



Who is and isn't being referred to social prescribing?

Context

This evidence summary is one of a suite commissioned by the National Academy for Social Prescribing from their Academic Partners in 2021

<https://socialprescribingacademy.org.uk/evidence-on-social-prescribing/our-academic-partners/>). The topics included in this suite were identified through a robust prioritisation process with individuals representing the breadth of the social prescribing landscape. The summaries were produced by researchers from the NASP Academic Partnership; specific teams are listed on each document.

Four of these topics had significant work conducted previously by members of our group, and so we report that work then build out using new database searches and broader grey searches; to produce synthesised conclusions about what is known (we term these 'platform' reviews). The remaining summaries are 'fresh' reviews of the evidence base as it stands.

The summaries are intended for a broad readership but have a policy and practice focus; bringing together what is known on specific areas relating to social prescribing and summarising the findings, limitations, and gaps in that field. Each summary contains a detailed bibliography, and we would encourage readers to follow these links for further, more detailed, reading on each topic.

Recommended Citation

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Question description

What does the current evidence tell us about the demographics of those being referred for social prescribing?

General overview

This ‘fresh’ review (as compared to our other ‘platform’ reviews) summarises the evidence, and identifies gaps, relating to the demographic profile of who is being referred for social prescribing, including but not limited to age, gender, ethnicity, socioeconomics/indices of multiple deprivation (IMD), disability, and reasons for referral.

How we produced the review

Searches

We undertook a systematic search for both peer reviewed literature and grey literature. The literature searches comprised terms for the concepts of social prescribing and demographics (see appendix 1). The databases Scopus and Web of Science were searched for peer reviewed literature. Grey literature including reports and evaluations were obtained by searching Social Care Online and Google.co.uk.

In addition, we asked our Academic Partners to provide any evaluations or reports of social prescribing they were aware of over the last 5-year period. These evaluation reports were screened for relevance, and any additional or new papers were identified as they were published.

Our inclusion and exclusion criteria were as follows:

<i>Inclusion criteria</i>	<i>Exclusion criteria</i>
Reports or evaluations	Abstracts or theses
Quantitative data (including from mixed method studies)	Documents lacking primary data
Data for at least one demographic characteristic	Experimental research focusing on one demographic, population, or cohort
Research conducted in England and published in English language	Documents published before 2017, as we were interested in contemporary data
Meets NASP definition of social prescribing	Sources not in the public domain

Rationale: We are aware that the social prescribing landscape has rapidly evolved over recent years, and we wanted reported figures to accurately reflect current practice as far as possible. We were also acutely aware that referral patterns have been impacted significantly by the COVID-19 pandemic, with more individuals referred to a link worker for well-being checks, instrumental support (medication or food) and to address loneliness. Therefore, we chose to include data from January 2017 onwards, covering a period when social prescribing became more formally and coherently entrenched in health systems and policy.

Screening, data extraction and critical appraisal: Located items were screened by one reviewer, with 10% independently screened by another and disagreements resolved through discussion and, where appropriate, a third reviewer. Demographic data were extracted onto a bespoke data extraction template.

Included studies were critically appraised using the What Works Wellbeing tool used in previous rapid evidence summaries (<https://whatworkswellbeing.org/wp-content/uploads/2020/10/Volunteer-wellbeing-technical-report-Oct2020-a.pdf>). We used the PROGRESS-Plus criteria (<https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus>) as a framework to assess, where possible, how far factors associated with health inequalities have been addressed in research. In doing so, we aimed to report where (i) there is evidence of inclusion of a particular group or cohort, (ii) there is evidence of disadvantage, (iii) no evidence reported.

Results

In total, 458 documents were screened, with 36 studies meeting the inclusion criteria¹⁻³⁶ (see Appendix 2). Of these, five were identified through the database searches of peer-reviewed literature^{1-2, 11, 13, 31}, and 31 through our grey searches and expert contacts^{3-10, 12, 14-30, 32-36}. Please see appendix 3 for full details. Specific details of included papers are available on request.

Summary of evidence

Data relating to the demographic profile of social prescribing participants were extracted from included studies, tabulated, discussed, and brought together into a narrative summary of characteristics which we present below.

Age

Social prescribing in England is, in principle, an all-age offer and link workers can engage individuals across all age groups that are referred. Broadly, we found this to be the case in practice with some minor exceptions.

In the 36 included studies, 21^{1, 3-5, 7, 10, 13, 15-16, 18-21, 23-25, 28-30, 32, 35} reported engaging populations below the age of 19. However, only 5^{5, 16, 19, 23, 25} of those 36 studies reported working with individuals under the age of 16, despite the move from policymakers and practitioners to engage more children and young people in social prescribing pathways.

Perhaps unsurprisingly, almost all (35/36) of our included studies included working-age cohorts (aged 18-65), the one remaining targeting an older cohort¹¹. Similarly, 35/36 studies also included individuals over the age of 65, up to a maximum reported age of 100. Only one study was specifically targeted at only young people¹⁹.

Given the breadth of the social prescribing offer, it is not surprising that - apart from young people - our included studies displayed few patterns in terms of age inclusion. It is encouraging that social prescribing appears to be being used across all age groups.

Gender

In the data reported in included studies, almost twice as many women accessed social prescribing than men. The study with the largest cohort of 1 million people

reported an average of 60% female and 40% men referred for social prescribing across 8 services³⁴. On average across included studies, this gap is larger, with 64% of included people identified as female, and only 35% as male (with missing data accounting for the other 1%).

Only four of our 36 included studies reported other genders^{10, 28-30}, including transgender, gender fluid and non-binary. In these studies, the cohorts were extremely small, with <1% in each.

Ethnicity

In our cohort of quantitative studies included here, ten did not report ethnicity. In all the remaining 26 studies^{1-4, 6, 8-10, 12-13, 15-23, 25-26, 28-30, 32-33}, the highest proportion of participants were reported as being either White, White British or White/Other.

In 13 of the 26 studies reporting ethnicity, there were no data given for the local population and so no inferences can be made about the representativeness, or not, of the ethnic breakdown given.

The remaining 13 studies did take the local population into consideration^{1-2, 12, 15-17, 19-20, 22, 28-30}. Mostly, we found that White populations in social prescribing either reflected the local populations or were over-represented. Again, for the most part, other ethnic groups were under-represented compared to local communities in social prescribing. White populations were only under-represented, and Black and Asian participants over-represented, in two studies^{12, 21}. A single study reported an equal number of included White and other ethnic group participants²², reflecting the local population in that area.

Socioeconomic (including education and occupation)/Indices of Multiple Deprivation (IMD)

Of our included studies, four papers reported socioeconomic data in the form of employment^{21, 25-26, 33}, and only one regarding education²¹. Of these limited data, the highest proportions of people were retired or unemployed, and the highest educational level was reported as aged '20+'. Three papers reported IMD, with one showing 22% of the cohort living in the top 10 areas of multiple deprivation¹, another with the highest proportion of those referred living in the lowest areas of deprivation²³, and a third showing that those living in deprived areas were either represented or over-represented²⁴.

Due to differences in reporting, and the lack of comparison to local population figures, it was not possible to aggregate these data, or make inferences regarding representativeness.

Disability

There was sparse information recorded relating to disability in the included papers, with only two papers specifying the proportion of cohorts self-identifying as having a disability (6%¹², and 38%²⁵ respectively).

More detail was provided relating to those identifying as having a long-term health condition. One paper identified those unable to work due to sickness (at 33%)¹⁸, and another those with long-term sickness (at 23%)²⁰. One study was more detailed, giving a breakdown of the long-term conditions people were living with (with each condition ranging from 5-17% of the cohort. This study included 52% of the cohort overall with Long Term Health Conditions, higher than the general population level at 23%¹². The highest proportion of chronic conditions reported in a social prescribing cohort in our included studies was the 87% and 90% reported across two sites²⁴, 46% and 55% of these respectively were reported as chronic mental health conditions.

Reason for referral

Given the limited number of commonly reported demographics, as well as interest from across the system, we included data relating to reasons for referral as a characteristic of populations.

Again, somewhat unsurprisingly, the most reported reasons for referral were those most often associated and understood to benefit from a social prescribing referral - common mild to moderate mental health difficulties (both symptoms and diagnoses of). Overall, the most-included referral reasons were:

- symptoms related to anxiety and depression.
- isolation and loneliness.
- other social needs.
- exercise-related referrals.
- referrals related to specific physical health complaints.
- issues relating to work or finances.
- struggling with life changes.
- being frequent attenders at primary or care services.

However, there were many and diverse other referral categories, including: severe mental health issues; addictions, including smoking, drugs and alcohol; low confidence and self-esteem; housing and homelessness; learning/education, training and employment; weight management and healthy eating; life events, including bereavement, abuse, and mental health of a parent; medical/hospital care not appropriate; specific conditions: anger, dyslexia and dementia; general support: information and advice, self-care management, carer support, sleep problems; issues associated with immigration; and, more recently, COVID-related issues.

Whilst we excluded reports solely reporting research data on one population (i.e., researchers selected groups of people based on certain characteristics) as we felt this would not accurately represent the reality of services, three of our included studies reported on programmes which themselves solely focused on specific groups: those with cancer³³, and those experiencing isolation or loneliness^{13, 22}.

PROGRESS-Plus

Age, gender, and ethnicity - and to a smaller extent, socioeconomic status, and disability - had been included as part of data collection for these papers, and it was clear that men and some ethnic groups were generally under-represented in social prescribing when compared to local population data. However, there was a scarcity of discussion around disadvantage or intention to address inequalities. For details on the PROGRESS Plus framework see <https://methods.cochrane.org/equity/projects/evidence-equity/progress-plus>.

Evidence gaps, limitations, and quality

We applied the What Works Wellbeing tool for critically appraising studies, and quality varied considerably.

There was significant variability in data reporting, with some studies only reporting demographics for those attending a first link worker contact, rather than the whole included cohort. It was also often the case that there appeared to be missing demographic data; for example, it is unclear what gender options were presented in included studies reporting only male and female responses.

One key challenge reported in included studies was around data collection itself, the fact that engaging with, collecting data relating to, and following up some cohorts is extremely difficult for practical and ethical reasons. It was also reported that data were occasionally inaccessible following the completion of a study or were lost during the programme.

We were interested in a large range of demographics and would have extracted data relating to living arrangements and relationship status, however these were included in either none or only single studies included in this review.

CONCLUSIONS

Data reported in this evidence summary indicate that, for the most part, social prescribing is an all-age offer. However, there are indications that children and young people are not accessing social prescribing pathways to the same extent. More could be done to explore this important issue and establish to what extent children and young people are, and could, use these programmes.

There appears to be a pattern in the data in terms of a gender divide, with more women accessing social prescribing than men. In terms of ethnicity and social prescribing, there is a need to do further research. Many studies did not report differences, however in those that did the overall picture was of ethnic minority groups not accessing social prescribing as much as other groups, though this is not the case in all situations. Reasons for referral are also broad, but most commonly include those identified by health policy as most appropriate for social prescribing; those experiencing mild to moderate mental health difficulties, social isolation, and loneliness.

Overall, there is a need for more research exploring all aspects of the demographic profile of those engaging in social prescribing.

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Appendix 1 - Search strategy

Scopus

TITLE-ABS-KEY ("social* prescrib*" OR "social prescription*" OR "community referral*" OR "social referral*" OR "non-medical referral*" OR "link worker*" OR "care navigator*" OR "linking scheme*" OR "referral scheme*") AND TITLE-ABS-KEY (demographic* OR evaluat* OR report OR audit) AND PUBYEAR > 2016

Web of Science

TOPIC: (("social* prescrib*" OR "social prescription*" OR "community referral*" OR "social referral*" OR "non-medical referral*" OR "link

worker*" OR "care navigator*" OR "linking scheme*" OR "referral scheme*") AND TOPIC: ((demographic* OR evaluat* OR report OR audit)) Timespan: 2017-2021. Indexes: SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI.

Social Care Online

- AllFields: "social* prescrib*" OR "social prescription*" OR "community referral*" OR "social referral*" OR "non-medical referral*" OR "link worker*" OR "care navigator*" OR "linking scheme*" OR "referral scheme*" - AND AllFields: demographic* OR evaluat* OR report OR audit

Google

allintitle: (evaluation OR audit OR report OR pilot) ("social prescribing" OR "social prescription" OR "link worker") (site:ac.uk OR site:nhs.uk OR site:gov.uk OR site:org.uk)

Appendix 2 - Table of included studies

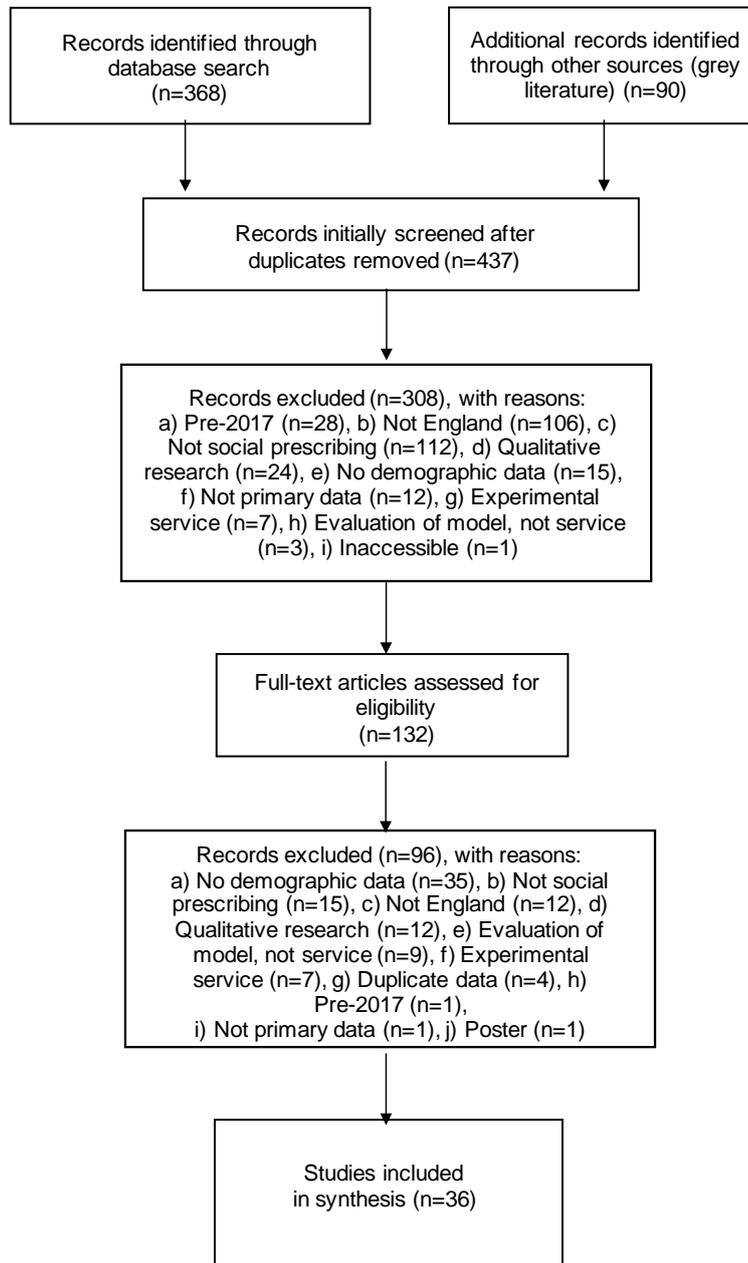
Identifier/year	Design	Sample size/no. referred	Demographic data included
Brighton & Hove extended pilot/2017	Service evaluation	308	Age, gender.
Dudley Council for Voluntary Service/2017	Service evaluation	5,766	Age, gender, ethnicity, reason for referral.
HALE Community Connectors/2017	Service evaluation	703	Age, gender, reason for referral.
Social Prescribing in Bexley/2017	Service evaluation	81	Age, gender, reason for referral.
Social Prescribing in the London Borough of Waltham Forest/2017	Service evaluation	600	Age, gender, ethnicity, socioeconomic, reason for referral.
Social Prescribing in Wessex/2017	Service evaluation (8 services)	1 million	Age, gender.
South East Leeds Connect for Health/2017	Service evaluation	112	Gender, ethnicity
Community Webs/2018	Service evaluation	393	Age, gender, ethnicity, socioeconomic, reason for referral.
East Merton Social Prescribing Pilot/2018	Service evaluation	223	Age, gender, ethnicity, reason for referral.

Healthy London Partnership(Family Action)/2018	Service evaluation	102	Age, gender, ethnicity, reason for referral.
Tower Hamlets/2018	Service evaluation	2,270	Age, gender, ethnicity, disability, reason for referral.
Tower Hamlets - Bromley by Bow & Mile End East/2018	Service evaluation	643	Age, gender, ethnicity, reason for referral.
Bromley by Bow Centre Social Prescribing Service/2019	Service evaluation	583	Age, gender, ethnicity, reason for referral
Connect Well Leeds North/2019	Service evaluation	>600 (exact figure unknown)	Age, gender, disability.
Elston et al./2019	Pre-post service evaluation	82	Age, gender, reason for referral.
Impact of Social Prescribing in York/2019	Service evaluation	71	Age, gender, reason for referral.
Islington Giving/2019	Service evaluation	271	Age, gender, ethnicity.
Macmillan East London pilot/2019	Service evaluation	1,456	Age, gender, ethnicity, socioeconomic, reason for referral.
Pescheny et al./2019	Pre-post quantitative study	448	Age, gender, socioeconomic.
Shropshire Demonstrator Site/2019	Service evaluation	515	Age, gender, ethnicity, socioeconomic, reason for referral.
Wolverhampton Social Prescribing Service/2019	Service evaluation	676	Age, gender, ethnicity, socioeconomic, reason for referral.
Worcestershire Social Prescribing Pilot/2019	Descriptive poster - design unknown	1,840	Age, gender, reason for referral.
Bristol Ageing Better/2020	Service evaluation	1,279	Age, gender, ethnicity, reason for referral.
City & Hackney Social Prescribing Scheme/2020	Service evaluation	166	Age, gender, ethnicity, socioeconomic.
Crediton Social Prescribing Project/2020	Service evaluation	72	Age, gender.

Crisis Social Prescribing at Bromley by Bow/2020	Primary data analysis	249	Age, gender.
Foster et al./2020	Service evaluation	10,643	Age, gender, ethnicity, disability, reason for referral.
HALE Community Connectors/2020	Service evaluation	1,984	Age, gender, ethnicity, reason for referral.
Oxfordshire MIND/2020	Service evaluation	3,985	Age, gender, ethnicity, reason for referral.
Social Prescribing in the London Borough of Redbridge/2020	Service evaluation	182	Age, gender, ethnicity, socioeconomic.
Social Prescribing Observatory/2020	Primary data analysis	29,000	Age, gender, ethnicity, IMD,
South East Sheffield/2020	Service evaluation	408	Age, gender, ethnicity, socioeconomic, disability, reason for referral.
Young People Social Prescribing Pilot/2020	Service evaluation	192	Age, gender, ethnicity, reason for referral.
Oxfordshire MIND/Mar 2021	Service evaluation	851	Age, gender, ethnicity, reason for referral.
Oxfordshire MIND/Sep 2021	Service evaluation	429	Age, gender, ethnicity, reason for referral.
Upscaling of Social Prescribing Service in Merton/2021	Service evaluation	576	Age, gender, ethnicity, reason for referral.

Appendix 3

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram for additional search element. This diagram depicts the flow of information through the different phases of this review. It shows the number of records identified, included and excluded, and the reasons for exclusions.



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