Title: Occupational therapist’s involvement in social prescribing: A qualitative interview study

Abstract

Introduction: Social prescribing is a process of helping people to access non-medical activities to promote wellbeing. For occupational therapists, this is not new although the social prescribing agenda is creating new roles around these approaches. This study aimed to explore how occupational therapists were involved in social prescribing in the United Kingdom and how they would like to contribute to future developments.

Method: Semi-structured interviews were carried out with nineteen occupational therapists who identified they were involved in social prescribing activities.

Findings: Thematic analysis led to two over-arching themes: (1) position and identity; and (2) making it work.

Conclusion: Participants perceived similarity with social prescribing, leading to difficulty positioning occupational therapy alongside this role, emotional responses and identity challenge. Points of distinction between the roles were articulated, including occupational therapy being more medical, having oversight of more complex needs and having more senior roles within teams. To manage workflow, occupational therapists delegate to social prescribing workers although there is a lack of clarity about competence and varying involvement in supervision. Part of desired future involvement included clearer workflow, occupational therapy involvement in supervision and service development and creating legitimacy for both roles to address social determinants of health.

35 **Introduction**

36 Social Prescribing is a means by which trusted individuals in both clinical and community
37 settings connect people with non-clinical activities to improve health and wellbeing
38 outcomes (Muhl et al, 2023). In the United Kingdom (UK), the General Practice Forward
39 View (2016) has created opportunities for increased funding and new social prescribing
40 roles, and the agenda was further emphasised within the NHS Long Term Plan (2019) which
41 committed to building the infrastructure for social prescribing in primary care. And while the
42 term social prescribing has been popularised in the UK and gained momentum through
43 explicit policy and funding, action to address healthy ageing, the burden of chronic disease
44 and social determinants of health are global areas concern (World Health Organisation
45 (WHO), 2010; WHO, 2023)

46 Enabling social participation is at the core of the occupational therapy profession and
47 professional bodies, such as The Royal College of Occupational Therapists in the UK, support
48 the key place the profession should have in leading and developing social prescribing
49 services (RCOT, 2020). However, it is difficult to understand the extent to which
50 occupational therapy is involved in this agenda; a picture which is made more complex by
51 different terminology and models of service provision. There are calls for occupational
52 therapists to articulate and strengthen their role within this agenda to benefit from the
53 growing momentum and opportunities (Bradley & Scott, 2021).

54

55 **Literature Review**

56 There is evidence of social prescribing developments in at least 24 countries (Global Social
57 Prescribing Alliance, 2023). Health benefits from social prescribing include improvements in
58 mood and psychological wellbeing (Chatterjee et al, 2018; Cooper et al, 2022), reduction in
59 social isolation and loneliness (Dayson & Bennett, 2016) and increased resilience (Moffat et
60 al, 2017). Social prescribing can also reduce pressure on General Practice and other health
61 services (Polley et al, 2017), and is receiving greater attention in non-primary care, for
62 example in pre-hospital urgent and emergency care (Scott et al., 2021). Factors affecting
63 adherence and engagement with social prescribing have also been investigated, with
64 accessibility of activities, support with early attendance and leadership with skilled
65 facilitators all highlighted (Husk et al., 2019).

66 Occupational therapists are one of 14 professions under the umbrella of Allied Health
67 Professions (AHPs), and The Royal Society of Public Health (RSPH) document 'Driving
68 forward social prescribing: a framework for allied health professionals' (2019) identifies four
69 main ways in which AHPs can engage with social prescribing. These are: active signposting;
70 referring to link workers; being a social prescriber; and promoting, growing and developing
71 social prescribing. From a survey of AHPs, RSPH found that 91% of respondents identified
72 signposting as an important part of their job role, over 50% said they did not know how to
73 refer to link workers and only 25% felt they had clear referral criteria for link workers (RSPH,
74 2019).

Despite examples of social prescribing initiatives which describe engagement in arts, environmental, cultural and physical activities (Husk et al, 2019), evidence-based examples of occupational therapy involvement in social prescribing programmes are lacking. The aims of this study were to explore how UK-based occupational therapists are currently contributing to the social prescribing agenda and how they perceive they could contribute to future developments.

Method

A qualitative research design was employed using semi-structured interviews to understand experiences of occupational therapists and their involvement in social prescribing. The study has been reported following COREQ guidelines for reporting qualitative research (Tong, Sainsbury & Craig, 2007). The core research team consisted of three qualified occupational therapists (female) and one member with a health psychology and public health background (male).

Recruitment of Participants

Information was circulated through RCOT specialist sections, the RCOT primary care network and through UK-based social prescribing networks. Each network had individualised methods of disseminating information for example through email distribution, e-newsletters and social media. Where appropriate, snowball sampling was used where individuals and networks would re-share information through their own linked contacts.

Occupational therapists were invited to take part if they met the following inclusion criteria: qualified occupational therapist; currently working in one of the four home nations in the United Kingdom; self-identified as being in a current role which involved social prescribing. Thirty-nine occupational therapists responded and were sent participant information, written with input from a person with lived experience of health and care services. Following discussion with the research team, two participants felt they were ineligible as their current role did not link to social prescribing. Eighteen participants either did not respond after initial information was sent, or responded after the interview period was complete. Written consent was obtained from all participants recruited to the study.

Data Collection

An interview schedule (See Supplementary Material) was developed by all authors and with input from both a person with lived experience of health and care services and an occupational therapist with experience of working alongside social prescribing link workers.

All interviews were conducted online, using MS TEAMS, by one member of the research team, an occupational therapist with previous experience of conducting qualitative

113 interviewing. The interviewer had no prior relationship with any of the participants and only
114 the researcher and the participant were present during interviews. Interviews lasted
115 between 28 and 100 minutes, with a mean duration of 48 minutes. All interviews were
116 video and audio-recorded. Video functionality was used to support relationship building
117 during the interview but was not utilised for the purpose of analysis. Audio-recordings were
118 transcribed verbatim with all identifiable information omitted from the transcript. No field-
119 notes from interviews contributed to the analysis.

120 The interview schedule was not formally piloted, and instead members of the research team
121 met after the first two interviews to review the content of interviews and to consider issues
122 such as the order and wording of questions. Only minor changes to the wording of questions
123 were made at this stage and all data were included in the final analysis.

124

125 ***Data analysis***

126 Data were analysed by all authors using reflexive thematic analysis (Braun and Clarke, 2020).
127 This approach to analysis was chosen as it helped to analyse the meaning from each
128 individual participant and then to draw meanings, connections, and contrasts across cases.
129 Two analysts carried out early stages including familiarisation with the data and generation
130 of initial descriptive codes. All authors were involved in subsequent stages, with themes
131 generated through a process of interrogating the codes for meaning and meaningfulness
132 and collapsing multiple codes in to overarching themes. Analysis meetings were used to
133 reflect on the coherence of themes, the examples of data which supported themes and the
134 extent to which themes helped to respond to the research aims. The final stages involved
135 defining and naming themes and ordering themes for the purpose of reporting.

136 Data analysis began while interviews were still ongoing, with one researcher (BA) involved in
137 both activities simultaneously. Concurrent interviews and data analysis assisted the team to
138 recognise similarity in interview responses, suggesting data adequacy (Braun and Clarke,
139 2021). Analytical software was not used during data analysis with the research team instead
140 using manual methods. Due to time and resource constraints, there was no opportunity to
141 go back to research participants to verify transcripts or to share themes.

142

143 ***Ethical Considerations***

144 Ethical approval was obtained from the Higher Education Institution of the corresponding
145 author at [Insert organisation and reference number].

146

147 **Findings**

148 Nineteen occupational therapists were interviewed for the study. From the 19 participants,
149 the majority (n=12) were employed as Primary Care Occupational Therapists and are
150 identified as participant numbers 1-12 in the analysis. The remainder of participants were

employed under a range of different and often unique, job titles. To protect anonymity, these job titles have not been individually identified although they are numbered as participants 13-19.

Most participants were employed by the NHS; other employers included a Higher Education Institution, voluntary sector organisations, social enterprises, and a community initiative company. Most participants were based in England, with one based in Wales.

From those employed in primary care, ten were employed at NHS Band 7 (an advanced practitioner level in the NHS, with significant post-qualification experience), one employed at Band 6 (an enhanced practitioner level, with specialist experience often in a particular area of practice) and one employed at Band 5 (a newly qualified practitioner level). Other participant roles were not graded using the NHS banding structure. Participants had a range of post-qualification experience from two to 24 years. Participants identified older people, people with long-term health conditions and frailty as the populations they most worked with although some were more specific, such as working with people with a BMI over 30 or working with people who were known to be frequent users of services.

Thematic analysis led to two over-arching themes: (1) *Position and Identity* and (2) *Making it work.* Within each theme, there are a number of subthemes. We represent the themes, subthemes and overall narrative in Table 1 [Table 1 near here]

Position and Identity

> "it's a means of enabling health…of connecting service users to non-clinical activities whether it's sort of based in community centres or voluntary organisations to… and it has the aim of helping people to promote their own health and wellbeing and be better connected to their communities" [Participant 17]

To begin this theme, we use the extract above to note that participants, in the main, were able to articulate definitions of social prescribing clearly. However, when participants attempted to then move on to how this related to occupational therapy, it was here that a clear struggle emerged. This struggle and the subsequent responses are explored in the subthemes below.

The struggle to position occupational therapy and social prescribing alongside each other

The first extract below provides insight into the struggle which emerges when trying to position social prescribing alongside the profession of occupational therapy:

> "the minute you ask me about OT and social prescribing together, I kind of feel like my brain goes to sort of jelly with it all, which is one and which is the other, because yeah, it's really wobbly and on different days I could feel different things" [Participant 9]

Reflection of 'which is one and which is the other' is indicative of overlap and similarity that participants found difficult. When articulating the nature of this similarity, some participants linked this to both roles starting from, and subsequently focusing on, what matters most to people. In the extract below, the use of the term 'bug bear' in relation to this similarity indicates a challenge that core elements of occupational therapy philosophy are now also fundamental elements of the 'new thing' that is social prescribing:

> "For me this new thing that's social prescribing, it's… I wouldn't say it's a bug bear, that's probably a bit too strong a word, but I think it is something that really aligns itself well to OT because basically OTs have been doing it for years, like forever and it's really a core part of our practice those sort of 'what's important to you' conversations that is pretty much the model for social prescribing now" [Participant 1]

This overlapping philosophy, starting from what matters most to people, is also articulated as problematic by Participant 9, who suggests this may then lead to questions about the value of, and requirement for, both roles:

> "You'll literally have a social prescriber sat there saying, oh we deal in what matters to the person and you've got the OT going, we deal in what matters to you. Well what's the difference between you? We pay a huge amount for you and not so much for you, we'll have more of you, thanks" [Participant 9]

Struggle is also reflected within the next extract with the suggestion that valued parts of occupational therapy that the profession have found it difficult to enact in practice are now being undertaken by social prescribing workers:

> "For me social prescribing is those bits of OT that we've always wanted to get involved with, but never been allowed to get involved with because of the roles that we've had" [Participant 10]

Another participant suggested that because the roles were similar, they found it difficult to separate activities, and this potentially represented an additional area of struggle:

> "The social prescribing is sort of a fundamental part of my role in terms of I will also… I will always check, you know, how connected patients are, how supported patients are. What are their social resources that are available to them. What social behaviours would they like to have and participate in, that they're not having access to… you can't kind of separate it off" [Participant 6]

Some participants conceptualised that social prescribing could be thought of as one part of the broader role of occupational therapy, and not seeing this as a 'bad thing' suggested not all participants found the position of social prescribing a struggle:

> "I know OTs don't have to be involved in all social prescribing, but I think all social prescribing has elements of OT" [Participant 13]

226 “I think occupational therapists need to realise actually social prescribing
227 is just one teeny tiny bit of our role...I don’t see that being a bad thing”
228 [Participant 14]

229

230 *The emotional response to identity challenge*

231 The narrative which began in the first theme – about how the emergence of social
232 prescribing has led to challenging questions about how this new role is positioned in relation
233 to occupational therapy – is developed in the second theme, which outlines strong
234 emotional responses and a challenge to identity.

235 “I’ve been asked about whether I feel sort of offended that social
236 prescribers have taken part of the OT role” [Participant 6]

237 “When I heard that social prescribers were getting involved in the
238 learning disability care plans, my head was screaming, that’s occupational
239 therapy, that’s occupational therapy” [Participant 10]

240 Words such as ‘offended’ and ‘screaming’ suggest a powerful emotional response, echoed
241 by other participants who discuss ideas being ‘poached’ from occupational therapy or
242 reflect that some may feel ‘anger’. Another participant responded that social prescribing has
243 ‘lovers and haters’ amongst the occupational therapy profession. The suggestion that social
244 prescribing may be taking part of the occupational therapy role links the emotional
245 response to a challenge to professional identity and is further developed in the extract
246 below:

247 “Are they, you know, being OTs without the name and the training of OTs… like
248 stepping on our toes…OT has always struggled a bit with identity and recognition
249 and you know, what we do is so holistic and can be so broad that it’s poorly
250 understood” [Participant 17]

251 One participant expressed a reflection that the Royal College of Occupational Therapists
252 (RCOT) had some responsibility for protecting the profession from a perceived threat from
253 social prescribing roles:

254 “Some of the research that I’ve done, you know, from like the RCOT’s
255 perspective as well is, you know, how is the link worker position been
256 allowed to happen, because obviously a chunk of what OTs do, it’s
257 connecting people and it’s supporting people to engage in what they
258 want to, need to and must do occupations” [Participant 12]

259

260 *Creating distinct positions*

261 Building on the first two subthemes, and potentially as a response to struggles with position
262 and identity, occupational therapists found different ways to emphasise points of distinction
263 between their own role and that of social prescribing. From a positive perspective, many

264 participants emphasised the extensive knowledge that social prescribers held about
265 community resources, viewing this as their specialist contribution, and as a point of
266 difference to occupational therapy:

267 "I would say social prescribers have got a better knowledge (of community activities)
268 because, obviously, that's what they do, that's their, that's their sort of speciality"
269 [Participant 3]

270 Other examples emphasised occupational therapy as a more 'medical' and 'clinical' role
271 than social prescribing:

272 "(The difference is) the medical issues and I think it's looking at, yeah, like
273 the long term medical issues, the physical issues and all those
274 comorbidities....It's having that understanding of those conditions and
275 physical limitations...doing those clinical assessments" [Participant 11]

276 "I don't think they should be doing any of the clinical work and I also do
277 have a little bit of an issue with, they do try and do a lot of prescribing
278 equipment" [Participant 3]

279 Another point of distinction related to level of complexity, with some participants
280 suggesting that people who were deemed to be complex should be under the oversight of
281 the qualified occupational therapist:

282 "OT tends to see if have multiple complexities, struggling with day-to-day
283 activities, have mobility problems, have had falls" [Participant 1]

284 "So it's really clear isn't it, with people with… At the top of the Universal
285 Personalised Care Triangle, with the 5% or whatever it is with the most
286 complex thing, really clear that actually they probably need an
287 occupational therapist in order to do some of the things they need, want
288 and have to do in a day" [Participant 9]

289 Participants made links to theoretical knowledge and reasoning skills as a way of further
290 emphasising points of difference. The first extract below highlights how fundamental
291 concepts of occupational therapy, would not be understood in the same way by social
292 prescribers, and refers to less complex reasoning process used by social prescribers. The
293 second extract develops this and reflects how theoretical underpinning enables
294 occupational therapists to analyse occupations in a different way:

295 "So social prescribing isn't just the sign posting, it's the conversation, it's the
296 exploration of what's going on for somebody…It is meaningful activity but again, not
297 all social prescribers will understand meaningful activity…It's to help people find
298 occupational balance, but social prescribers won't understand that. social
299 prescribers jump is from 'what I've heard', to 'what I think somebody needs', but
300 they're not actually exploring the meaning of the activity to the person" [Participant
301 9]

> "I think that [occupational therapists] have that sort of fundamental, holistic understanding of occupational performance and the multiple dimensions of occupational performance…where we're involved in social prescribing, it is far deeper and broader than just looking at social activities. We have the training to use activity analysis to consider the…complexity of the barriers" [Participant 6]

Finally, and to synthesise many of the points about a professional role which has more involvement in clinical assessment, management of complexity and with a 'deeper and broader' understanding of the link between activity and health, many participants highlighted a point of difference in relation to seniority and hierarchy:

> "when you're working as a Band 7, you know, a lot of the signposting and I suppose the social prescribing doesn't need to be done by somebody who's a Band 7" [Participant 6]

Making it work

The second of our over-arching themes explores how occupational therapists were working alongside social prescribing to manage workflow in their current roles, and how they imagined working in the future. Set against the background of challenges outlined in the first theme, the next theme is named *making it work* to reflect that occupational therapists were finding ways to make sense of both current practice and future ways of working.

Managing workflow

Although there was heterogeneity in relation to team structures and models of service provision, there were also commonalities in the ways in which participants were managing workflow between occupational therapy and social prescribing.

Linked to the final extract in the theme above, occupational therapists discussed a hierarchical difference between the roles and it is therefore understandable that a strategy to manage workflow included delegation. Of particular interest in the extract below, Participant 7 refers to a traditional structure of occupational therapists and occupational therapy assistants to frame delegation of responsibilities:

> "And like I could see social prescribers sometimes being on the same kind of work as my OTA in terms of, if like social prescribers could run with something if they had the guidance" [Participant 7]

Furthermore, some participants reflected that this delegation to social prescribers would happen at a particular point in a pathway:

> " (I) try to use them as like a step down service. So we will do some intensive work with them to prepare them to work with social prescribing in the first place, and then we are like right, now we've done all this work, we will pass you on and step you down out into the community with the social prescribers" [Participant 14]

340 The term 'step down' was used by several participants and reflects earlier themes of
341 occupational therapists proposing that they have a central role in managing complexity and
342 that social prescribers may get involved during a subsequent and potentially more stable
343 phase.

344 Many participants also discussed that the management of workflow should not be
345 considered in terms of people needing one role or the other. Joint cases and joint visits were
346 mentioned frequently:

347 "I've had a few patients that I've gone out to see where they've got very…quite a lot
348 of sort of, what I call clinical needs, which obviously I can address…so if we go out
349 together and we can have a chat and we can identify what the needs are and then
350 we obviously divide and do our own bits" [Participant 3]

351 Participants did voice challenges in relation to management of workflow. One area was the
352 potential for duplication and the risk that this causes confusion for people accessing
353 services:

354 "Because there is that risk of us duplicating, trying to do the same thing with the
355 person…because sometimes patients get referred here, there and everywhere and
356 they've got loads of different people involved and it's like who's… Who are you?
357 [Participant 5]

358 Another risk highlighted was the potential for social prescribers to be working outside of the
359 boundaries of their role:

360 "I think for me, probably the challenge is around exactly what I just said, around
361 what's clinical and what's not clinical. I have to say, well, you're now working in the
362 realms of the clinical side of work, so perhaps one of us needs to do that on your
363 behalf" [Participant 10]
364
365
366 Implied in the above extract is the importance of supervision and oversight, which was
367 mentioned by many participants as an important strategy for managing workflow and
368 delivering safe services, but an area where there was varying levels of involvement. In the
369 first extract below, supervision is described as happening informally, although barriers to
370 formal arrangements for supervision are highlighted in the second extract:
371
372 "So, you know, if they've just come off the phone and it was a difficult
373 case or they were concerned there was a safeguarding issue or they
374 weren't sure what the next step should be. So, we do a lot of that where
375 they're able to kind of get in touch with us and be like, oh this has just
376 happened, you know, what's your advice? Or what should I do next? Or
377 who do I need to tell about this?" [Participant 5]

378 "No (not involved in supervision), because it is run by that different company"
379 [Participant 14]

380 A further participant suggested a lack of clarity about arrangements and approaches to
381 supervision for social prescribing workers:

382 “What are their competencies, what do they need to be demonstrating,
383 you know, what structure should that supervision have?” [Participant 5]

384

385 *Imagining a positive future*

386 Discussions about a positive future for occupational therapy and social prescribing often
387 reflected examples of what was working well now, particularly in relation to co-working,
388 joint cases and smooth workflow:

389 “So, if I start a piece of work with somebody, I will do some social prescribing myself
390 or if I think it is perhaps going to be a longer piece of work, I might co-work people or
391 people may move between us in the team. So that’s, yeah, that’s how it’s working,
392 how I envisage it (to) work in the future as well” [Participant 1]

393 Returning to the importance of personalised approaches and focussing on what matters
394 most to people, many participants reflected on the natural allyship between occupational
395 therapy and social prescribing based on shared values. They therefore imagined a future
396 with occupational therapists advocating for this shared agenda:

397 "I think as OTs we really understand what, how powerful that meaningful
398 and purposeful activity can be. I think that’s the simplest way to put it
399 and I think we, we’re in a position to advocate for that to support social
400 prescribing" [Participant 2]

401 Involvement in supervision and leadership were revisited as part of reflecting on a positive
402 imagined future, alongside involvement in recruitment, management and commissioning of
403 services for local populations:

404 [Participant 17]

405 In general, participants suggested that better understanding of occupational therapy was an
406 essential element of the profession working effectively and seamlessly alongside those in
407 social prescribing roles. One participant voiced a call to action for professional bodies to
408 strengthen the identity and position of the occupational therapy profession in relation to
409 social prescribing, and then recognised the subsequent responsibility for organisations and
410 individuals:

411 “I’d like to see the Royal College of Occupational Therapists give a clear
412 position statement that we do social prescribing. [They need] to put on
413 training for staff. It then needs to come down to individual places of
414 employment. So OT managers need to make sure their staff are clear on
415 what their specific role is within that work remit…it needs to be in pre-
416 registration standards, that we teach it as mandatory”. [Participant15]

417

Discussion

This is the first study to our knowledge exploring the perceptions of occupational therapists and how they are contributing to the social prescribing agenda. Participants in this study were predominantly employed in primary care roles and were recruited to the study through self-identifying as being involved in social prescribing activities. Despite clear links to occupational therapy values and roles beyond primary care, this is an interesting finding to note and supports the reflection that social prescribing is gaining traction in primary care, potentially through the language and structures which are being created to support legitimacy and familiarity with the concept (Bradley & Scott, 2021).

Occupational therapists were able to share definitions of social prescribing, although subsequently positioning this definition in relation to their own profession was more problematic. Participants recognised that both roles started from foundations of what matters most to people, evidencing alignment with professional values to build from strengths-based, occupation-centred approaches (Whalley-Hammell, 2023) and policy drivers relating to personalised care (NHS, 2019). However, participants also articulated that they could not always fully enact this in their practice. Being unable to practice in a manner congruent with professional values has been linked to stress and burnout in occupational therapists (Walder et al, 2021), and emotional responses shared in this study may indicate such risks.

Occupational therapists created identities and positions in relation to social prescribing to potentially cope with challenges. Key positions emerged; positioning the profession as more senior, and positioning the profession as more medical. We have previously proposed that the theory of *Institutional Work* (Lawrence & Suddaby, 2006) provides an explanatory framework for how rules, boundaries and identities have aligned social prescribing with a medical model of health, and given authority to medical professionals (Bradley & Scott, 2021). Through this study, we note similarities in that occupational therapists are also trying to construct their own boundaries and create their own identities to legitimise authority and position.

To explore this positionality, it is important to acknowledge the social and political context influencing the creation of identity. For occupational therapists, this context is influenced by both historical challenges and contemporary developments. Well-documented challenges to occupational therapy identity from generic roles and 'role creep', where other professions assume some roles which are traditionally considered the domain of occupational therapy (Walder et al, 2021), were being discussed and reflected on in this study. There have also been examples where occupational therapists have felt the need to use language of dominant bio-medical models to develop identity and legitimise roles, potentially when their own language of occupation is not easily understood (Murray et al, 2015). With most participants in this study situated in primary care where a medical model of health is potentially shaping the social prescribing agenda (Bradley & Scott, 2021), alignment with a dominant discourse to be more 'clinical' than others in social prescribing roles is reflective of this.

459 Additionally, many participants were practicing under the Additional Roles Reimbursement
460 Scheme (ARRS) – a funding stream in the UK to support development of new roles in
461 primary care (NHS England and NHS Improvement, 2019) - and struggles with identity,
462 autonomy and contribution are reported elsewhere for this group (The Kings Fund, 2022).
463 Professions named under this relatively recent ARRS scheme are facing unique
464 opportunities from new funding and roles but with challenges of trying to evidence their
465 value and make a distinct contribution in a competitive marketplace. Again, the desired
466 positions of adding value by being 'more clinical' and providing value for money by being
467 'more senior' can further be understood through such reflection.

468 Delegation was an important mechanism supporting occupational therapists to manage
469 workflow alongside social prescribing. Professional standards relating to delegation highlight
470 the importance of the person who is being delegated to being competent in the identified
471 activities (RCOT, 2021). Yet occupational therapists suggested a lack of clarity about
472 competencies for social prescribing roles and suggested varying levels of oversight or
473 involvement in supervision. The fact that a UK competency framework for social prescribing
474 was only published in 2023 (after the data collection phase of this study) and includes
475 limited specific reference to occupational therapy (NHS England, 2023) raises further
476 questions about understanding of competence and safe delegation.

477 Employment and contracting arrangements were cited as challenging factors, particularly in
478 relation to supervision. Approaches to contracting of ARRS roles in primary care have been
479 compared to 'supermarket sweep', where those in leadership roles ran around and threw
480 roles in the trolley because they were free (The Kings Fund, 2022; p9). It is important to
481 acknowledge that Primary Care Networks were operating under uncertainty and pressure at
482 this time, but such unplanned approaches were always likely to have consequences. For
483 occupational therapists this now includes confined positions in relation to supervision and
484 influencing the growth of the social prescribing agenda. Interestingly, an overview of the
485 international picture suggests some countries, rather than specifically developing new social
486 prescribing roles, are adding the responsibilities to roles such as social workers and allied
487 health professionals (Morse et al, 2022). Yet explicit reference to occupational therapy in
488 these examples is lacking and may once again reflect the profession having limited influence
489 in wider developments.

490 Participants did reflect on their deep understanding of how people engage in occupations
491 and their ability to look beyond one-size-fits-all reasoning processes to enable participation
492 and mitigate against barriers and inequalities (Whiteford et al, 2021). For some, such
493 reflections were already helping to create positive identities and positions, recognising that
494 occupational therapy can benefit from social prescribing, and visualising involvement in
495 developments as they move forwards. For others who were experiencing stress and
496 negative emotions, such reflections are important reminders and can help with reframing
497 and repositioning roles.

498

499 **Limitations**

500 It was not the focus of this study to explore implementation of the occupational therapy
501 role under the ARRS structure, yet this emerged as important and warrants further research.
502 Similar studies which evaluate the integration of other professions in primary care systems
503 have highlighted important opportunities, risks and recommendations (Eaton et al, 2021;
504 Mills et al, 2022). Furthermore, despite sharing information to networks reaching all four
505 home nations of the UK, all of our participants were based in England and Wales.
506 Understanding the landscape across other nations of the UK, and internationally, is an area
507 for further research. And whilst focussing on occupational therapists in the UK will not fully
508 reflect the international picture, themes are likely to resonate with an international
509 occupational therapy audience and can particularly support countries and services where
510 developments are at different stages of maturity.

511 Our study focussed on the perceptions of occupational therapists about how they are
512 contributing to the social prescribing agenda and how they perceive they could contribute
513 to future developments. Exploring the perceptions of those in social prescribing roles, of
514 other professionals, and of people who access services would further extend understanding
515 on this topic.

516 We suggest this exploratory study can be a foundation for research which evaluates
517 effectiveness and acceptability of occupational therapy-led social prescribing interventions,
518 and those offered by link workers. This would help inform commissioning of, and role-
519 sharing within, services for local populations. Implementation and evaluation of professional
520 development interventions for the occupational therapy and social prescribing workforce is
521 another important focus for future practice development and research.

522

523 Conclusion

524 Occupational therapists in this study perceived both alignment and points of distinction
525 between their role and social prescribing although similarities and differences were often
526 troublesome and contributing to questions about identity and legitimacy. Whilst recognising
527 benefits in shared values of focussing on what matters most to people and connecting
528 people to activities which promote health, there are risks within services such as duplication
529 and lack of clarity about scope of practice. There are also risks to the profession if
530 occupational therapy cannot articulate and evidence a unique contribution and value for
531 money.

532 Practically, participants wanted clearer workflow and task-sharing between roles, and saw
533 supervision and professional development as integral to relationships and role
534 development. Robust professional development activities and clear curriculum guidance are
535 some of the practical ways professional bodies can support.

536 Together, occupational therapists and those in social prescribing roles have an opportunity
537 to work collaboratively towards primary care and community services which address the
538 social determinants of health. Opportunities for funding and wider role-creation are also

likely to follow, and perhaps more importantly, services orientated to outcomes that are meaningful to people who access services.

Key findings

- Occupational therapists see alignment and difference between their own profession and social prescribing values and roles.
- One challenge of alignment is questions about identity and legitimacy for occupational therapists.
- Some occupational therapists are now involved in supervision, recruitment, and professional development of social prescribers but are asking for clearer guidance and structures to support them in these roles.

What the study has added

This study has developed understanding about how developments in social prescribing in the UK have been experienced by occupational therapists and how occupational therapists view their own contribution to this agenda moving forwards.

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684 **Table 1 – Overview of themes, sub-themes and narrative of themes**

Theme	Subtheme	Narrative
Position and Identity	The struggle to position occupational therapy and social prescribing alongside each other	When I put them together – which is one, which is the other? This new thing that focuses on what matters most – but we've been doing that for years. They look similar but we cost a lot more. They get to do the bits we've never been allowed to. How can I separate out how connected people are to social resources from the rest of my role? All social prescribing has elements of OT, but not all OT is social prescribing.
	The emotional response to identity challenge	I'm screaming 'that's occupational therapy' There is a familiar feeling here - is it because we have always struggled with our own identity? How has the link worker position been allowed to happen?
	Creating distinct positions	The distinct position for social prescribing is knowledge of community activities. Occupational therapy is more medical and more clinical than social prescribing. Occupational therapy should have oversight over patients with complex needs. Occupational therapists have a deeper understanding of meaning of occupation and barriers to participation. Occupational therapists have a more senior role within teams

Making it work	Managing workflow	Occupational therapists delegate to social prescribers. Delegation is seen as a step down in intensity, after complex issues have been evaluated. Joint and co-working can be needed - it is not necessarily one role, or the other. Similar roles can mean a risk of duplication, confusion and unclear scope of practice. Supervision and caseload oversight is key to managing risk – but there are organisational barriers
	Imagining a positive future	Positive experience of co-working and joint cases. Occupational therapy can be advocates for meaningful activity and social prescribing. We can lead and manage services and community-level interventions. A call for collective responsibility to promote occupational therapy, starting with professional bodies

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