Q&A

Question: With the rapid successful emergence of social prescribing is there a need for a new tertiary qualification for SP or do we just modify existing delivery?

Prof Nick Goodwin: Social prescribing is an approach to supporting people with their wider health and social care needs, and as the seminar demonstrated, there seem to be many different models and approaches that are being used, often modified depending on their primary purpose e.g. to support health promotion, disease management, social and aged care support and so on. Given it's not a specific role, then a 'tertiary qualification' for Social Prescribing might better be thought of as to the role of the care professional that primarily supports SP – i.e. to the link worker or care navigator role. I do think the time has come to have professional qualifications for such care coordinators, and at the CCRI we have launched a Professional Certificate in Care Coordinator aimed at health and social care professionals likely to take on such roles. However, I am not sure social prescribing requires a tertiary qualification, and the roles might equally well be taken up by trained peer workers or through vocational education.

Dr Linus Chua: Social Prescribing should be accessible to the masses, so having a tertiary qualification would not be helpful. However, link-workers should be "trained" to understand the various activities and resources available in the community well, as well as to be skilled in motivational-interviewing techniques to help them be effective in their roles as link-workers. An orientation course or professional certificate may be helpful for this purpose.

Prof. Jose M Valderas: The fundamental aspect of social prescribing is the linkage to the resources in the community. As such, social prescribing should not be confused with patient activation, behaviour change or lifestyle interventions. Effective matching of community resources and services with patient needs can be achieved within existing professional profiles, thus I do not feel additional credentials are necessary.

Question: Can "unhealthy" hobbies that keep the patients occupied and happy be recommended by care providers?

Prof Nick Goodwin: The key to social prescribing is that it encourages engagement in activities that support people's activation and enables their health and wellbeing. Perhaps we need to know more about the 'unhealthy hobbies' to which you refer, since there is a possible trade-off with addressing social isolation and supporting activation. As a general rule, you'd want SP to keep people happy and healthy!

Prof. Jose M Valderas: Autonomy is a key ethical principle in healthcare delivery. Services and resources most consistent with the patient well/being in its broadest sense should be promoted.

Question: Which programs have shown good patient participation? What were the key elements for this? Were there ethnic differences?

Prof Nick Goodwin: The evidence base is not so advanced as to make a definitive judgement on this question, but there seems to be some consensus in relation to programs that actively engage people in those interests that matter to them and which are provide by people they trust and feel an affinity towards [i.e. more positive] as opposed to participation in, say, activities seeking to change health seeking behaviors that are 'done' to them, or by those they might not feel trust. There is some evidence that 'social' prescribing is less effective if done through a medical lens, so it should not be the same model as chronic disease management. However, evidence seems to suggest that societal (ethnic) differences will definitely play a part, so the approach taken in a

specific location needs to find the right adaptation. A key is the link worker role itself, where our early review work points to the importance of a kind, trusting, compassionate relationship between navigator and patient – and the ability to act as coach or mentor to someone's needs that provides relational continuity, and so not just a referral agent to other services.

Dr Linus Chua: Anecdotally there have been some health promotion / lifestyle events that have had good uptake and acceptance if it's supported by ethnic and religious communities in Singapore.

Prof Jose M Valderas: It is important to remind ourselves of how essential it is to develop local evidence in support of social prescribing due to its very complex and contextual nature. Participation of the local population in services and use of community resources is very likely to be dependent of a number of local factors which are unlikely to have been fully addressed in studies in other geographical and cultural contexts.

Question: How do we achieve a shift in mindset in residents, from traditional acute care for health - to a holistic regular check in for health?

Prof Nick Goodwin: Yes, this is hard, but it's a combination of health literacy (understanding why it's important), supporting self-efficacy (enabling people to actually do it) and system supports (making it easy to access, trusted and in some cases 'part' of what you are required to do 'as usual' – for example, via empanelment in primary care).

Question: Just wondering: What metrics are used to assess the effectiveness of social prescribing interventions in improving patient health and well-being?

Prof Nick Goodwin*:* This was covered in my presentation, and the answer is many and varied. A good article that examines this question is Ashe, M. C., et al. (2024). "Outcomes and instruments used in social prescribing: a modified umbrella review." Health promotion and chronic disease prevention in Canada: research, policy and practice **44**(6): 244. View full text.

Question: Does social prescribing represent a shift in responsibility from the medical system to community or non-healthcare sectors? How well is this approach likely to be received by the community, healthcare professionals, and other sectors involved?

Prof Nick Goodwin: The responsibility should be a shared one, rather than a shift, since SP requires a collaborative effort where the value of both medical and social support is recognized. Developing networks or new organizational forms that enable different professionals to work together effectively is indeed problematic - it requires an understanding of the benefits to people that can be achieved through a new way of working, a recognition of the different roles people play, and good leadership and management that enables people to keep working together to meet such a combined objective in the face of the multiple barriers to partnership working that inevitably exist.

Question: 1. What sorts of evidence is NUHS using to do social prescribing? Currently seems like there's just a "menu" of services available without (1) proper and systematic use of evidence to prescribe, and (2) co-developing the prescription with the patients

Dr Linus Chua: In NUHS we're still in relative infancy stage. The priority at this point is to refer patients with care needs and gaps to relevant care services which are available in the community to address their care needs and social determinants of health to achieve better health outcomes.

In NUP the care-coordinators co-develop their health plan with the patients with one of the possible interventions being a referral to the local active ageing centre for social activities.

Question: 2. I am not surprised patients are reluctant to visit AACs when referred. Can you elaborate whether behavioural scientists or some form of interdisciplinary teams are involved in social prescribing? If not, how could this be improved?

Prof Nick Goodwin: Interesting idea - the evidence does not say much on this, but certainly the development of effective teams to support SP requires new /shared ways of working that may challenge the status quo and require managers or program leaders to have such skills.