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Research Article

Barriers and Facilitators to the Design and Delivery of Social Prescribing Services to Support Adult Mental Health: Perspectives of Social Prescribing Service Providers

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Objective. To elicit the barriers and facilitators experienced by social prescribing service providers when designing and delivering social prescribing services to support adult mental health. *Design*. Semistructured interviews were conducted with social prescribing service providers across England and Wales in the third sector. Data were analysed in accordance with the Theoretical Domains Framework (TDF) and Thematic Framework Analysis (TFA). *Results*. Twenty-one providers (15 females and 6 males) from 17 social prescribing services agreed to participate. Nine analytical themes were identified across seven TDF domains associated with the design of services (e.g., skills and environmental context and resources). Thirteen analytical themes across nine TDF domains were associated with the delivery of services (e.g., beliefs about consequences and optimism). Key recommendations for future social prescribing services were increasing public knowledge of social prescribing; clearly communicating the role of a social prescriber to the public and professionals; providing training to providers on how to safely and effectively lived experiences; adopting a person-centred approach, including use of person-centred measures of mental health and well-being; and strategies to address sustainability of social prescribing services. *Conclusions*. Service providers are an essential part of the design and delivery of social prescribing services. Person-centred care, sustainable funding, and improved knowledge of social prescribing all warrant further research. Sustainable funding for social prescribing remains a salient policy-level barrier.

1. Introduction

The World Health Organization (WHO) reports that common mental health disorders such as depression and anxiety are a leading cause of disability worldwide [1]. Depression and anxiety are the most prevalent mental health disorders in the United Kingdom (UK) affecting 1 in 6 adults (depression) and 6 in 100 adults (anxiety) [2, 3]. It is estimated that out of all those who experience symptoms that meet the clinical threshold for diagnosis, fewer than 50% of adults will seek help for depression or anxiety [4]. Furthermore, the National Institute for Health and Care Excellence (NICE) in the UK suggests <30% of people who seek clinical support for depression and anxiety receive an adequate level of care [4]. Social prescribing is defined as a pathway that connects and refers people to nonclinical services (practical and psychological, community-based services) to support their nonmedical health and well-being needs [5, 6]. The term "social prescribing" was first introduced within the UK National Health Service (NHS) as part of the personalised care agenda outlined in the NHS Long-Term Plan, which

aims to provide patients with more control and choice over their care by focusing on individual needs and preferences [7].

Social prescribing is a holistic offering that considers the wider determinants of physical, mental, and social health, which are widely reported by the Marmot reviews [8]. Social prescribing attempts to make a positive difference to the health of service users by supporting engagement in community-based and social care services, thus going some way to address the social and mental health of service users rather than the direct physical symptoms of ill health. Social prescribing offers an alternative or adjunct to medical care to create meaningful changes in mental health outcomes [9–11], including significantly improving self-reported anxiety and depression [12, 13]. Reviews have reported that social prescribing can improve self-esteem [14, 15], self-efficacy [16, 17]. anxiety or depression [15], social isolation and loneliness [14, 15, 17], and general well-being [9, 10, 14, 16], by supporting the construction of connections and support networks, as well as providing additional links to social care services. Social prescribing typically covers both statutory healthcare providers (such as the NHS) and the third sector. The third sector is defined by the National Audit Office as "*a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives*" [18].

To design and deliver social prescribing, two key resources offer blueprints: the NHS Standard Model (as part of the Universal Personalised Care Model) [19] and the World Health Organization toolkit on implementing social prescribing [20]. However, both lack details on the theoretical underpinning of social prescribing in terms of how it impacts behaviours and subsequent health outcomes, which is reflected in the evidence base for social prescribing interventions [9–11, 15–17, 21]. The lack of clear guidance on the selection and use of a theory to inform the development of intervention components (active ingredients) targeting specific behaviours and behavioural outcomes prevents clear conclusions about the impact of interventions to be made, and replicability is hindered [22, 23].

The lack of underpinning theory has led to issues with reliable communication of what social prescribing is and what support can be offered to people to manage their mental health [9, 24]. Previous reviews have reported a lack of stakeholder involvement, including social prescribing service providers (SPSPs) and service users, in the development of localised social prescribing, which detrimentally affects outcomes [11, 21]. The lack of stakeholder involvement has been associated with reduced engagement in services due to issues with connectedness with community resources, in turn leading to poor service user experience and outcomes [11, 21]. Therefore, this research aimed to identify the barriers and facilitators experienced by SPSPs when designing and delivering social prescribing services to support adult mental health.

2. Materials and Methods

2.1. Study Design. A qualitative study utilising semi-structured interviews was conducted in accordance with the Consolidated Criteria for Reporting Qualitative Research Checklist (Supplementary Material 1).

2.2. Research Team. Two members of the research team were PhD candidates with postgraduate qualifications (MSc) in health psychology (MC and KA). Three members (LA, DF, and JS) have PhDs, and two (DF and LA) are registered practitioner health psychologists with the Health and Care Professions Council. All members of the research team were trained in qualitative research methods, and three members have extensive experience in the conduct of qualitative research (JS, DF, and LA).

2.3. Eligibility Criteria and Sampling Strategy. SPSPs eligible to participate were aged ≥18 years who were employed as service directors and chief operating officers, service managers and team lead, or link workers (or iterations of this role, including but not limited to community health workers, support workers, and link practitioners) in the third sector. A purposive sampling strategy [25] was used to recruit SPSPs from social prescribing services in the third sector with a geographical spread across the UK to capture a wide range of services and roles from multiple perspectives (maximal variation). Invitations (along with the participant information sheets) were sent via publicly available e-mail addresses and a National Social Prescribing Network [6] or via existing networks of research team members.

2.4. Data Collection. All participants provided informed written consent before the interviews were conducted. MC conducted all interviews and had no prior relationship with participants before the commencement of the research. The interviews were audio recorded using a Dictaphone and transcribed verbatim.

The topic guide was developed with reference to the evidence gaps identified from published systematic reviews [24, 26]. Open-ended questions were used to identify barriers and facilitators to the design and delivery of social prescribing services for adults with mental health needs. The topic guide was piloted with the first two participants who agreed to be interviewed and was revised iteratively. Demographic data (sex, job title, geographical location of service, and length of time in post) were also collected from participants.

2.5. Data Analysis. The Theoretical Domains Framework (TDF) was used to facilitate the analysis of interview data following Thematic Framework Analysis (TFA) [27, 28]. The TDF is a framework that helps to identify and describe the factors that influence behaviour. It was developed by combining theoretical constructs from 33 behaviour change theories into a framework, and the latest version includes 14 theoretical domains [29]. It has been used to develop

complex interventions targeting a range of health behaviours [29] and more recently to elicit barriers and facilitators to shared decision-making and mental health [30]. The TDF can provide a method for assessing implementation issues and identifying behaviours and behavioural determinants in the context of intervention development [25]. The TDF was used in this study to facilitate the identification of behavioural targets for future intervention development.

TFA is a "*matrix-based analytical method which facilitates rigorous and transparent data management such that all the stages involved in the analytical hierarchy can be systematically conducted*" [31]. This involved a three-stage process reported previously (Figure 1) [29, 31–34]. Using this method, analytical themes were distinguished from descriptive themes by providing a level of interpretation beyond the primary finding.

Interviews were conducted to the point of data saturation in terms of whether new themes were identified or further data were required to explore/support a specific theme [35]. To determine whether data saturation was achieved, interviews were conducted and analysed in batches. This consisted of ten interviews, then batches of three interviews thereafter.

The trustworthiness of the data was enhanced by: adhering to a transparent process of coding and explicit use of an analysis framework (audit trail) [36, 37]; utilising multiple coders (MC, KA, and LA) to analyse data; presenting provisional analyses during team meetings where all study authors served as peer debriefers [38, 39]; and use of direct verbatim quotes from participants to support themes, which enable the reader to make a judgement about their credibility.

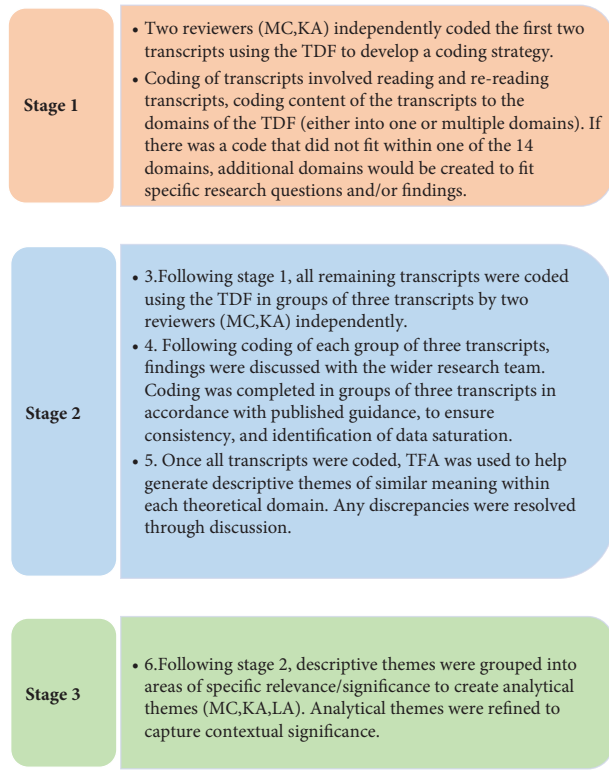

Figure 1: Three-stage method used to analyse data.

3. Results

Twenty-one interviews were conducted with SPSPs (15 females and six males) from 17 social prescribing services in the third sector across England (one national, eight North East, one North West, three Yorkshire and the Humber, two South West, and two South East) and Wales (one national, one North, one South, and one West Wales). The 17 social prescribing services varied in their population reach, i.e., some covered part of a city (e.g., West of Newcastle upon Tyne), a region (e.g., North of England), or had national coverage (e.g., a service operating across Wales). All social prescribing services provided support for mental health and social health needs within local communities. Four participants had job titles in executive management positions (Chief Executive Officer or Managing Director), eight in senior management, two were team leaders, and seven were link workers (or iterations of this role). Participants had been in their role for an average of 4.6 years (SD = 5.3) with a range of 6 weeks to 25 years. They reported involvement in the field of social prescribing for an average of 7.7 years (SD = 6.5) with a range of 7 months to 24 years. The mean length of interviews was 60 minutes (range: 35 to 84 minutes).

Social prescribing service providers' perspectives on the barriers and facilitators to the design of services

Nine themes across seven TDF domains were associated with the design of social prescribing services (Figure 2).

3.1. Knowledge

Analytical theme: Knowledge of resources and provisions help SPSPs to shape social prescribing services

One analytical theme was identified within the Knowledge domain (defined as "*an awareness of the existence of something*") [29] which highlighted the importance of SPSPs being in possession of the knowledge to help shape services, which was a facilitator to the design of services. This theme mapped to the Knowledge domain of the TDF as it captured where the SPSP felt they lacked the awareness of specific details around person-centred care and mental health symptoms.

SPSPs discussed how they would take time to ensure "*they mapped out all the available, relevant services that their clients might need*" (P21), so when they would meet with a service user, a database was available to provide options. SPSPs used this opportunity to build their knowledge and ensure they could provide support to any need presented by a service user. Second, SPSPs reported the need to understand the symptoms of mental health conditions and the

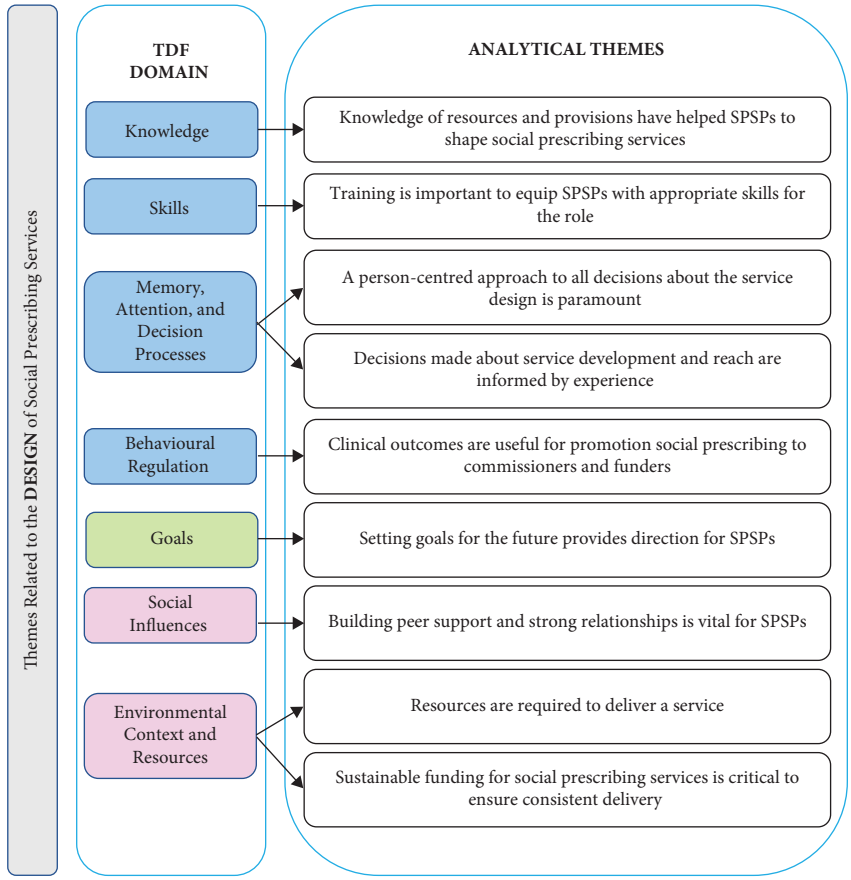

Figure 2: TDF domains and analytical themes related to the design of social prescribing services.

breadth of potential needs. It was reported that having knowledge of these needs helped SPSPs to adopt a person-centred discussion about what mattered to service users: "*So, it was constantly going back to them saying, what next? What do you need and then decide*"(P20).

3.2. Skills

Analytical theme: Training is important to equip SPSPs with appropriate skills for the role

Within the Skills domain (defined as "*an ability or proficiency acquired through practice*") [29], SPSPs discussed the importance of receiving training at the appropriate level, for example, tailoring content to what a SPSP would practically require and overloading with nonpractical information. This was considered a facilitator to the design of services and was related to the Skills domain of the TDF as SPSPs wanted to become more proficient in their role and have career development opportunities focused on social prescribing.

SPSPs reported the benefits of engaging in continuing professional development to be adaptable to changing service user needs. There was an emphasis placed on training being delivered at the right skills level for SPSPs, as some of the currently available training is largely *"teaching them [SPSPs] to suck eggs"* and that *"assessment process wasn't fit for purpose in regard to feedback"* (P02), suggesting the current level of skills training is too low.

Senior SPSPs (e.g., team leaders and managers) reported valuing the varied backgrounds of SPSPs and how different approaches to support, strengthened their team's breadth and depth of skills, providing a holistic service:

> "most of our professionals have come with degrees in public health, nutrition, they've all got, or physical activity degrees or personal training so they've all got some kind of something similar to what we do" (P15)

Due to the nature of social prescribing, many people will present with complex issues that SPSPs believed was beyond their current skill set and indicated a need for additional skills training:

> "health can change very quickly but also sometimes you're having people who have actually got really complex needs that perhaps we haven't got the training or support available" (P09).

3.3. Memory, Attention, and Decision Processes

Analytical theme: A person-centred approach to all decisions about service design is paramount

SPSPs emphasised the importance of a person-centred approach to decisions about service design. This theme was related to the domain Memory, Attention, and Decision Processes of the TDF (defined as *"the ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives*") [29] as the narrative from SPSP was focused on how they could make better person-centred decisions to the design of services and respond to service users' needs.

As such, planned reviews with service users would occur to "*find out if they have engaged and, yeah, so if they haven't, why not?*" (P02). This informed the basis of decisions about whether the service was right for that individual. When arranging appointments with service users, SPSPs commented that they would consider "*bespoke spaces, bespoke routes*" (P09) for each individual and made sure they were "*able to get the help at a time that's convenient*" (P07). Person-centred processes were used by SPSPs in the context of service design, such as: "*support plans*" (P06) and a "*goal-based approach*" (P21) to ensure an individual's ownership of the support. SPSPs mentioned using person-centred outcome measures (e.g., a service user being able to step out of the house when previously that was unmanageable): *"to guide you in terms of what you're doing with them and how to help them to achieve their goals"* (P06).

SPSPs felt the option of a flexible service provision where there was an open-ended referral offer would be appropriate, and allowed for "*a life-changing event, moving, you die, something like that*" (P15). SPSPs accepted that many service users may not be in the right place to think about making changes to their behaviour and social prescribing offers should be reflective of this.

Barriers to the design of services were the geographical proximity of community-based groups, where the travel and cost involved in attending a service that was distal, impacting referral decisions:

> "You were getting people to travel from across (Location) to come to us, which wasn't necessarily where they lived or the best place for them to connect with to make up those sorts of local connections" (P07).

Analytical theme: Decisions made about service development and reach are informed by experience

This theme is within the Memory, Attention, and Decision Processes domain in the TDF (defined as "*the ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives*") [26] as it captured how SPSPs used their practical experience to inform the design of future services. SPSPs felt discussing mental health issues was more accepted and this allowed people to be *"more open now to get support when they are struggling with mental health issues"* (P11). Adjusting the design of services (e.g., offering support over the telephone) had increased their potential to reach more people:

> "People who would never have had the chance to engage with this project can now, those that are agoraphobic, that wouldn't go out and couldn't go out, those who have illnesses that they can't get out can now engage with the service which is phenomenal" (P04).

However, SPSPs reported being cautious about offering a telephone-based service and emphasised the need to be led by service user preferences, *"if the phone didn't work, we would go out, we would do something else, but we can't do that, we've thought about it differently now, we're doing the texts which seems to be working well"* (P17)

3.4. Behavioural Regulation

Analytical theme: Clinical outcomes are useful for promoting social prescribing to commissioners and funders

The Behavioural Regulation domain of the TDF is defined as *"anything aimed at managing or changing objectively observed or measured actions"* [29]. The influence of the commissioning stipulations for use of specific outcome measures had an impact on performance indicators, impact the delivery of social prescribing.

SPSPs were aware that the commissioning of services was based on the need to meet set criteria, usually outlined in the initial commissioning agreement or when applying for funding that would be reflected in the design of the service. Performance indicators (e.g., clinical scores) would be presented to the commissioners or funders *"saying as to whether we've done a good job or not"* (P04). SPSPs reflected on how demonstrating impact was important for sustainability and building evidence of effectiveness, but believed they lacked a focus on outcomes that were important for the individual.

3.5. Goals

Analytical theme: Setting goals for the future provides direction for SPSPs

SPSPs receive direction from the goals that individual services set that are directly associated with the Goals domain of the TDF (defined as "*mental representations of outcomes or end states that an individual wants to achieve*") [29]. The service objectives could, for example, be to support a specific symptom cluster or at-risk population. Alternatively, goals could be grouped into outcome goals, for example, a specific target for the number of referrals. Ultimately, SPSPs "*will work with anyone that has any needs that can't be met by the GP practices*" (P8). SPSPs discussed the importance of updating service objectives and goals to reflect the changes in mental health needs of the population they support.

3.6. Social Influences

Analytical theme: Building peer support and strong relationships is vital for SPSPs

The Social Influences domain of the TDF is defined as *"those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours"* [29]. This theme captures Social Influences as SPSPs reported providing social support to service users to develop relationships with peers.

Peer support *"is a massive key and you need that within your team"* (P18). This quote underpins the importance of SPSP peer-to-peer support to facilitate discussions about new referrals, sharing of resources or discussing decisions about care. SPSPs who had good peer support felt:

> "it's having those relationships as well with people and knowing who you can say, right I'm struggling a little bit, can you give us a little bit of support" (P18).

This fostered confidence within a team and a better working environment. Senior management also discussed that regular one-to-one supervision with their team members allowed them to see "*how [the job] impacted on them as well"* (P08) and helped to maintain the well-being of the team. However, not all SPSPs felt they had the same opportunities to engage with peer support as it was not planned into the design of services and "*felt sometimes a bit alone because sometimes there might be days when you wouldn't speak to other colleagues"* (P17).

In addition, building quality relationships with other services and organisations was important for providing optimal care for service users. SPSPs highlighted the critical importance of having strong and stable relationships with partner services/organisations when it came to designing services:

> "[you] need good partners to work alongside with. . . that give you feedback, that let you know what's happening with clients that you've referred onto them" (P06).

3.7. Environmental Context and Resources

Analytical theme: Resources are required to deliver a service

The resources required to deliver a service were dependent on what was available in the local community or what the service could provide, which reflects the Environmental Context and Resource domain of the TDF (defined as "*any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour"*) [26, 29]. SPSPs felt they were "*limited by what is available"* (P11) and this impacted delivery. SPSPs reported doing their best to "*find the best match for that person"* (P02), but ultimately if a resource had not been identified in the design stage, it was difficult to refer on. Senior SPSPs (team leaders or managers) commented on how service users "*who were on waiting lists for three or four weeks, were now talking 18 months for accessing the service"* (P14), and this risked deterioration in mental health conditions.

Analytical theme: Sustainable funding of social prescribing services is critical to ensure consistent delivery.

The sustainability of social prescribing services was universal across interviews with SPSPs. The lack of resources outlined within this theme makes it directly applicable to the domain Environmental Context and Resource of the TDF (defined as "*any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour"*) [26] due to how it influences the practice behaviour of SPSPs. It was stated that services struggled to secure the appropriate funding, and it was felt that SPSPs *"can't work out how to offset that* [operational] *cost"* (P09). Where services had secured funding, SPSPs were acutely aware that when *"a service gets funded for a period of time, people get support and then the money dries out and then the service stops"* (P20). This short-term funding model led to continuity issues (a central component of person-centred care), breakdown of support for service users, and service closures that had demonstrated consistent and positive changes in outcomes that mattered to service users.

Social prescribing service providers' perspectives on the barriers and facilitators to the delivery of services

Thirteen themes, across nine TDF domains, were associated with the delivery of social prescribing (Figure 3).

3.8. Optimism

Analytical theme: Social prescribing can create meaningful change

The Optimism domain of the TDF is defined *"the confidence that things will happen for the best or that desired goals will be attained"* [29]. SPSPs reported their role was *"very, very demanding job on a day-to-day basis"* (P1) and their beliefs about their impact on service users was affected by *"the enormous gaps in service provision and people being let down time after time after time"* (P6). SPSPs' optimism in their ability to have a meaningful impact on the service user served as a motivating factor for them to continue to provide support in challenging conditions. SPSPs held the belief they could still help people and gained a sense of "*satisfaction when things go right, and you can see the difference that it's made to people*" (P6).

There was concern about future impact on their ability to provide support due to external influences (e.g., the medicalisation of social prescribing and short-term funding) and fear of "*ever-longer social prescribing waiting lists*" (P19). This led to worries about sustainability that influenced their beliefs about the impact of social prescribing on service user care. There was also concern about resources (e.g., SPSPs, social prescriptions, and community-based groups) being more centralised as opposed to community-based:

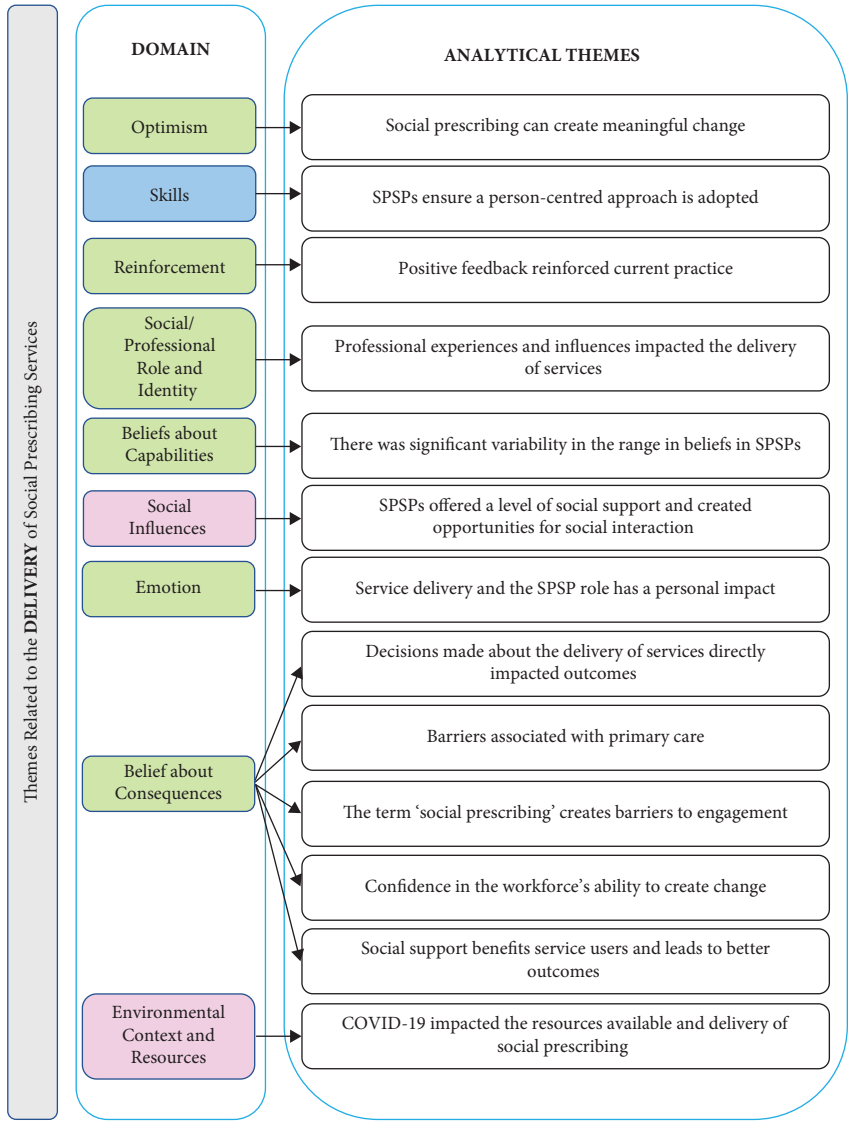

Figure 3: TDF domains and analytical themes related to the delivery of social prescribing services.

"I just think we've medicalised social prescribing and it should actually be all about. . . it should be just happening out in your community" (P20).

3.9. Skills

Analytical theme: SPSPs ensure a person-centred approach is adopted

A person-centred approach was considered the most effective way to provide support and SPSPs needed to have the skills to deliver this type of support to service users; therefore, this was coded within the Skills domain of the TDF (*defined as "an ability or proficiency acquired through practice")* [26]. SPSPs strived to ensure decisions were "*very much determined by what people wanted, rather than what we thought they wanted*" (P20). Therefore, it is important that the support service users received were tailored to their needs and preferences. SPSPs expressed a need for person-centred skills training to ensure effective professional practice and aid discharge decisions.

When SPSPs adopted a person-centred approach to the delivery of social prescribing, they felt service users showed "*more willingness to engage*" (P5). SPSPs wanted service users to make their own choices but "*at the end of the day, it's down to the patient*" (P5). This allowed flexibility with the delivery, whereby service users are encouraged to reflect on their progress and "*see if the choices that [were] made together about what would work for [them] are actually working*" (P11). Ensuring service user ownership of change supported the withdrawal of support also, "*we'll say to them, we think that you're doing really well, I don't think you need me to contact you all the time, how do you feel about me not contacting you or just contacting you less*" (P17).

Fostering an environment of trust and openness was widely reported by SPSPs to facilitate the delivery, ensuring "*they [service users] have someone who is there to listen to*

them and to try and look at things from their point of view" (P17). This supported the building of a therapeutic alliance and to formulate plans to address barriers to change that were caused by negative experiences in the past.

3.10. Reinforcement

Analytical theme: Positive feedback reinforces current practice

Receipt of positive feedback from service users and reported changes in their health reinforced SPSPs practice reflected the domain of Reinforcement of the TDF (defined as *"increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus")* [29]: "*talking to people, you get an absolute huge idea of how people's lives are affected"* (P11). Positive feedback provided SPSPs with a sense of pride and achievement:

> "I would say that there is huge satisfaction to be had when you are able to work with somebody, I mean, empower them to actually take steps that they perhaps didn't know they were able to do". (P11)

3.11. Social/Professional Role and Identity

Analytical theme: Professional experiences and influences impacted the delivery of services

SPSPs had experience with a variety of roles and often reported personal experiences of mental health difficulties, which reflected the Social/Professional Role and Identity domain within the TDF (defined as *"a coherent set of behaviours and displayed personal qualities of an individual in a social or work setting")* [29]. SPSPs felt they could use their personal experience to help them to support service users and was an important part of their professional identity. They described how they would actively share their lived experience of mental health conditions with service users, which helped to engage on mutual ground: "*they've not travelled the same path, they've been down the same road"* (P6). SPSPs were mindful of the impact of the role on them personally and as such they needed to "*offload and feel that they've got a comfortable space to be able to do that*" (P7). Social prescribing was described as "*a very progressive project and field and philosophy"* (P16), and as such, SPSPs felt they had to be "*open and flexible to new skills"* (P17).

SPSPs stated their role and what a service could offer was often misinterpreted by others. They felt their roles went beyond what they expected and impacted their perceptions about delivering a quality service. Unrealistic or inaccurate perceptions led to questions about the professionalism of the role: *"It is quite tricky because in a way social prescribing can be a bit vague"* (P17).

SPSPs reported having organisational goals and plans within the service are crucial. "*Having the plans, and the rotas, and how things are all going to work out, are very important*" (P10). In addition, being able to discuss ideas and opinions was emphasised as an important element of a service. SPSPs felt they needed reminded referrers about the types of support available: "*if you don't speak and if you don't shout out, [they] don't send"* (P14).

3.12. Beliefs about Capabilities

Analytical theme: There was significant variability in the range in beliefs in SPSPs

SPSPs had varying beliefs in their capabilities that were coded as the Beliefs about Capabilities domain in the TDF (defined as "*acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use*") [29] as these beliefs influenced their practice behaviour. Some SPSPs believed their role was making a positive impact on service users and improving their mental health. SPSPs spoke of "*a very good success rate of people who've been referred and who engage"* (P02) and were proud to talk about this achievement. However, many SPSPs were quick to report how service users whose needs were complex and often beyond their capabilities, *"their needs were so great that there was no way we could make a difference"* (P06). The belief in their own capabilities was influenced by the complexity of the service user needs.

3.13. Social Influences

Analytical theme: SPSPs offer a level of social support and created opportunities for social interaction

The Social Influences domain of the TDF (defined as *"those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours")* [29]. SPSPs described social support as the main expectation from service users when accessing social prescribing. SPSPs created a social environment that fostered the development of a therapeutic alliance with service users, as well as creating opportunities for peer support. This facilitated the development of peer groups that would become self-sustaining. In many cases, service users would ask SPSPs to help with developing peer groups:

> "though client request, we did actually start a new project. And it was a big social group because a lot of them just wanted to socialise with someone" (P02).

3.14. Emotion

Analytical theme: Service delivery and the SPSP role has a personal impact

Sessions with service users were described as emotionally demanding, and this was coded to the Emotion domain of the TDF (defined as *"a complex reaction pattern, involving experimental, behavioural and physiological elements, by*

which the individual attempts to deal with a personally significant matter or event") [29] when "*all you've got is your ears and your voice, that's all you've got, and that is very draining*" (P6). On occasions, SPSPs experienced negative emotions and they described a need to be cautious to prevent a negative impact on themselves. SPSPs did speak about enjoying their role, "*what makes you want to do your best for people, because it's enjoyable helping them as well*" (P13) which was motivating.

3.15. Beliefs about Consequences

Analytical theme: Decisions made about the delivery of services directly impacted outcomes

Outcomes specified by commissioners (as opposed to the service) limited SPSPs flexibility (behaviour) to deliver person-centred care that was coded within the Beliefs about Consequences domain of the TDF (defined as "*acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation*") [26].

> "*it's a less flexible thing, just because we're driven by those outcomes, if we don't achieve those outcomes, we don't get paid*" (P1).

SPSPs felt that the "*vast amounts of paper evidence*" that "*[funders] have demanded in the past*" (P19) has been a barrier to service user engagement due to the "*complexity of getting signatures on things*" (P19). However, SPSPs stated that, despite this, they could adapt their ways of working and continue to build relationships with other providers (e.g., GP practices) to gain commissioning support for services.

Analytical theme: Barriers associated with primary care

SPSPs experienced difficulties when providing support due to a lack of understanding in primary care about what social prescribing could offer, which affected their beliefs about the consequences of offering support. This was coded within the Belief in Consequences domain of the TDF (defined as "*acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation*") [26]; "*it took them [referrers] a while to actually understand what social prescribing was and why*" (P2). Reliance on primary care referral pathways was considered suboptimal because it was perceived that those in greatest need may not be able to access social prescribing services.

One referral route into services was considered insufficient, "*you've got to care about not providing support*" (P18), and it was felt there needed to be multiple entry points to the service. Additional barriers were created in primary care due to the COVID-19 pandemic, and while the consequences of the environmental changing are relevant here also, they are captured in the domain Environmental Context and Resources.

Analytical theme: The term 'social prescribing' creates barriers to engagement

A lack of knowledge about what the term "social prescribing" created ambivalence and coded within the Beliefs about Consequences domain (defined as "*acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation*") [26]: "*No-one knows what social prescribing is*" (P17). This limited knowledge was reported to impact negatively on the expectations of service users who did engage with social prescribing services and directly affect the behaviour of SPSPs as they believed it was out of their control. One SPSP commended on how a service user would "*get a bit disappointed at first, and think, oh, I thought you were the counsellor*" (P5).

Digital poverty was also highlighted as a salient barrier that prevented service users from engaging with services. This became more apparent when online delivery methods had been trialled or when services had moved to an online system: "*not as many are using the internet. . .or have smart phones*" (P13).

Analytical theme: Confidence in the workforce's ability to create change

Senior SPSPs (team leaders or managers) stressed the importance of having confidence in their workforce's ability to foster change in service users and was coded in accordance with the Beliefs about Consequences domain of the TDF (defined as "*acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation*"), [26]. SPSPs' beliefs in the consequences of not having a credible workforce affected their practice behaviour. Senior SPSPs felt a positive workplace culture, where support offered from both senior positions and colleagues, was important for building confidence in the capabilities of their team to deliver a quality service. Senior SPSPs believed that "*a link worker cannot be an expert in all those different areas*" (P3), but with good support mechanisms in place and knowledge sharing within teams, this can facilitate continued support.

Analytical theme: Social support benefits service users and leads to better outcomes

Providing a level of social support helped SPSPs to learn more about the lives of service users, their reactions to events, and emotions, which facilitated their behaviour around tailoring of support (and their beliefs about the consequences of the support they provided). This theme was coded to the Beliefs about Consequences domain of the TDF (defined as "acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation") [26]: "*we've all got pretty good relationships anyway so I can usually tell if somebody's not happy*" (P15). This enabled them to better provide reactive support to changes in health and emotions, which ultimately lead to a better outcome for the service user.

3.16. Environmental Context and Resources

Analytical theme: COVID-19 impacted the resources available and delivery of social prescribing

The COVID-19 pandemic forced services to change the behaviour of SPSPs in terms of delivering support that reflected the Environmental Context and Resource domain of the TDF (defined as "*any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour*") [26].

While some services adjusted their delivery methods to only a digital offer, other services did not provide an alternative, and unfortunately, digital support was associated with lower levels of engagement from older adults:

"Covid was a massive problem because people want face-to-face support, they don't want telephone support, they don't want support via zoom, they want support there in front of them" (P6).

However, for other service users where travelling was a barrier to engagement (e.g., those with agoraphobia or mobility issues), digital delivery of the service enabled them to engage and increased their engagement.

COVID-19 also limited access to resources, including restricting which services were available. Despite this, SPSPs described how home working increased their efficiency and saved time:

"*because you can jump in and out of meetings without traveling, means [you have] probably achieved a lot more than [you] would if [you] were travelling between meetings*" (P13).

However, given the importance of relationship building and interactions, the preference of SPSPs was reported to be

"*to have someone sitting in front of me and having that face-to-face consultation because like I say, you get a lot of personal and a lot better by face-to-face than you do over the phone*" (P18).

Service delivery was also severely impacted as referrals into the service from primary care were not prioritised:

"*that opportunity to get a referral, for a GP to sit there and think, why don't I move someone into the social prescribing's service, just vanished overnight*" (P1).

Service users had a pressing need for support: "*screaming out that they needed someone to assess their needs and they wouldn't go*" (P13). This had a negative impact on SPSPs and they "*felt like there was nowhere to send people to*", which was compounded by lack of Internet access. SPSPs experienced a negative impact on their own personal well-being: *"it made us feel useless because there was a limit to what we could do"* (P6).

References to job satisfaction were common, and SPSPs described this as being largely positive before the pandemic. Several SPSPs spoke about being taken out of their role: "*redeployed left, right, and centre*" (P15) to organise food parcels or medical supplies for service users. The impacts reported here by SPSPs overlap with those themes previously reported in the domains of Emotions and Social/Professional Role and Identity.

Despite the challenges that COVID-19 placed on service delivery, SPSPs learned from the experience:

"*being able to have that infrastructure is key, so that if there was another lockdown tomorrow, everybody would still be able to continue working*" (P16).

SPSPs also felt confident that the system would be able to better meet the needs of service users in future public health emergencies.

"*Knowing that they succeeded in moving it online pretty quickly, having had that experience, I think the assumption would be, we could do it again, equally quickly if not faster*" (P19).

4. Discussion

This study reports on the barriers and facilitators experienced by SPSPs to the design and delivery of social prescribing services for adults with mental health needs in the UK. Person-centred care, sustainable funding, and improved knowledge are areas that warrant further investigation and highlight some key policy-level barriers, such as sustainable funding for social prescribing.

The use of the TDF to analyse data about the experiences of SPSPs is a novel approach in social prescribing research, which provides additional insights into the factors impacting on their roles. While this is the first study to focus on the design and delivery of social prescribing services, the TDF-informed analysis identified a range of targets for influencing the design and delivery of social prescribing services, i.e., address capabilities of SPSPs (e.g., increased knowledge, skills), opportunities (e.g., sustainable funding and appropriate supervision), and motivators (e.g., peer support and beliefs about impact). There was however overlap between several analytical themes across different TDF domains. For example, a person-centred care approach was evident within four TDF domains (skills; memory, attention, and decision processes; social/professional role and identity; and social influences) and was an integral process of their role.

The delivery of person-centred care is one of the key pillars of social prescribing for empowering the person living with mental health needs to improve and manage their health [40]. A person-centred approach to the delivery can support service user adherence to services and achievement of personal goals [41]. Healthcare professionals without the knowledge and skills to deliver person-centred care represent a key barrier to delivery of high-quality care [42, 43]. Where the routine practice is paternalistic and team members do not share values about the impact of person-

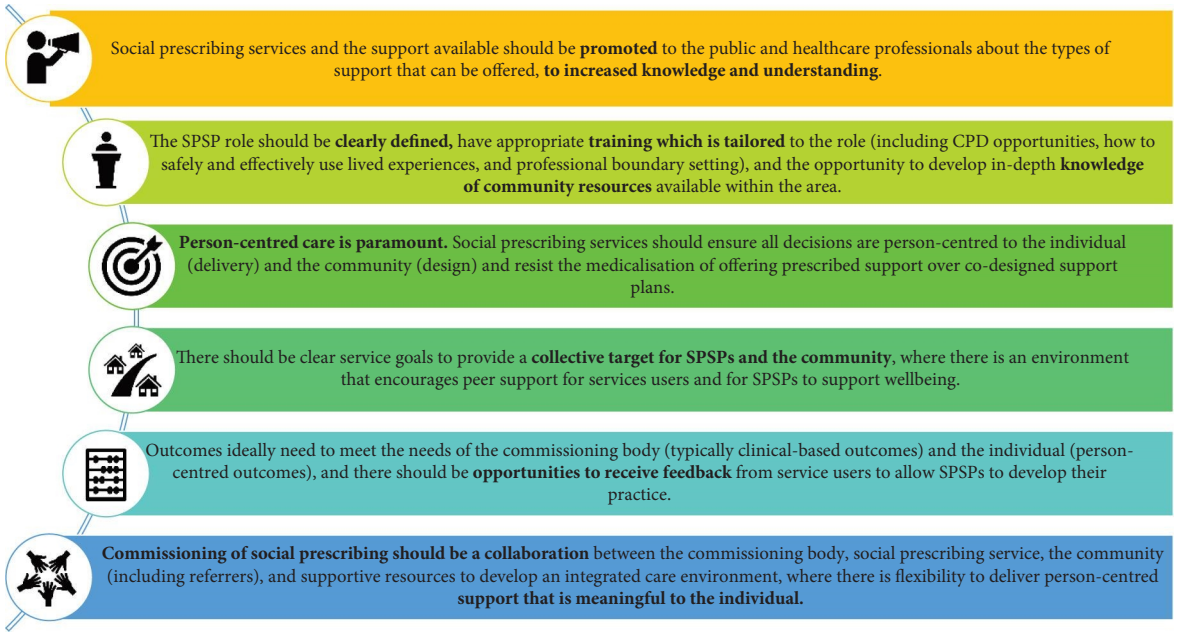

Figure 4: Recommendations for the design and delivery of social prescribing services to support adult mental health.

centred care, this represents a significant implementation challenge [44, 45]. Based on the findings of the current study, Figure 4 provides a summary of the recommendations for the design and delivery of social prescribing services to support adult mental health.

The sustainability of funding influenced both the design and delivery of services. This is a key priority for all health and social care systems, with an emphasis on ensuring efforts are financially viable for both short- and long-term impact on health outcomes [46]. There is a need to enable equitable access to social prescribing as outlined by previous sustainability development research [47, 48]. However, there is also a need to demonstrate impact and effectiveness (on both mental health outcomes for service users and cost-effectiveness for services) to the public and commissioners. This is hindered by the lack of knowledge of social prescribing and the lack of person-centred measures (e.g., the ability to capture someone's change in social housing status).

SPSPs described a lack of public knowledge about what social prescribing is, and the services available to support adults with their mental health. This is consistent with public perspectives in previous research where the language/terminology of social prescribing and mental health influence engagement rates of service users [49]. Moreover, the lexicon surrounding the prescription of services potentially places social prescribing within a medical model [50].

Previous research has made pleas to raise public awareness and knowledge about social prescribing with steps taken to support this in the UK [49]. For example, the National Academy of Social Prescribing has delivered multimedia campaigns (videos, social media campaigns, and a podcast) to raise public awareness and knowledge of social prescribing (work is ongoing to establish the effectiveness of this approach) [5, 49]. The current study also identified a need to increase awareness of social prescribing in staff from referral agencies to ensure appropriate referrals into social prescribing services and to manage the expectations of service users. However, there is a need to develop a more robust evidence base for the implementation of services and better training for healthcare professionals to increase knowledge about social prescribing [51, 52].

4.1. Strengths and Limitations. Strengths of the current study include a geographically diverse sample (spread across England and Wales) of SPSPs with a range of different roles and models of service delivery, despite recognised challenges in recruitment to social prescribing research [53]. The application of the TDF and TFA provided a grounding of data in behaviour change theory. This approach offers a high degree of rigour and trustworthiness to the findings through the methods applied and the transparency of the approach [54, 55].

Participants were all employed within the third sector, and their experiences are likely to have differences when compared to SPSPs employed by the NHS, which employ different models of social prescribing (and differences in funding of the role and placement of SPSPs within primary care teams). This has implications for the transferability of the findings to SPSPs in the NHS.

5. Conclusions

The nature of social prescribing needs to be better communicated to the public and professionals to increase engagement of adults with mental health needs and raise the profile of the potential utility of social prescribing. The role of an SPSP was poorly defined and not well understood by others, with the term "social prescribing" itself confusing. A person-centred care approach that involves collaborative

working within local communities is crucial for services to address the population needs. The sustainability of services in the VCSE sector is critical, where funding can be constrained and unpredictable. Current and future social prescribing service design and delivery should consider the recommendations outlined in this work. Research should consider utilising the behavioural approach taken in supporting further development of theory-informed models for the training of SPSPs.

Data Availability

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Supplementary Materials

Supplementary Materials 1: COREQ Checklist. (*Supplementary Materials*)

References

[1] WHO, "Depression—world health organisation 2022," https://www.who.int.

[2] C. H. Pindar, "Depressions statistics UK: 2022 2022," https://championhealth.co.uk/insights/depression-statistics.

[3] J. Pindar, "Anxiety statistics UK: 2023 2023," https://championhealth.co.uk/insights/anxiety-statistics/.

[4] Nice, "How common is it?" 2022, https://cks.nice.org.uk/topics/generalized-anxiety-disorder/background-information/prevalence/.

[5] National Academy of Social Prescrbing org uk, "What is social prescribing," 2022, https://socialprescribingacademy.org.uk/about-us/what-is-social-prescribing/.

[6] Social Prescribing Network org, "What is social prescribing: social prescribing Network.org; 2022," https://www.socialprescribingnetwork.com.

[7] NHS LNU, "Online version of the NHS long term plan 2022," https://www.longtermplan.nhs.uk/online-version/.

[8] M. Marmot, "Health equity in England: the Marmot review 10 years on," *BMJ*, vol. 368, 2020.

[9] K. Husk, K. Blockley, R. Lovell et al., "What approaches to social prescribing work, for whom, and in what circumstances? A realist review," *Health and Social Care in the Community*, vol. 28, no. 2, pp. 309–324, 2020.

[10] L. Bickerdike, A. Booth, P. M. Wilson, K. Farley, and K. Wright, "Social prescribing: less rhetoric and more reality. A systematic review of the evidence," *BMJ Open*, vol. 7, no. 4, Article ID e013384, 2017.

[11] M. Elliott, M. Davies, J. Davies, and C. Wallace, "Exploring how and why social prescribing evaluations work: a realist review," *BMJ Open*, vol. 12, no. 4, Article ID e057009, 2022.

[12] D. M. Crone, E. E. O'Connell, P. J. Tyson, F. Clark-Stone, S. Opher, and D. V. James, "Art Lift intervention to improve mental well-being: an observational study from UK general practice," *International Journal of Mental Health Nursing*, vol. 22, no. 3, pp. 279–286, 2013.

[13] S. A. Afuwape, T. K. Craig, T. Harris, M. Clarke, A. Flood, and D. Olajide, "The cares of life project (CoLP): an exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder," *Journal of Affective Disorders*, vol. 127, no. 1-3, pp. 370–374, 2010.

[14] J. V. Pescheny, G. Randhawa, and Y. Pappas, "The impact of social prescribing services on service users: a systematic review of the evidence," *The European Journal of Public Health*, vol. 30, no. 4, pp. 664–673, 2020.

[15] H. J. Chatterjee, P. M. Camic, B. Lockyer, and L. J. Thomson, "Non-clinical community interventions: a systematised review of social prescribing schemes," *Arts and Health*, vol. 10, no. 2, pp. 97–123, 2018.

[16] A. Kilgarriff-Foster and A. O'Cathain, "Exploring the components and impact of social prescribing," *Journal of Public Mental Health*, vol. 14, no. 3, pp. 127–134, 2015.

[17] A. Costa, C. J. Sousa, P. R. C. Seabra, A. Virgolino, O. Santos, and J. Lopes, "Effectiveness of social prescribing programs in the primary health-care context: a systematic literature review," *Sustainability*, vol. 13, no. 5, p. 2731, 2021.

[18] N. A. Office, "What are third sector organisations?" 2024, https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/.

[19] NHS England, "Universal personalised care: implementing the comprehensive model," 2019, https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.

[20] WHO, "A toolkit on how to implement social prescribing 2022," https://www.who.int/publications/i/item/9789290619765.

[21] D. Vidovic, G. Y. Reinhardt, and C. Hammerton, "Can social prescribing foster individual and community well-being? A systematic review of the evidence," *International Journal of Environmental Research and Public Health*, vol. 18, no. 10, p. 5276, 2021.

[22] S. Michie, "Designing and implementing behaviour change interventions to improve population health," *Journal of Health Services Research and Policy*, vol. 13, no. 3_suppl, pp. 64–69, 2008.

[23] R. Davis, R. Campbell, Z. Hildon, L. Hobbs, and S. Michie, "Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review," *Health Psychology Review*, vol. 9, no. 3, pp. 323–344, 2015.

[24] M. Cooper, L. Avery, J. Scott et al., "Effectiveness and active ingredients of social prescribing interventions targeting mental health: a systematic review," *BMJ Open*, vol. 12, no. 7, Article ID e060214, 2022.

[25] L. A. Palinkas, S. M. Horwitz, C. A. Green, J. P. Wisdom, N. Duan, and K. Hoagwood, "Purposeful sampling for qualitative data collection and analysis in mixed method implementation research," *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 42, pp. 533–544, 2015.

[26] M. Cooper, D. Flynn, L. Avery et al., "Service user perspectives on social prescribing services for mental health in the UK: a systematic review," *Perspectives in Public Health*, vol. 143, no. 3, pp. 135–144, 2023.

[27] D. Hayes, J. Edbrooke-Childs, R. Town, M. Wolpert, and N. Midgley, "Barriers and facilitators to shared decision making in child and youth mental health: clinician perspectives using the theoretical domains framework," *European Child and Adolescent Psychiatry*, vol. 28, pp. 655–666, 2019.

[28] J. Cane, D. O'Connor, and S. Michie, "Validation of the theoretical domains framework for use in behaviour change and implementation research," *Implementation Science*, vol. 7, pp. 1–17, 2012.

[29] S. Michie, L. Atkins, and R. West, "The behaviour change wheel," *A Guide to Designing Interventions 1st Ed Great Britain*, Silverback Publishing, Sutton, UK, 2014.

[30] F. Cowdell and J. Dyson, "How is the theoretical domains framework applied to developing health behaviour interventions? a systematic search and narrative synthesis," *BMC Public Health*, vol. 19, pp. 1–10, 2019.

[31] L. Atkins, J. Francis, R. Islam, D. O'Connor, A. Patey, and N. Ivers, "A guide to using the theoretical domains framework of behaviour change to investigate implementation problems," *Implementation Science*, vol. 12, no. 1, pp. 1–18, 2017.

[32] J. Ritchie, J. Lewis, C. M. Nicholls, and R. Ormston, "Qualitative research practice: a guide for social science students and researchers: sage," 2013.

[33] V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77–101, 2006.

[34] S. Parkinson, V. Eatough, J. Holmes, E. Stapley, and N. Midgley, "Framework analysis: a worked example of a study exploring young people's experiences of depression," *Qualitative Research in Psychology*, vol. 13, no. 2, pp. 109–129, 2016.

[35] J. J. Francis, M. Johnston, C. Robertson et al., "What is an adequate sample size? Operationalising data saturation for theory-based interview studies," *Psychology and Health*, vol. 25, no. 10, pp. 1229–1245, 2010.

[36] M. A. Hadi and S. José Closs, "Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy," *International Journal of Clinical Pharmacy*, vol. 38, pp. 641–646, 2016.

[37] J. Adams, R. J. McNaughton, S. Wigham, D. Flynn, L. Ternent, and J. Shucksmith, "Acceptability of parental financial incentives and quasi-mandatory interventions for preschool vaccinations: triangulation of findings from three linked studies," *PLoS One*, vol. 11, no. 6, Article ID e0156843, 2016.

[38] V. Janesick and D. Peer, *The Blackwell Encyclopedia of Sociology*, John Wiley and Sons, Ltd, Hoboken, NY, USA, 2015.

[39] S. Spall, "Peer debriefing in qualitative research: emerging operational models," *Qualitative Inquiry*, vol. 4, no. 2, pp. 280–292, 1998.

[40] M. Polley, J. Whiteside, S. Elnaschie, and A. Fixsen, *What Does Successful Social Prescribing Look Like? Mapping Meaningful Outcomes*, University of Westminster, London, UK, 2019.

[41] L. Moore, N. Britten, D. Lydahl, Ö Naldemirci, M. Elam, and A. Wolf, "Barriers and facilitators to the implementation of person-centred care in different healthcare contexts," *Scandinavian Journal of Caring Sciences*, vol. 31, no. 4, pp. 662–673, 2017.

[42] T. S. Alharbi, E. Carlström, I. Ekman, and L.-E. Olsson, "Implementation of person-centred care: management perspective," *Journal of Hospital Administration*, vol. 3, no. 3, p. 107, 2014.

[43] L. Gask and P. Coventry, "Person-centred mental health care: the challenge of implementation," *Epidemiology and Psychiatric Sciences*, vol. 21, no. 2, pp. 139–144, 2012.

[44] J. Pescheny, G. Randhawa, and Y. Pappas, "Patient uptake and adherence to social prescribing: a qualitative study," *BJGP Open*, vol. 2, no. 3, 2018.

[45] A. Fixsen, H. Seers, M. Polley, and J. Robins, "Applying critical systems thinking to social prescribing: a relational model of stakeholder buy-in," *BMC Health Services Research*, vol. 20, pp. 1–13, 2020.

[46] A. Sepetis, "Sustainable finance in sustainable health care system," *Open Journal of Business and Management*, vol. 8, no. 01, p. 262, 2019.

[47] H. Barton, M. Grant, and R. Guise, "Shaping neighbourhoods: FOR local health and global sustainability: Routledge," 2021.

[48] G. H. Brundtland, "Our common future—call for action," *Environmental Conservation*, vol. 14, no. 4, pp. 291–294, 1987.

[49] K. Khan, F. Ward, E. Halliday, and V. Holt, "Public perspectives of social prescribing," *Journal of Public Health*, vol. 44, no. 2, pp. e227–e33, 2022.

[50] G. Bradley and J. Scott, "Social prescribing nomenclature, occupational therapy and the theory of institutional work: creating, maintaining and disrupting medical dominance," *Occupational Therapy in Health Care*, vol. 37, no. 1, pp. 40–53, 2023.

[51] C. Frostick and M. Bertotti, "The frontline of social prescribing–how do we ensure link workers can work safely and effectively within primary care?" *Chronic Illness*, vol. 17, no. 4, pp. 404–415, 2021.

[52] H. Aughterson, L. Baxter, and D. Fancourt, "Social prescribing for individuals with mental health problems: a qualitative study of barriers and enablers experienced by general practitioners," *BMC Family Practice*, vol. 21, pp. 1–17, 2020.

[53] M. Cooper, J. Scott, L. Avery, K. Ashley, and D. Flynn, "Exploring service providers' perceptions of the barriers and enablers to recruitment of service users into social prescribing research," *Cogent Psychology*, vol. 11, no. 1, Article ID 2355779, 2024.

[54] E. G. Guba and Y. S. Lincoln, "Effective Evaluation: Improving the Usefulness of Evaluation Results through Responsive and Naturalistic Approaches: Jossey-Bass," 1981.

[55] Y. S. Lincoln and E. G. Guba, *Naturalistic Inquiry*, Sage, 1985.