CREATIVE AGEING & SOCIAL PRESCRIBING: BRIDGING THE GAP BETWEEN THE SERVICER USERS, SERVICE PROVIDERS AND POLICY MAKERS ENGAGED IN SOCIAL PRESCRIBING IN WALES

Policy briefing, July 2023

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Overview and policy context

Within the updated Programme for Government[1] is a pledge to: "*Introduce an all-Wales framework to roll out social prescribing to tackle isolation*". Social prescribing is a key component of universal personalised care where patients are in control of their care package – and, as a recent Senedd Research Service briefing[2] noted, social prescribing aligns with the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014, both of which are founded upon models that recognise the impact of social aspects on health and wellbeing.

Yet despite this acceptance of social prescribing's important role for wellbeing, an evaluation of social prescribing interventions concluded that "*social prescribing is being widely advocated and implemented but current evidence fails to provide sufficient detail to judge either success or value for money*"[3]. This missing detail consists of unwritten lived experiences and knowledge that creative professionals and participants have. Furthermore, although social prescribing has been cited for its efficacy in reducing psychosocial problems stemming from social isolation in an estimated 20% of GP referrals[4,5], there is a lack of systematised evidence for its impact[6]. There are also concerns that uptake is too often from people who are already engaging well with services and are culturally active[7]. Tailoring cultural offers to the variety of conditions and circumstances encountered in later life, and to changes in social circumstances, is central to social prescribing for older people involving the cultural sector. Adaptations should be directed towards achieving key benefits for older people who have reported feeling lonely, anxious and unwell during the pandemic and recovery from it[8].

In order to respond to this challenge this British Academy Innovation Fellowship-funded work aimed to increase understanding of who gets excluded from social prescribing and how do minoritised groups experience this process with a particular focus on people living in former mining towns in the Welsh Valleys, South Asian women, the African diaspora, Deaf British Sign Language users, and LGBTQ+ people. The focus was particularly intersectional in order to explore the similarities and differences in the experiences of under-represented groups.

Research findings

Drawing on interviews, focus groups and observations with 27 creative professionals linked to social prescribing in 14 organisations across Wales, it was clear that many people affected by social isolation and loneliness and/or dementia do not access community arts interventions through social prescribing in primary care even though these organisations are very well known and widely used among service user groups in the community. These organisations were PhotoMan, Choirs for Good, Impelo, Forget-me-not chorus, Head4Arts, Pride Cymru, South Wales Gay Men's Chorus, British Deaf Association, Deaf Hub Wales, Disability Arts Cymru, Women Connect First and Sub Sahara Advisory Panel. These

organisations have their own ways of engaging older adults and reaching people who would traditionally be considered 'hard-to-reach'. This indicates the operation of a well-established arts and health network that is not connected to formalised social prescribing and related databases of organisations (e.g. Infoengine and Dewis) which however shares the similar principles and engages under-represented service user groups.

The following key experiences were brought to our attention:

Experiences of professionals in health, social care and the creative sector involved in social prescribing: Creative professionals reported increased engagement with link workers based in the voluntary sector, local councils and housing associations but not with professionals based in primary care. Creative professionals in secondary care felt that social prescribing can be part of the hospital discharge process and that it was a missed opportunity.

Social prescribing experiences of older adults who experience social isolation: Participants brought to our attention that no everyone needs to socialise in the same way and some people choose a more reclusive life. Therefore, referral to group activities might not be a desirable objective but rather a referral to activities that can be accessed online and can be done in minimal-interaction environments. For people who sought company, open community events were much preferred because they were able to blend it without the label of being lonely.

Social prescribing experiences of older adults who experience dementia: People with dementia were actively engaged in choirs such as the Forget-me-chorus, Singing for the Brain organised by the Alzheimer's Society and Cradle organised by the Welsh National Opera. These groups provided spaces not only for respite but also for knowledge exchange about support structures in the community. This important sphere is what can be referred to as the 'paramusical bricolage'[9].

Social prescribing and EDI: how do minoritised communities of older adults engage with SP and their own cultural traditions? Even though most of the older service users engaged in this study belonged in an under-represented group and/or lived with a chronic condition and/or were a social care service user and regularly accessed organised creative activities, they had not heard of social prescribing and were not aware how to contact a link worker. Engagement in creative service provision occurred through trusted organisations that offered a safe place for people to socialise and learn new skills.

The following five themes were identified in the participant narratives and explored in co-design sessions:

1) Open vs closed creative activity groups
   There are pros and cons for each group type. Open groups increase contact between different demographics and can help reduce stigma associated with certain conditions. Closed groups on the other hand can offer a safe space for more bespoke interactions and sharing of painful experiences.
2) Arts for health and wellbeing vs skills-based learning
   Arts for health and wellbeing was very popular among people living with dementia but had negative connotations for other groups affected by social isolation. Therefore that 'badge'

would serve as a barrier and hinder recruitment. Focussing on skills-based learning and working towards a performance was an appealing alternative for some groups.

3) Cultural and spiritual activity not identified as creative activities

   This was reported by some ethnic minority elders in particular who did not identify themselves as 'artistic' but who nevertheless engaged in creative activities such as calligraphy, embroidery, food decoration, chanting, dancing and playing music as part of their faith and cultural practices

4) Safe vs brave spaces

   This topic was brought up specifically for open community arts groups aimed to reduce social isolation that people from different walks of life access. Moderating difficult conversations was identified as a core facilitation skill that community artists needed to have.

5) Evaluating impact through standardised and bespoke ways

   Most participants expressed concerns about evaluation and how to best capture the impact of their work. There is a trend to favour standardised quantitative questionnaires in evaluation, however these methods might not adequately capture the complexity of applied arts interventions and might alienate service users. Capturing feedback orally and the transcribing it can help as well as considering mixed methods.

These findings show that engagement in creative activities in the community by older people affected by dementia and/or social isolation is a very selective process were the nature of the activity, the group attending and the relationship with the facilitator is key. Methodological and epistemological barriers were reported in measuring the impact of engagement in creative activity on health and wellbeing. This means that formalised social prescribing could potentially not be reaching its potential as really valuable organisations are not included in the referral system, link worker capacity limits the engagement of relevant organisations and evaluation capacity limits evidence-based practice.

Recommendations

As Welsh Government develops its policy to introduce an all-Wales framework on social prescribing to tackle isolation and seeks to embed Prudent Healthcare principles, the following recommendations can be suggested:

1) Explore further the rates of participation of under-represented groups and the role of the third sector as a mediator between service users and link workers.
2) Explore the potential of Health Boards as referral areas for people discharged from secondary care.
3) Collate evidence of existing impact and understand the variety of local practices in collecting impact data and which methods have been found work for which service user group of older adults.
4) Assess the capacity of link workers to undertake developmental work and increase the number of organisations they refer people to, including those running relevant short-term projects.
5) Organise virtual tailored consultation sessions with creative professionals working on specific health conditions so that they can meet commissioners and link workers in person.
6) Engage and include community arts organisations which foster inclusive spaces for diverse groups of people to come together and engage in creativity.

References

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This project is funded by the British Academy's Innovation Fellowship scheme. For further information, please contact: **vougioukalous@cardiff.ac.uk**