribing initiatives are beginning to be implemented in other countries, including Australia, Canada, Denmark, the Netherlands, and Norway [25][36][37][38][39][40][41], as potential avenues for improving public health and preventing health crises.

Despite its popularity, reports indicate that scientifically rigorous and validated evidence of the impact of social prescribing is sparse [3][6]. Few studies implement internally or externally valid research designs to connect social prescribing programmes to changes in loneliness, isolation, well-being, connectedness, demands on health and social care, community-level changes, or other outcomes associated with public and preventive health. Notwithstanding the lack of systematic evidence of social prescribing's impacts on individuals, systems, or communities, there is enthusiasm for these types of programmes from both service delivery personnel and programme participants [42][43][44]. To glean insights and guidance, programme administrators are forced to turn to reports and studies that are not peer-reviewed and do not include randomised controlled trials (RCTs) or other recognised means of causal inference.

The potential and interest in social prescribing is driven by the person-centred approach, support planning that is based on one's needs, resources, and strengths, and the methods to empower individuals to actively participate in decisions regarding their health and well-being. This model of personalised care is delivered by social prescribing professionals who are experienced, informed, and knowledgeable about community resources. They are referred to as link workers (community connectors), who are trained to assist individuals to navigate their health needs and

resources available to address them [5]. The key aspect of any social prescribing programme is this interaction between the link worker and the individual (or a carer) over the course of one's programme participation. This interaction distinguishes social prescribing from other community-based approaches to health promotion and disease prevention [45]. Most importantly, it is the quality of this relationship that is argued to be the reason for choosing social prescribing as the person-centred approach to use and is cited as a key reason for some of the social prescribing programme successes [43][44]. Still, this lack of evidence raises questions regarding the ethics and feasibility of delivering social prescribing as a strategy to improve public and preventive health. Some health care providers have expressed reservations about referring patients to a service that might not have the same level of quality control or expertise regarding confidentiality and safeguarding as national health services would [42].

Based on the need for innovative preventive public health services to address issues such as loneliness, isolation, well-being, and connectedness and the marked increase in social prescribing as a proposed solution to this need and subsequent demand for rigorous, externally validated research on the topic, we present this systematic review. Our work contributes to the Special Issue on New Challenges and Crucial Topics for 2030 Public Health by providing insight into social prescribing initiatives and their potential to promote public and preventive health by affecting loneliness, isolation, well-being, and connectedness, and by affecting individual participants, health and social care system-level demands, and community-level outcomes. We systematically review the literature on social prescribing over the last 20 years and synthesise the results by identifying: (1) the extent of evidence of social prescribing impact on individual participant loneliness, social isolation, well-being, and connectedness; (2) the type and quality of evidence used to demonstrate impact; and (3) the impact of social prescribing programmes that are designed to improve our four key outcome measures on public and preventive health challenges at the individual, system, and community levels.

Our efforts build on previous work in at least two important ways. First, our consideration of loneliness, isolation, well-being, and connectedness as four distinct items of interest is a focus we have not seen in previous work, which systematically reviews the effects of social prescribing on physical health, healthcare usage, and well-being [45][46], or which examines only loneliness as an outcome [47] but does not address isolation or connectedness. Second, we report on these outcomes of interest at the individual, system, and community levels. We find that a lack of evidence regarding how social prescribing works, and for whom, is partially due to how programme impact is assessed and categorised and partially due to how evaluations are designed and conducted. Our work thereby expands the conversation and restricts the claims about the impact and effectiveness of programmes such as social prescribing.

## 3. Conclusion

Social prescribing is recognised as a vital resource for its potential to positively impact health, enhance individual and community assets to address consequences of issues such as loneliness and social isolation, reduce vulnerabilities, and build social support among individuals during the pandemic and beyond [48]. The most recent report by the UK Government on their Loneliness Strategy efforts to reduce loneliness specifies social prescribing

as a useful and needed model for providing welfare checks and practical support for the world's loneliest and most isolated individuals [12].

Levels of loneliness, isolation, well-being, and connectedness were considered a threat to public health even before the COVID-19 pandemic [8][49]. Finding ways to combat loneliness and social isolation has become a central focus of governmental and community organisations in the United Kingdom (UK) and is rapidly becoming pertinent across the rest of the international community. Overall, there is a positive response to the social prescribing initiatives, from participants, from the health and social care staff, and from community actors involved in programme delivery. Yet improvements are needed in clarifying and measuring outcomes, particularly in terms of differentiating concepts from each other and from similar concepts. The studies that evidence how improvements changes in loneliness, well-being, isolation, and connectedness help individuals engage with others, gain independence, gain better control of their health, and better understand available resources and how to utilise these, provide the strongest theoretical basis from which to link these elements to financially sustainable preventive and public health. Creating and maintaining these positive impacts, and gaining new skills, insights, and resources to improve one's health, *should* position individuals to contribute to their own health and the health of those around them, take demand off of overburdened health and social care systems, and contribute to greater community productivity. Whether or not these processes *do* occur remains to be investigated.

As an innovative approach to managing health and social care, social prescribing has the potential to offer both preventive and acute benefits to individual health, system-level management, and community-level well-being. The best thing about social prescribing is also its greatest weakness: *potential*. It seems that social prescribing has the potential to help address nearly any problem related to individual health and well-being; over-burdened health and social care systems; and community connectedness, resilience, and productivity. Yet in recognising the breadth of possibilities social prescribing can address, research into social prescribing efficacy becomes equally broad, considering divergent and incomparable outcomes, measures, and programme designs. Until evaluations of social prescribing programmes become more standardised and comparable, the vast potential of social prescribing to cause change both increases the reasons to implement the approach and weakens the argument for doing so.

While the studies that effectively demonstrate and evidence impact of their programmes are useful and informative, others that are less successful in providing such evidence can also contribute to our understanding on how social prescribing works and what can be done to better assess its impact. This concern is particularly relevant when it comes to social isolation, the issue most commonly cited as a reason for participation in social prescribing programmes, yet also the issue least likely to have sufficient conceptual or methodological clarity when evaluated. Importantly, our work reveals a gap in the current social prescribing and public health literature on establishing the links that exist between various health and well-being outcomes and ways to account for these related, yet distinct, phenomena.

Our review highlights an urgent need to develop and establish guidelines to assess the impact of social prescribing at the community level, because it is precisely at the community level that preventive and public health innovations are most needed. Given that social prescribing is a community-based initiative, with community resources being

the central focus of delivery, more effort is necessary to establish impacts of these programmes on structures that play a fundamental role in its implementation. Research into social prescribing would also benefit from greater acknowledgement and consideration of the complexities of health and its implications for designing and implementing person-centred programmes such as social prescribing. The evidence needed to assess the impact ranges from contextual factors (target population, needs, referral sources) to individual and community health and well-being measures, and sectoral conditions, including effects on the voluntary, public, and corporate sectors.

Initiatives that address underlying vulnerabilities at the individual, system, and community level are rapidly expanding, and we look forward to new releases of evidence and impact evaluations every day. As studies and evidence are implemented and updated, we urge evaluators to consider improvements in loneliness, isolation, well-being, and connectedness to be not just an end in themselves, and not just a means by which to reduce demands on the health and social care system, but also as a step closer to successful achievement of financial sustainable universal health.

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