Social prescribing

A call to action

Dominik Alex Nowak MD MHSc CCFP Kate Mulligan MA PhD

R.E. presents to her family physician with several concerns. She has high blood pressure and illness suggestive of generalized anxiety disorder with depressed mood. R.E.'s family physician understands that R.E. is a sole parent for 3 young children: "I wish I could get out of the house or book an hour for talk therapy, but it is just not feasible for me." In addition to trying medication, they decide to connect R.E. to a local link worker. The link worker is able to help R.E. organize municipally subsidized child care and provide a social prescription to a parent exercise group co-located with the child care centre, thereby also finding time for talk therapy. Through a social prescription that addresses R.E.'s social needs, R.E. is able to take part in a care plan that allows for a comprehensive approach to her multiple medical issues.

The social determinants of health represent a paradox in family practice. On one hand, family doctors have the ability to understand how a person's social context affects that person's health.[1] R.E.'s family doctor, for instance, identified lack of child care as an obstacle to R.E.'s treatment for hypertension and anxiety. However, despite awareness and appreciation of social context, there are barriers to addressing the social determinants of health and relevant social needs in primary care. Medical training and guidelines are often reductionist and disease specific.[2] In both prevention and treatment, the biomedical model is focused on proximal causes, such as comorbidity and lifestyle, rather than fundamental causes, which are often social.[1] Many in our professional communities feel underprepared and unsupported in addressing social needs,[3] while others argue that social determinants of health are beyond the scope of primary care.[4]

Social care for social needs

Nonetheless, a routine day in primary care is enough to intuitively understand the importance of social context in the treatment of medical illness.[5] The social determinants of health are not a new concept—in fact, we understand that they contribute to 80% of health and well-being.[6-8] On a population level, modest increases in spending on social services in Canada have been associated with decreased mortality.[9] On an individual level, social conditions are fundamental causes for medical illnesses that present in primary care, and social needs are the downstream manifestations of these social conditions.[1] By connecting people with social care, social prescriptions are a culture shift away from the medicalization of social needs.[10] This realization has influenced the United Kingdom's National Health Service, for example. It plans to make available a thousand new social prescribing link workers to family practices by 2021, with the goal to connect at least 900 000 people with a social prescription by 2024.[10,11] Limiting primary care to medical needs for medical illnesses, therefore, represents a missed opportunity for addressing the fundamental causes of illness.[1]

In the article that follows, we promote social prescribing as an optimistic way forward. Associate Scientific Editor of *Canadian Family Physician* Dr Roger Ladouceur recently wrote about an aspirational state in family medicine, where family doctors might "prescribe happiness" as easily as they could prescribe a medication.[12] Unlike diabetes or asthma, concepts like happiness, early childhood development, and social inclusion might seem difficult to address in a clinical setting. However, current models of social prescribing are both practical and effective.[13,14] Screening, referrals, and supports for social needs approach clinical aspirations around the social determinants of health at the individual level.

Social prescribing empowers clinicians to connect people to community supports that have been shown to improve health and well-being.[14] Under the umbrella of social prescribing is a group of interventions that are person centred and evidence based.[15] In our age of complexity and chronicity, social prescribing has the potential to transform the way we practise family medicine. Social prescribing allows nonmedical treatment options for the myriad primary care illnesses influenced by social context. We suggest 3 fundamental values that facilitate clinical discussions pertaining to social prescribing.

Fundamental values

Social prescriptions should emerge from the foundational relationships family doctors develop with people and communities

People: Social prescriptions can be natural consequences of the mutual trust, understanding, and respect family physicians already build in recurrent clinical encounters. These relationships can influence beliefs, receptivity, and expectations around a social prescription—all factors that affect the success of social prescribing programs.[16]

Communities: Family physicians often have strong links with their communities and local health systems.[17] These relationships vary depending on context.

Physicians in team-based models might have more intrinsic supports available (in Ontario, these models include community health centres, family health organizations, and family health teams; in Alberta, examples of these models include the Crowfoot Village Family Practice and the Taber Clinic). Virtual, telephone-based, or off-site supports might also serve as a high-value gateway toward social prescription regardless of practice setting.[18] In other communities, supports might include municipalities, public health departments, local hospitals, the Royal Canadian Legion, or Canada 211 (accessible by dialing 211 or online at **211.ca**).

Social prescriptions should build on the strengths of the recipient and the clinician

Individual strengths: The biomedical model focuses on disease and deficiency.[2] Social prescriptions, on the other hand, can focus on strengths and build on what matters to patients.[11] In fact, they are often an opportunity for individuals to contribute to their community. For example, a social prescription for a meaningful volunteer program in a newly retired older adult might add purpose, benefit the community, and prevent social isolation. **Table 1** provides examples of such programs. Such programs might also stave off depression, preserve cognition, and reduce chronic pain.[19] Therefore, a single strengths-based social prescription has the potential to benefit the recipient in several ways and to benefit many others.

Clinician strengths: Family doctors are specialists in person-centred primary care. A family doctor's understanding of an individual can direct him or her in introducing a social prescription. In many contexts, physicians might explore and introduce social prescriptions themselves. In other contexts, physicians could refer to a local professional or organization that is better equipped or has more time to explore and support a social prescription. When supported by a team (eg, with the referrals in **Table 2**), a family doctor's strength in the context of a social prescription might be in screening for this need and in expanding the circle of care to a system navigator or a link worker, whose role is to co-design a social prescription with the recipient.[11] However they happen, social prescriptions can connect recipients with social care in their communities. In creating a pathway for family physicians to integrate with community assets, a social prescription allows for a shift toward demedicalization of social needs.

Social prescriptions should involve tracking and follow-through

Tracking: Social prescriptions should continue to be tracked, measured, and evaluated. Social resources have existed for decades, but current programs incorporate nuance in evaluating uptake, health improvements, and effects on systems.[9,13,14]

Follow-through: Unfortunately, not all social prescriptions or referral programs are universally available to clinicians. In light of these discrepancies, a referral to a telephone number or website with no clear follow-through can worsen distress in people seeking our help. Family physicians should therefore be knowledgeable of the social prescribing referrals available in their communities and should ensure short-term follow-up to evaluate whether the referral was effective.

Social prescriptions are interventions that seek to address social needs. They have the potential to bring happiness and purpose, but also community connection, good nutrition, sustainable exercise, and benefits

Table 1. Examples of social prescriptions in Canadian communities

PROGRAM	DESCRIPTION
Fresh Food Rx	Individuals and families experiencing food insecurity are provided access to nutritious foods through community partnerships, such as a free Good Food Box or subsidies toward food from a local farmer's market
FoodFit	Participants prepare a meal, exercise, and eat together
Gallery visit	Peer-facilitated meditative walk through an art gallery, followed by an art-making workshop
Gender Journeys	Group for transgender and questioning people to explore gender identity and expression and be provided with reliable information and resources
Life after grief	Peer-facilitated bereavement support group that provides an opportunity to meet new friends and share resources
Nordic pole walking	Groups take a guided walk through nearby nature trails with equipment from community funders
Seniors' Centre Without Walls	Telephone-based programs for older adults that include health and wellness, language classes, book clubs, support groups, and more
Student-Senior Isolation Prevention Partnership	A national calling program for older adults, with weekly calls from health professional students around health promotion, social needs, and friendly connection
Soup and Crochet Social	Social gathering where participants learn to crochet while dining together
Walk to Quit	Education and physical activity program to support individuals to reduce or quit smoking

Table 2. Examples of possible referrals to initiate an appropriate social prescription

PROGRAM	DESCRIPTION
TeamCare (Advancing Access to Team-Based Care)	A registered family physician refers an individual to TeamCare. A system navigator contacts the individual directly, conducts an assessment, and connects the individual to a range of allied health, social, and community supports
Canada 211	A family physician can contact 211 on behalf of or with individuals for suggestions of available resources within a region, such as available programming in local social service agencies and community organizations. With individuals' permission, 211 can also perform follow-up calls to speak with individuals directly and provide further resources
McMaster Family Health Team System Navigator	A family physician refers an individual to the team's system navigator. Functionality is similar to TeamCare but is co-located and integrated with the individual's in-person primary care team
Ontario Caregiver Helpline	A centralized resource available 24 hours a day, 7 days a week, for information and support for caregivers
SCOPE mental health program	A registered family physician refers an individual to the SCOPE mental health program or SCOPE registered nurse health coach. The SCOPE social worker or health coach supports the clinician and patient through service navigation, community supports, and psychiatry consultation (if needed)
Social prescribing navigator (eg, in Ontario family health teams)	A possible future service. There is opportunity to include social prescribing navigators within regional teams. Clinicians might refer an individual to the navigator, who would conduct an assessment through co-creative, strengths-based conversations, and connect the individual to a range of social and community-based supports

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Table 3. ALF (assess, link, follow-up) social prescribing challenge

STEP	PHASE	INSTRUCTIONS
1	Assess	Identify a person, family, or caregiver in your practice with social needs. Several tools exist to support these conversations[20-23]
2	Link	Together with the identified persons, families, or caregivers, connect with Canada 211 to discuss their situation and co-design a referral to fit their strengths and challenges
3	Follow-up	Track and follow up with the identified person, family, or caregiver on the co-designed social prescription within a reasonable time frame. Use a reminder through the electronic medical record to track the social prescription and initiate follow-up

in other domains of health and well-being. Policy makers and systems advocates should support family doctors in expanding access to in-person or virtual teams, dedicated community navigators or link workers, and other high-quality referrals to social and community services. In turn, family physicians can be informed by their relationships with people and communities to introduce strengths-based social prescriptions. In light of the potential effects of addressing social needs, we challenge family physicians nationwide to more formally and systematically incorporate social prescribing into their daily work (**Table 3**).[20-23] We welcome local examples, anecdotes, and discussion—to comment on this article, open it at **www.cfp.ca** and click on the eLetters tab.

Conclusion

There is a need for new and effective interventions that address social needs in primary care and, in doing so, reduce the effect of social context on health. Social prescribing is dependent on healthy public policy, investment in community and social services, and high-quality clinical care.[10] Social prescriptions can bridge these disparate systems[14] and change the lives of people in our practices for whom social context influences their health. For further details, we encourage readers to view the frameworks shared by the United Kingdom's National Health Service or Ontario's Alliance for Healthier Communities.[11,24] Social prescriptions can realize our aspirations to address social needs, achieve health equity, and transform how we practise person-centred primary care. Family physicians are ideally placed to model high-quality social prescribing and thus lead the way for a healthier Canada.

Dr Nowak is a family physician and adjunct faculty member in the Department of Family and Community Medicine at the University of Toronto in Ontario. **Dr Mulligan** is Assistant Professor in the Social and Behavioural Health Sciences Division at the Dalla Lana School of Public Health, Director of Policy and Communications at the Alliance for Healthier Communities, and a member of the Toronto Board of Health.

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Competing interests

Dr Nowak has no competing interests to declare. **Dr Mulligan** works with the Alliance for Healthier Communities, an organization that received funding from the Ontario Ministry of Health to conduct a social prescribing pilot project.

Correspondence

Dr Dominik Alex Nowak; e-mail **dominik.nowak@medportal.ca**

References

1. Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *J Health Soc Behav* 2010;51(Suppl):S28-40.
2. Fuller J. The new medical model: a renewed challenge for biomedicine. *CMAJ* 2017;189(17):E640-1.
3. Lee A, Sundar S. Social prescribing: an essential but neglected component of the undergraduate medical curriculum. *Educ Prim Care* 2018;29(6):385.
4. Solberg LI. Theory vs practice: should primary care practice take on social determinants of health now? No. *Ann Fam Med* 2016;14(2):102-3.
5. Tong ST, Liaw WR, Kashiri PL, Pecsok J, Rozman J, Bazemore AW, et al. Clinician experiences with screening for social needs in primary care. *J Am Board Fam Med* 2018;31(3):351-63.
6. Andermann A; CLEAR Collaboration. Taking action on the social determinants of health in clinical practice: a framework for health professionals. *CMAJ* 2016;188(17-18): E474-83. Epub 2016 Aug 8.
7. Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. *Am J Prev Med* 2016;50(2):129-35. Epub 2015 Oct 31.
8. Mikkonen J, Raphael D. *Social determinants of health. The Canadian facts.* 1st ed. Toronto, ON: York University School of Health Policy and Management; 2010. Available from: **https://thecanadianfacts.org/The_Canadian_Facts.pdf**. Accessed 2021 Jan 11.
9. Dutton DJ, Forest PG, Kneebone RD, Zwicker JD. Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study. *CMAJ* 2018;190(3):E66-71.
10. Roland M, Everington S, Marshall M. Social prescribing—transforming the relationship between physicians and their patients. *N Engl J Med* 2020;383(2):97-9.
11. NHS England. *Social prescribing and community-based support summary guide*. Redditch, UK: NHS England and NHS Improvement; 2020. Available from: **https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/**. Accessed 2021 Jan 11.
12. Ladouceur R. Prescribing happiness. *Can Fam Physician* 2019;65:599 (Eng), 601 (Fr).
13. Alderwick HAJ, Gottlieb LM, Fichtenberg CM, Adler NE. Social prescribing in the US and England: emerging interventions to address patients' social needs. *Am J Prev Med* 2018;54(5):715-8. Epub 2018 Mar 15.
14. Drinkwater C, Wildman J, Moffatt S. Social prescribing. *BMJ* 2019;364:1285.
15. Mulligan K, Bhatti S, Rayner J, Hsiung S. Reply to: looking before we leap: building the evidence for social prescribing for lonely older adults. *J Am Geriatr Soc* 2020;68(2):434-5. Epub 2019 Dec 16.
16. Husk K, Blockley K, Lovell R, Bethel A, Bloomfield D, Warber S, et al. What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review. *Syst Rev* 2016;5:93.
17. Baum FE, Legge DG, Freeman T, Lawless A, Labonté R, Jolley GM. The potential for multi-disciplinary primary health care services to take action on the social determinants of health: actions and constraints. *BMC Public Health* 2013;13:460.
18. Lockhart E, Hawker GA, Ivers NM, O'Brien T, Mukerji G, Pariser P, et al. Engaging primary care physicians in care coordination for patients with complex medical conditions. *Can Fam Physician* 2019;65:e155-62. Available from: **https://www.cfp.ca/content/65/4/e155.long**. Accessed 2021 Jan 18.
19. Mulligan K, Bhatti S, Rayner J, Hsiung S. Social prescribing: creating pathways towards better health and wellness. *J Am Geriatr Soc* 2020;68(2):426-8. Epub 2019 Dec 16.
20. Goel R. *A social history tool using the IF-IT-HELPS mnemonic*. Toronto, ON: Centre for Effective Practice; 2016. Available from: **https://cep.health/download-file/1542915867.061284-96/**. Accessed 2021 Jan 8.
21. American Academy of Family Physicians. *Social Needs Screening Tool*. Leawood, KS: American Academy of Family Physicians; 2018. Available from: **https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html**. Accessed 2021 Jan 8.
22. Centre for Effective Practice. *Poverty: a clinical tool for primary care providers*. Toronto, ON: Centre for Effective Practice; 2016. Available from: **https://cep.health/clinical-products/poverty-a-clinical-tool-for-primary-care-providers/**. Accessed 2021 Jan 8.
23. Kaiser Permanente. *Your Current Life Situation*. Seattle, WA: Kaiser Permanente; 2018. Available from: **https://sdh-tools-review.kpwashingtonresearch.org/screening-tools/your-current-life-situation**. Accessed 2021 Jan 8.
24. Alliance for Healthier Communities. *Rx: Community – social prescribing in Ontario. Final report*. Toronto, ON: Alliance for Healthier Communities; 2020. Available from: **https://www.allianceon.org/Social-Prescribing**. Accessed 2021 Jan 11.

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