A Social Identity Approach to social prescribing: Developing a Community Prescribing Toolkit to minimise disengagement by facilitating social identification

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Abstract

Social prescribing is a non-medical health initiative that empowers individuals to manage their health and well-being by connecting them to local community resources, including community groups. However, disengagement and a prior lack of theory guiding social prescribing prevents our understanding of how and when social prescriptions to community groups promote health and wellbeing. To address these gaps, this research applied the Social Identity Approach to Health (SIAH, Haslam et al., 2018; Jetten et al., 2012) to social prescribing, to further establish a theoretical foundation and mitigate disengagement by promoting social identification. A four-study exploratory, sequential mixed method approach aimed to answer the overarching research question: How can the application of the SIAH improve the social prescribing referral process to community groups? Interviews with 27 social prescribing stakeholders in Study One revealed tacit understanding of group processes such as need satisfaction, fit, shared similarities, and belonging within social prescribing. These insights shaped the creation of a toolkit aimed at facilitating social identification during a community group social prescription.

Study Two refined the toolkit through focus groups and an online qualitative questionnaire with seven Link Workers and three group leaders. However, Study Three's questionnaire with 70 Link Workers outlined the impracticalities of trialling the toolkit whilst services were recovering from the COVID-19 pandemic. Thus, Study Four was altered to deepen understandings of the facilitators and barriers to engagement with recommended community groups via five service-user interviews. Analysis indicated that complex or traumatic social histories for service-users impacted the perceived accessibility of community groups by fostering distrust, social avoidance, and disengagement. These findings were integrated into the developed toolkit. This work has been pivotal in

evidencing the SIAH to social prescribing and developing a social identity-informed social prescribing toolkit, providing the necessary groundwork for future trialling of the toolkit.

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Chapter 1: Thesis overview

This chapter briefly contextualises this thesis and introduces the core topics of social prescribing and the Social Identity Approach to Health (SIAH) that form the foundation of this thesis. Social prescribing and the climate surrounding it is introduced first, followed by the SIAH, and how the theory applies to social prescribing. The aims of the research detailed in this thesis are then presented before providing an overview of the upcoming chapters.

Social prescribing

Approximately 70% of health outcomes are believed to be influenced by social factors, and social problems are involved in about 20% of primary care consultations (Ladds, 2021). To address these concerns and align with evolving governmental policies that emphasise an empowering approach to health, alternative solutions to the medical model of healthcare have been explored. Social prescribing is one such approach that reflects a non-clinical health initiative, shifting away from a solely medical model of healthcare (Nowak & Mulligan, 2021). Instead, social prescribing acknowledges the social determinants of health that underlie health inequalities (Shah, 2021). The social determinants of health encompass non-medical factors that significantly impact health outcomes and are influenced by individuals' socio-environmental conditions throughout their life course (Baxter et al., 2020; WHO, 2022). Health inequalities denote systematic disparities in health status observed among different demographical groups, with variables such as education, employment status, gender, ethnicity, and income level affecting both health status and access to healthcare (Baxter et al., 2020; WHO, 2018). A recent Delphi study developed an internationally accepted definition of social prescribing with 48 social prescribing experts across 26 countries and five continents (Muhl et al., 2023, pg 9):

> "a means for trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription—a non-medical prescription, to improve health and wellbeing and to strengthen community connections"

In the United Kingdom (UK), social prescribing entails providing personalised support tailored to an individual's needs and connecting them with local community resources capable of addressing those needs (Jones, 2020; NHS England, 2020; Parums, 2015), aligning with the personalised care movement (Department of Health, 2008) and the loneliness agenda (HM Government, 2018). Thus, reducing loneliness is a key outcome for some social prescribing schemes in the UK (NHS England, 2020; Polley et al., 2017b). Community resources can include community groups, nature-based activities, gyms, weight management, housing support, and debt advice (Garside et al., 2020; McKenzie et al., 2021; Milligan et al., 2021). A Link Worker forms a core component of social prescribing (Jones, 2020; Makanjoula, 2021) and are outlined as a key feature of NHS, community, and council-based schemes from 2014 onwards. Similar developments have occurred globally with a Link Worker model of social prescribing aimed at tackling loneliness having been developed in Australia, New Zealand, and Canada (Morse et al., 2022; Muhl et al., 2023; Sharman et al., 2022). For example, in Australia, the Link Worker model of social prescribing has been found to significantly reduce loneliness and distress, and significantly improve perceived health, wellbeing, and social trust in service-users accessing social prescribing over an 18-month period, compared to service-users accessing GP treatment as usual (Sharman et al., 2023). The success of social prescribing was reliant on Link Workers breaking down service-user barriers and helping service-users rebuild a sense of self by connecting them to groups they could fit in and belong to (Sharman et al., 2023). Whilst these global insights into social prescribing are useful in understanding the health

benefits of social prescribing, the UK's integration of social prescribing into national health policies (Calderón-Larrañaga et al., 2022; National Academy for Social Prescribing, 2022) means it remains the ideal place to research the Link Worker model of social prescribing.

Social prescribing Link Workers assist service-users (patients) to identify their needs and collaboratively design action plans that address those needs (Husk et al., 2020; NHS England & NHS Improvement, 2019). Drawing on their local knowledge, Link Workers recommend relevant community resources to support the service-user's specific requirements (Husk et al., 2020; NHS England & NHS Improvement, 2019). Empirical evidence demonstrates the positive impact of social prescribing on health and well-being. For instance, art-based social prescriptions have shown benefits in enhancing well-being through increased social connection and support (Stickley, 2020; Tan et al., 2022; Thompson R. et al., 2021; Zalantai et al., 2021). Social prescribing can also support the management of long-term conditions (Thomas et al., 2021), motivate lifestyle changes through hobby-based groups like walking groups (Searle et al., 2021), and address loneliness (Ellender & Bonner, 2021; Reinhardt et al., 2021).

One of the challenges impacting the effectiveness of social prescribing is service-user disengagement with Link Worker appointments and social prescriptions (Bickerdike et al., 2017; Polley et al., 2017a). Limited research has explored why service-users may disengage or decline a social prescription. One possible explanation is inappropriate referrals to social prescribing and community resources (Husk et al., 2020). When service-users are referred to social prescribing for issues that are not suitable for this approach or are directed to community groups that do not meet their needs, disengagement becomes more likely. An evaluation report by SPRING Social Prescribing (2020) reported that 31% of referrals to social prescribing in Scotland and Northern Ireland between July 2019 and October 2020, were closed for various reasons including inappropriate referrals that could not meet a service-user's needs (6%), service-users declining their social prescription (10%) and not attending Link Worker

appointments (5%). Such disengagement reduces the likelihood of service-users experiencing improved health and wellbeing that may have been obtained through continued engagement with social prescribing.

Social prescribing has previously been critiqued for lacking a theoretical underpinning (Halder et al., 2018; Stevenson et al., 2020a) and for varying in service provision (Husk et al., 2019; Stevenson et al., 2020a) which continues to impact assessments of social prescribing's effectiveness (Al-Khudairy et al., 2022). Assessing the literature from 2020 onwards, there appears to be pockets of theories being applied to social prescribing, i.e., occupational science (Bodell et al., 2019) or used as a framework for interpreting the success of social prescribing, such as social capital, patient activation (Tierney et al., 2020), and Self-Determination Theory (Hanlon et al., 2021). However, there is no universally accepted application of theory. The absence of a robust universal theoretical framework is thought to contribute to the inconsistencies in effectively building social connections that reduce loneliness by matching individuals appropriately with community resources (Hamilton-West et al., 2020; Laing et al., 2017).

The UK governments efforts to tackle loneliness through the publication of their loneliness strategy in 2018 (HM Government, 2018) may have become diluted through their introduction of a universal personalised care plan (NHS England, 2019b; Reinhardt et al., 2021). The universal personalised care plan intended to increase the publics self-management of their health and wellbeing and advocates social prescribing as a solution for improving health and wellbeing in communities, including reducing loneliness (NHS England, 2019b; Reinhardt et al., 2021). However, the provision of person-centred care that empowers an individual to self-manage their health and wellbeing may have taken priority over reducing loneliness, as it could improve other areas of concern such as unemployment (NHS England, 2019b). That is, until the national social distancing measures implemented throughout the COVID-19 pandemic re-

highlighted the importance of addressing loneliness due to reports of increased loneliness for those already vulnerable to it during the pandemic (McQuaid et al., 2021; Reinhardt et al., 2021; Vidovic et al., 2021). The Emerging Together Strategy (Gov UK, 2021b) advocates for greater funding to support access to community initiatives that reduce loneliness in its aim to support the recovery of communities from the impacts of the pandemic. Applying a theoretical approach to social prescribing that can address loneliness, whilst increasing the likelihood of suitable matches to community groups being provided is crucial for minimising disengagement. The SIAH is one such theory that is gaining recognition in this context (Halder et al., 2018; Stevenson et al., 2020a; Wakefield et al., 2019).

The Social Identity Approach to Health

The SIAH suggests that group memberships improve health and wellbeing when they are internalised through a process of 'social identification' (Jetten et al., 2014; Wakefield et al., 2019). Social identification refers to the psychological connection and sense of belonging individuals feel toward a group (Tajfel, 1978). Belonging to groups fulfils psychological needs and offers benefits such as social support during stressful situations, which positively impacts health (Greenaway et al., 2016; Wakefield et al., 2022).

However, facilitating social identification goes beyond joining a group. Group memberships that hold greater personal importance, align with individual values, and meet individual needs are more likely to foster social identification and subsequently improve health and well-being (Haslam et al., 2018; Tarrant et al., 2020). Interventions based on the SIAH, such as Groups4Health, have shown promising outcomes in terms of health and well-being improvements (Haslam et al., 2016; Cruwys et al., 2021). As a result, researchers have started exploring whether the SIAH can help elucidate the mechanisms behind the positive effects of social prescribing on health and well-being (Halder et al., 2018).

The Social Identity Approach to Health and social prescribing

Halder et al. (2018) explored the relevance of the SIAH to social prescribing in their study protocol for an evaluation of a social prescribing service, following concerns that social prescribing was atheoretical. The researchers were the first to apply the SIAH to social prescribing, to understand whether the SIAH was a suitable theory to explain how social prescribing resulted in health gains. Two reports of the findings from the subsequent empirical studies indicated that social prescriptions were more likely to have health and wellbeing benefits when they facilitated group identifications (Kellezi et al., 2019c; Wakefield et al., 2022). Group memberships accrued via social prescribing improved health and wellbeing through social identification processes of increased belonging, social support, and reduced loneliness (Wakefield et al., 2022). This body of research provides preliminary evidence of social prescriptions improving health and wellbeing when they facilitate social identification (Stevenson et al., 2020a; Wakefield et al., 2019), supporting the application of the SIAH to social prescribing.

In summary, social prescribing involves connecting individuals with local community resources to address their non-medical needs, facilitated by Link Workers who provide personalised guidance. However, social prescribing was not designed with a theoretical foundation, which is concerning considering its wide distribution across the NHS (Frostick & Bertotti, 2019). This concern, when combined with reports of disengagement and inappropriate connections to community resources, suggest a need to provide appropriate social prescriptions based on theory and evidence-based practice.

The SIAH proposes that group memberships, when integrated into one's social identity, can support health and well-being by satisfying psychological needs and providing social support. Applying the SIAH to social prescribing suggests that social prescriptions to community groups are most effective when they promote social identification. Therefore, it is important to

support Link Workers in providing social prescriptions that facilitate social identification. One solution is to create a resource that can support Link Workers to provide social prescriptions to community groups that facilitate social identification. Nurturing the process of group identification could enhance our understanding of how and why social prescribing is effective, and when it is not. A toolkit that applies a SIAH to social prescribing should provide the flexibility required to be utilised in various settings, supporting the variability in social prescribing services (Ladds, 2021). Thus, creating a toolkit informed by the SIAH that supports social prescriptions to community groups is a core aim of this thesis, as explored in the following section.

Aims of the thesis

This thesis aimed to answer the overarching research question of: How can the application of the SIAH improve the social prescribing referral process to community groups? The following subsidiary aims facilitated and supported the primary aim of this thesis and helped answer the overarching research question:

1. To gain Link Worker, service-user, and community group leader perspectives on the community group referral process to inform toolkit development.
2. To gain Link Worker, service-user, and community group leader perspectives on the presence and their understanding of possible group processes that facilitate or prevent social identification during social prescriptions to community groups.
3. To collaboratively develop the Community Prescribing Toolkit for social prescribing stakeholder use.
4. To explore the feasibility of the Community Prescribing Toolkit in practice with social prescribing Link Workers.

5. To determine the effectiveness of the toolkit at improving service-user's health and wellbeing via social prescribing Link Worker connections to community groups.

Aims one to three were achieved within this thesis, however, aims four and five were unattainable due to the impacts of the coronavirus pandemic detailed in Chapter Four. Thus, a further three aims were generated to continue the research programme in support of the research question and the core aim of developing a theoretically informed Community Prescribing Toolkit. Chapter Five provides further insight into the justification for these new aims:

- To explore the possibility of conducting a feasibility trial of the Community Prescribing Toolkit (new aim four).
- To deepen understandings on why service-users may decline or disengage with recommended group activities (new aim five).
- To further explore the potential facilitators that may encourage service-user engagement with community groups (aim six).

Three research phases explored these aims. Phase one involved the creation and refinement of the Community Prescribing Toolkit following Study One and Two. Phase two explored the practicality of trialling the toolkit during social prescribing's recovery from COVID-19 in Study Three. Phase three explored the barriers and facilitators influencing service-user engagement with recommended groups in Study Four. These phases and studies are outlined further in the following section.

Overview of the thesis

The first four chapters introduce the research topic and theory used to support the research programme documented within this thesis. This chapter (Chapter One) has introduced social prescribing, the SIAH, and its relevance to social prescribing, alongside the aims and upcoming content of this thesis. Chapter Two details social prescribing and the Link Worker model of

social prescribing, before critically evaluating the evidence for social prescribing and the barriers preventing successful social prescriptions, e.g., disengagement, lack of theory, poor evidence base. Chapter Three then introduces the SIAH, the theory underpinning this thesis. The origins of the theory are introduced, alongside the mechanisms behind how social identity improves health and wellbeing. The SIAH is then applied to social prescribing in Chapter Four, outlining the relevance of the theory for the health initiative. Chapter Four finishes by contextualising the research environment that has governed the research documented in this thesis, throughout the COVID-19 pandemic.

Chapters Five to Nine summarise the methodological decisions, the empirical work produced during the research programme, and the development of the Community Prescribing Toolkit. Chapter Five introduces the ontology, epistemology, and methodology underpinning the research. A pragmatic approach to an exploratory, sequential mixed methods research programme was adopted (Allemang et al., 2022), utilising realist ontology (Sobh & Perry, 2006) and contextualist epistemology (Braun & Clarke, 2021b; Madill, 2000) throughout the qualitative research. A phenomenological lens is also utilised in Study Four to support a more idiographic exploration of the barriers and facilitators to engagement with social prescribing as experienced by service-users (Budd et al., 2010; Willig, 2013). Chapter Five also provides a brief overview of the conducted studies.

Chapter Six introduces Study One as part of a two-step process of toolkit development, which explored the research question: 'What would Link Worker, community group leader, and service-user stakeholders include in a Community Prescribing Toolkit supporting social prescriptions to community groups', addressing aims One and Two. Semi-structured interviews were utilised with social prescribing stakeholders to explore the presence and participant understanding of group processes during the social prescription process to community groups. The information obtained from this study, was utilised alongside the wider SIAH literature, to

create a draft version of the Community Prescribing Toolkit to be collaboratively reviewed and refined in Study Two reported in Chapter Seven. Study Two forms step two of a two-step process of toolkit development and involved conducting focus groups with Link Workers and an online questionnaire with group leaders to collaboratively refine the draft Community Prescribing Toolkit. Study Two answered the research question: 'How would social prescribing stakeholders refine the Community Prescribing Toolkit,' responding to aim three. The aligned research process of topic exploration and collaborative refinement through consensus reaching during Study's One and Two is somewhat akin to Delphi research which involves multiple iterations of feedback until consensus is reached (Fink-Hafner et al., 2019; Thangaratinam & Redman., 2005). However, unlike Delphi research which provides insight into expert opinions on social reality (Fink-Hafner et al., 2019), the research described in this thesis captures the social reality of social prescribing as experienced from multiple perspectives of those either working, supporting, or experiencing it.

Chapter Eight details Study Three which utilised a qualitative and quantitative questionnaire to explore whether a feasibility trial of the refined toolkit was possible whilst social prescribing was recovering from the COVID-19 pandemic. At the time of Study Three, the UK had entered a roadmap to recovery from COVID-19 and legal restrictions on socialisation and social distancing that were implemented during national lockdowns were easing (Institute for Government Analysis, 2022). Study Three thus explored the research question: 'Can social prescribing and communities practically support a feasibility trial of the Community Prescribing Toolkit, whilst recovering from the ongoing impacts of the COVID-19 pandemic', addressing the new aim four. Alongside exploring the potential to trial the toolkit Study Three utilised the questionnaire to further explore whether the toolkit would be considered useful during social prescribing's recovery from the pandemic and how well Link Workers understood and utilised the SIAH during social prescribing. The outcomes of Study Three

confirmed the impracticalities of trialling the toolkit within a social prescribing setting recovering from COVID-19, due to the community and voluntary sector being slow to recover and reports of high demand for social prescribing amidst a low supply of community resources (O'Connor et al., 2021).

Following the outcome of Study Three, Chapter Nine details an alternative research avenue for Study Four. Rather than a feasibility trial, a decision was made to deepen understanding of the barriers preventing service-user engagement with recommended groups, to further develop the toolkit and a SIAH to social prescribing. Study Four thus utilised online semi-structured interviews with service-users who had declined to attend a recommended group to explore the research question: 'How can the experiences of service-users who disengage or decline to engage with recommended community groups, inform understanding of the barriers and facilitators to engagement with social prescribing', supporting aims five and six. Insights from these interviews were incorporated into the Community Prescribing Toolkit to minimise the risk of future disengagement. Following Chapter Nine, Chapter Ten provides an overall discussion of the research presented in this thesis. Discussions on how the research aims were met, the strengths of the philosophical approaches taken, and the relevance of the research for the wider literature are presented. The implications of the research, the potential applications of the toolkit and the potential impact of the project are discussed, before presenting concluding thoughts and future directions.

Chapter 2: Social prescribing

Chapter overview

As of July 2023, 7.6 million people are waiting for routine treatment on the NHS (UK Parliament, 2023), an increase of 3.2 million from the 4.4 million waiting for treatment in December 2019 (Gardner & Fraser, 2021). The surge in demand has exceeded the capacity of healthcare services, necessitating the involvement of the community and voluntary sector assuming a more active role in primary care (South et al., 2008). Supporting communities, the third sector provides tailored care for service-users (Crombie & Coid, 2000) by filling service gaps and providing health information, local activity-based support including self-help groups, and community-orientated activities, such as walking groups (South et al., 2008). Social prescribing has been recognised as a potential bridge that connects healthcare with the community and voluntary sector, by supporting referrals to local community resources (Islam, 2020). However, poor communication across organisations challenges the effectiveness of communities supporting primary care, resulting in a need to build inter-organisational collaboration which is thought to be accomplished via social prescribing (Kimberlee, 2015; Polley et al., 2017b). The following chapter outlines what social prescribing is, who is involved and how effective it is.

What is social prescribing?

Social prescribing involves connecting individuals with nonmedical health and wellbeing concerns to local community resources (Calderón-Larrañaga et al., 2022; Cunningham et al., 2022; Islam, 2020; Muhl et al., 2023; Polley et al., 2017b). These concerns encompass various socioeconomic and psychosocial issues, such as financial stress, educational concerns, poor housing, low self-esteem, social isolation, loneliness, relationship difficulties, autism and learning difficulties, and physical and mental health concerns (Barnes, 2020; Chatterjee et al.,

2018; Featherstone et al., 2021; Polley et al., 2017b; Reinhardt et al., 2021). Social prescribing is promoted as a holistic approach that tailors support to the specific needs of service-users (also referred to as patients) and their families within the context of local and national governance (Polley et al., 2017b; Public Health England, 2019; The King's Fund, 2017). Consequently, social prescribing was initially utilised to address barriers to engagement, promote health and wellbeing and more recently, reduce health inequalities in community settings by building local communities (Calderón-Larrañaga et al., 2022; Public Health England, 2019). In this thesis, the term service-user is utilised to describe users of social prescribing over patient, to reduce perceptions of social prescribing being medicalised which is considered to be counterproductive of social prescribing's ethos (Evans, 2023).

Community resources encompass housing associations, the Citizen's Advice Bureau, community groups, gyms, community centres, and hobby/interest groups such as dance, fishing, singing or creative arts (Calderón-Larrañaga et al., 2022; Parums, 2015; Singing for Health Network, 2021), alongside the utilisations of green (nature) and blue (water) spaces (Juster-Horsfield & Bell, 2021; Rough, 2021). The plethora of health and wellbeing concerns supported through social prescribing reflects the customisation of schemes to meet localised need (Fixsen et al., 2021; Ladds, 2021; Wallace et al., 2021). Early quantitative and qualitative research suggests that social prescribing yields positive outcomes, including improvements in physical, social, and emotional health and wellbeing, increased community support and enhancement of social determinants of ill-health (Islam, 2020; Social Prescribing Network, 2016).

Over the past few years, NHS England have become the leading pioneers in integrating social prescribing into national health policies to create a more uniformed provision of social prescribing using the Link Worker model (Calderón-Larrañaga et al., 2022; Morse et al., 2022; National Academy for Social Prescribing, 2022). The frontier status ascribed to England's

implementation of social prescribing explains why it is a core focus of this thesis. Other countries have also recognised the Link Worker model of social prescribing to be an effective social prescribing model including Scotland, Australia, Canada, Portugal, Spain, Austria, and Japan (Muhl et al., 2023; National Academy for Social Prescribing, 2022; Sharman et al., 2022). Whilst part of the UK, Scotland and Wales do not follow the same social prescribing guidance provided by the NHS for England, such as their Model of Personalised Care (NHS England, 2019b). Social prescribing in England is primarily delivered via a General Practitioner (GP) referral and Link Worker delivery, which are based in integrated care systems and funded by the Department of Health and Social Care (National Academy for Social Prescribing, 2022; NHS England, 2019a; 2022b). In Scotland, social prescribing is primarily delivered through 14 regional health boards via NHS Scotland and unlike the schemes rolled out via NHS England, every scheme in Scotland is unique in its delivery (Fixsen et al., 2021; National Academy for Social Prescribing, 2022). In Wales, social prescribing delivery primarily utilises a community-based holistic intervention approach as opposed to a primary-care based approach as seen with England (Mind Cymru, 2021; National Academy for Social Prescribing, 2022; Wallace et al., 2021). In other countries, social prescribing can vary from localised initiatives tailored and delivered by provinces, territories, or communities as seen in Northern Ireland, the Republic of Ireland, Canada, Spain, Japan, and Australia (Morse et al., 2022; National Academy for Social Prescribing, 2022; Sharman et al., 2022) and primary care based approaches as seen in Portugal and Austria (Morse et al., 2022; National Academy for Social Prescribing, 2022), with ongoing investments or interests in nationalised programmes in Portugal, Canada and Australia (National Academy for Social Prescribing, 2022; Sharman et al., 2022). The social prescribing referral process for England is described below.

What is the referral process in England?

Referrals to social prescribing have evolved overtime ranging from signposting, light, medium and holistic social prescriptions (Kimberlee, 2015; 2016). Social prescribing schemes considering all needs surrounding a referral are considered optimal (Calderón-Larrañaga et al., 2021; Elston et al., 2019). For instance, supporting a diet-based referral may involve addressing budgeting, nutrition, addiction, loneliness, and employment access (Kimberlee, 2015). Service-users can access social prescribing through their GP, other non-health, and healthcare professionals (e.g., nurses, physiotherapists, police, firefighters, job centres etc.), self-referral, and Link Workers (Garside et al., 2020; Thomson et al., 2015).

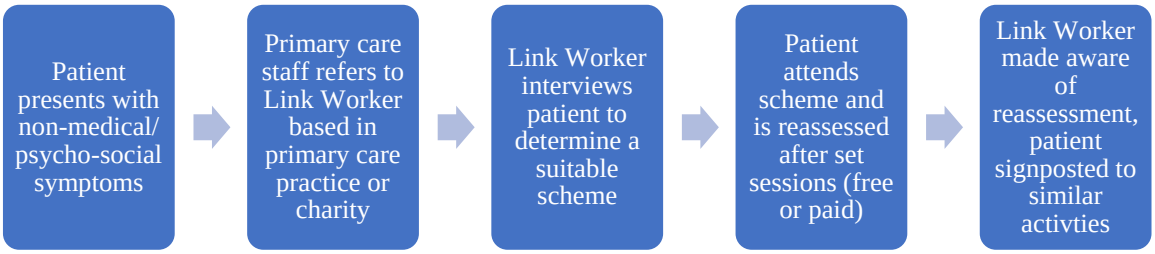
Link Workers, also known as community connectors, social prescribing co-ordinators or wellbeing advisors in social prescribing schemes outside of NHS England, play a central role in supporting the concerns of GPs and in assessing a service-user's needs and connecting them with appropriate community resources (Frostick & Bertotti, 2019; Polley et al., 2017b). They serve as repositories of local knowledge regarding available community resources (Brown et al., 2021; Harris et al., 2017; Makanjuola, 2021; O'Connor et al., 2021), are considered essential to social prescribing initiatives (Bertotti et al., 2018; Foster et al., 2021; Husk et al., 2020; Kilgarriff-Foster & O'Cathain, 2015; O'Connor et al., 2021), and are a focal point of this thesis.

Thomson et al.'s (2015) review from eight years ago provides an outline of the varying referral pathways in social prescribing, including the Link Worker pathway (Figure 2.1). The authors note that the selected community resources and subsequent sessions are free of charge or subsidised for the duration of the social prescription. The Link Worker pathway gained prominence following the endorsement of social prescribing by the NHS in 2014. Earlier referral pathways involved GP direct referrals, before these were widened to other healthcare professionals, and occasionally referrals from Improving Access to Psychological Therapies

(Thomson et al., 2015). The final pathway stems from the potential mental health benefits associated with social prescribing which are explored further in the strengths and limitations subsection. The next subsection explores the Link Worker pathway in more detail.

Figure 2.1

Link Worker referral to social prescribing (Thomson et al., 2015)



The Link Worker pathway

The Link Worker pathway is one of the most widely endorsed social prescribing models (Frostick & Bertotti, 2019). Link Workers are fundamental in supporting local agencies and primary care staff to refer service-users to tailored advice that addresses their non-medical needs (NHS England, 2022b; NHS England & NHS Improvement, 2019). Tailored advice allows service-users to focus on their priorities, make shared decisions, and develop action plans to achieve their goals (Brandling & House, 2009; Husk et al., 2020; NHS England, 2022b; Thomson et al., 2015). The NHS endorsement of social prescribing acknowledges its potential to connect service-users to the third sector, including community groups, and provide practical and emotional support using a holistic approach to health and wellbeing (NHS England, 2022b), as previously discussed.

The documentation of the Link Worker referral process in social prescribing is limited, yet several studies provide insight into the process (Bertotti & Temirov, 2020; Moffat et al., 2017;

Stevenson et al., 2020b; Ward et al., 2020; Wildman et al., 2019a), aligning with the pathway outlined in Figure 2.1. After entering social prescribing, service-users are typically contacted by Link Workers via an initial phone call to schedule an assessment. The assessment can occur over the phone or in person (Wildman et al., 2019a), and can last between 30 minutes (Bertotti & Temirov, 2020; Ward et al., 2020) to an hour (Stevenson et al., 2020b), depending on the social prescribing scheme (Sandhu et al., 2022b). The consensus is that each assessment should be longer than a ten-minute GP assessment to give service-user's time to explore their needs (Anfilogoff, 2020b; Ward et al., 2020).

During the assessment, Link Workers employ active listening skills to identify the service-users' needs and priorities (National Association of Link Workers, 2019a), which is crucial for developing a trusting, genuine and caring relationship (Anfilogoff, 2020b). This allows the Link Worker to be responsive to the service-user to collaboratively create an action plan (Wildman et al., 2019a). The action plan may involve referrals to different services, including local community groups. In cases where a community group is identified as suitable, the Link Worker may accompany the service-user to their first session to facilitate engagement (Anfilogoff, 2020b). Service-users and services themselves state this to be a key step for promoting engagement in a social prescription (Moffatt et al., 2017). Throughout the service-user's social prescription journey, which typically spans six to 12 weeks or longer depending on the scheme (Pescheny et al., 2018a; Sandhu et al., 2022b), the Link Worker regularly checks on their progress and addresses any additional issues that arise. Interviews with Australian Link Workers in Sharman et al. (2022) further outlined how overcoming barriers to attending a community resource and building confidence to attend a community resource were important skills for Link Workers in supporting a successful social prescription. These skills are undoubtedly beneficial for encouraging service-users to engage with their community and should be relevant for UK Link Workers, although the variability in length and type of scheme,

and workload level (i.e. a six-week scheme with high workload) may limit the capacity of UK based Link Workers to both overcome barriers and build service-user confidence to engage with community resources.

A Link Worker also collaborates with multi-disciplinary teams to support a smooth referral (NHS England, 2022b; NHS England & NHS Improvement, 2019). Communication is particularly important for Link Workers and GPs who have submitted a referral to the Link Worker. GPs wish to be updated on their patient's progress (Bertotti et al., 2018) with effective communication between GPs and Link Workers supporting open discussions to address any concerns that may arise. Open support of social prescribing by the local primary care network promotes such effective communications (NHS England & NHS Improvement, 2019). Communication is equally important between Link Workers and the third sector who provide community resources (NHS England, 2022b; South et al., 2008). Strong relationships with local Voluntary Community and Social Enterprise (VCSE) organisations are required to effectively support a social prescription (Anfilogoff, 2020b).

Link Workers require guidance to fulfil their responsibilities effectively. The National Association of Link Workers (NALW) serves as the primary professional network for Link Workers in the UK, providing them with necessary support (NALW, 2019a). NALW reports emphasise the importance of Link Workers being person-centred, empathetic, and skilled in active listening (NALW, 2019a; 2019b). The reports also highlight the need for Link Workers to access formal supervisory support (NALW, 2019b). However, concerns have been raised within the report (NALW, 2019a) and wider social prescribing literature (Moore et al., 2023), regarding the lack of formal training available to Link Workers, particularly in areas such as mental health, first aid, autism, and addressing social issues. Training is also needed to effectively support migrants who may have multiple needs. Link Workers believe that such training would enhance their ability to establish rapport with service-users and provide

appropriate referrals and advice. Formal supervisory support is also considered vital, although its availability varies depending on the location of the Link Worker (NALW, 2019b; Zhang et al., 2021). Additional support may be provided through guidance and toolkits. The next section outlines the different tools Link Workers may use to support their role.

Link Worker tools

Link Workers may utilise tools to help them provide a holistic and effective service. These tend to be outcome based, although more generalised toolkits have been created to support the referral process. Currently, there are no standardised screening tools or outcome measures for social prescribing within the UK (Alliance for Healthier Communities, 2020; Polley et al., 2020; Vidovic et al., 2021). Furthermore, the completion of multiple forms is thought to impede the patient-centred nature of social prescribing (Roland et al., 2020), indicating care may be required in how and when Link Workers engage in this process. A recent mapping review of social prescribing identified 387 unique outcomes across 87 social prescribing schemes across thirteen countries (Sonke et al., 2023). The most reported unique outcomes included general wellbeing, confidence, social isolation, GP visits, anxiety, physical activity, depression, and loneliness (Sonke et al., 2023).

Attempts have been made to establish a minimum standard of care across England with NHS England endorsing specific referral and assessment outcome tools for social prescribing, although these are not widely utilised across schemes. These tools included measures used in other healthcare sectors, such as the Patient Activation Measure (PAM) and the Office for National Statistics (ONS4) Wellbeing Scale (NHS England, 2019c). The ONS4 scale is a nationally validated measure that adequately captures change in wellbeing following social prescriptions (Mukuria et al., 2016; NHS England, 2019c; Vidovic et al., 2021). The PAM assesses one's confidence in managing their own health and wellbeing and whilst effective in

some healthcare settings (Roberts et al., 2016), the tool may not comprehensively support social prescribing service-users. Informal conversations with Link Worker participants during Study One (see Chapter Six) revealed concerns that the PAM does not adequately support a service-user to manage their health and wellbeing because it does not capture a service-user's full range of needs that impact their ability to manage their health and wellbeing. A pilot intervention study exploring the PAM's suitability for supporting stroke survivors' self-management, found that the PAM did not fully capture stroke survivors needs, with survivors perceiving themselves to be unable to manage their health and wellbeing, despite PAM scores indicating that they could (Kidd et al., 2015). Existing tools need to accurately assess and support a service-user to manage their health and wellbeing through a social prescription, thus the use of the PAM may not be appropriate for social prescribing due to the inconsistencies between recorded and perceived capacity to manage one's health and wellbeing.

Outside of the NHS, new tools are being developed alongside local social prescribing schemes. The Salford Social Prescribing Hub (SSPH), based at the University of Salford in Manchester, has developed a referral tool (detailed in Chapter Four) to help improve social prescribing outcomes for service-users (Bodell et al., 2019). Developed collaboratively with Link Workers, the SSPH offers a person-centred assessment tool developed from occupational science theory (Bodell et al., 2019). Occupational science suggests that social prescribing outcomes can be improved if a person balances a complex relationship between who they are, where they are based, and the occupation (activity) they engage in (Kielhofner, 2008). The tool can be utilised by varyingly experienced Link Workers and supports onward referrals for cases that cannot be covered by the social prescribing service and formal training on utilising the tool is provided (Bodell et al., 2019). Early thoughts from Link Worker participants in Study One (see Chapter Six) who reported trialling the tool have found it beneficial in centralising their role in social prescribing and helping service-users make the most of their social prescriptions.

The effectiveness of the Link Worker role

Limited research exists on the effectiveness of Link Workers in social prescribing (Kiely et al., 2019). Kiely et al. (2022) conducted a systematic review that included eight studies, five of which were randomised controlled trials, to assess the health outcomes and costs associated with Link Worker social prescribing pathways. However, due to the risk of bias from a lack of randomisation and inconsistencies between trial and control samples in the reported studies, the authors conclude there is limited evidence to support the effectiveness of Link Workers supporting improvements in health and well-being outcomes, enhancing primary healthcare utilisation, or reducing costs. Whilst Kiely et al. (2021b) have published a protocol for a randomised controlled trial investigating the effectiveness of a Link Worker social prescribing scheme for people with multimorbidity, following an uncontrolled pilot study (see Kiely et al., 2021a), the current breadth and quality of research restricts definitive conclusions regarding the effectiveness of Link Workers.

Some studies have shown promising results of Link Worker effectiveness. For instance, a before and after study demonstrated that Link Workers positively supported older individuals with complex multimorbidity in a holistic social prescribing service, leading to significant improvements in health, well-being, and goal fulfilment (Elston et al., 2019). However, the uncontrolled nature of the study means that the ability to assess the extent to which these health benefits are due to the Link Worker is limited. Additionally, a cohort study indicated that Link Workers effectively empowered service-users to manage Type 2 diabetes, with significant improvements in glycaemic control compared to a control group (Wildman & Wildman, 2021). Nevertheless, greater quantitative evidence is needed to establish the overall effectiveness of Link Workers in supporting service-users.

Qualitative research offers valuable insights into the effectiveness of Link Workers. Moffatt et al. (2017) conducted semi-structured interviews with service-users to explore their experiences

of a Link Worker pathway supporting long-term conditions. Thematic analysis revealed that service-users highly valued the non-judgmental and personal approach of Link Workers, which fostered trust and positive engagement with the social prescribing scheme, aligning with findings in Dayson and Leather's (2020) social prescribing evaluation. The positive relationship with Link Workers empowered service-users, enabling them to feel in control of their treatment, aligning with findings from Wildman and Wildman (2021), and led to positive behavioural changes, improved health-related behaviours, enhanced mental well-being, reduced social isolation, and practical advice on addressing issues such as debt. These findings highlight the holistic nature of the Link Worker role in effectively managing long-term conditions and associated health determinants. However, these studies do not capture a service-users level and intensity of engagement with socially prescribed resources, thus it is uncertain whether the reported health and wellbeing benefits in these studies are solely due to the Link Worker role, or the Link Worker supporting engagement with appropriate community resources.

Knowledgeable and skilled Link Workers are important to facilitate effective social prescribing and social prescriptions (Husk et al., 2019). Conducting follow-up interviews with participants from Moffat et al. (2017), Wildman et al. (2019b) further emphasises how Link Workers acted as a gateway to social prescribing, facilitating initial and continued engagement in referral activities. Positive and trusting relationships with Link Workers encouraged service-users to attend referrals and sustain positive changes in behaviour, mental health, and socioeconomic aspects of health. Service-users reported long-lasting improvements and expressed confidence in managing their long-term conditions. The benefits outlined by these qualitative insights, coupled with the recognition of Link Workers as a core component of social prescribing, justify the focus on studying Link Workers in this thesis. Future work is required to determine whether the reported improvements in health and wellbeing can reach all service-users, whether they

are long-term in nature as opposed to periodic as suggested in Wildman et al. (2019b), and importantly, how best Link Workers can be supported to facilitate health and wellbeing benefits. Given the focal role that Link Workers have in facilitating social prescriptions, understanding the challenges they experience is essential for understanding the type of support Link Workers need to help them facilitate health and wellbeing improvements. One type of support suggested within this chapter and explored further in Chapter Four is an evidence-based toolkit.

The challenges facing Link Workers

Maintained UK governmental funding cuts to the public and voluntary services from late 2010 onwards (Jones et al., 2016) are believed to have caused extra workload for Link Workers (Laing et al., 2017; Wildman et al., 2019a), due to a reduced availability of suitable community resources increasing demand for social prescribing and waiting lists for referrals (Pescheny et al., 2018b; Skivington et al., 2018). High Link Worker turnover further impedes relationships between Link Workers and their communities (Pescheny et al., 2018a; Skivington et al., 2018). In their qualitative interview study, Skivington et al. (2018) found high staff turnover in community resources resulted in poor working relationships because key contacts were lost. Furthermore, Pesceheny et al. (2018a) found that weak organisational relationships added a sense of unpreparedness for Link Workers, which impacted service progression and slowed development of an effective system. This may be due to external partners having unrealistic expectations of Link Workers (Brunton et al., 2021; Rhodes & Bell, 2021), reflecting a limited understanding of social prescribing.

Frostick and Bertotti (2019) conducted interviews highlighting various challenges faced by Link Workers. Their thematic analysis revealed that Link Workers needed sufficient time and space to address service-users' concerns, and that maintaining visibility to healthcare

professionals while promoting the service was time-consuming. The study also emphasised the importance of relevant training for Link Workers, including mental health, benefits, and safeguarding. These findings align with the concerns expressed in the study by Laing et al. (2017), and the NALW (2019a; 2019b) reports where Link Workers felt ill-prepared for the complex and diverse nature of their role.

The rapid recruitment of Link Workers to meet the NHS's social prescribing target may contribute to the training needs, as some Link Workers report feeling rushed into the role without adequate support in establishing a social prescribing service (Brunton et al., 2021; Moore et al., 2023; Rhodes & Bell, 2021). Furthermore, the training provided to Link Workers may vary depending on the social prescribing provider. Rhodes and Bell (2021) found that NHS-based Link Workers received basic training with limited opportunities for development, while Link Workers from VCSE organisations had more opportunities for growth. In contrast, Pedro et al. (2021) suggested that NHS-based Link Workers in primary care networks were more integrated into social prescribing, while VCSE-based Link Workers, particularly those employed by the National Association for Voluntary and Community Action, felt more isolated. These discrepancies indicate that the available training may not be comprehensive enough to support the Link Worker role. To address this, it is recommended that Link Workers have access to evidence-based training that supports complex needs and environments to appropriately address the health inequalities experienced by service-users.

Situating social prescribing in policy

Policies promoting social prescribing gained momentum during the late 2000's, aligning with the personalisation movement in health and social care (Department of Health, 2008). The movement aimed to empower individuals to have a stronger voice in the support they received. Social prescribing, when implemented effectively, enables service-users to self-manage their

health and wellbeing. It serves as a mechanism for integrating primary care with broader health and care systems, promoting empowerment, and reducing the burden on primary care services (Brunton et al., 2021; Islam, 2020).

Between 2010 and 2020, social prescribing witnessed a significant increase in usage (Holt et al., 2021) due to policy changes, investments in social prescribing, growing pressures on GPs and a recognition of the influence of psychosocial factors on overall health (Anfilogoff, 2020b; Howarth & Donovan, 2019; Husk et al., 2020; Rolewicz et al., 2020). Social prescribing was seen as a solution to such concerns because of its capacity to address health inequalities within communities, which aligned with recommendations from the Marmot Review (Marmot, 2010) and the 'Big Society' initiative developed by the UK coalition government promoting third sector partnerships within communities (Thomson et al., 2015). The Health and Social Care Act (Department of Health, 2012) and 'A No Health Without Mental Health Strategy' (Department of Health, 2011), further endorsed the need for a multi-agency approach to managing healthcare. Consequently, social prescribing switched from a bottom-up policy to a top-down policy in 2012 (Dayson, 2017), to support its wider adoption.

The largest policy shift involved the NHS adoption of social prescribing to support person-centred care policies. From 2014, the NHS has widely promoted social prescribing (Husk et al., 2020), incorporating it into their Five Year Forward View (NHS England, 2014), their long-term 40-year plan (Annual report of the Chief Medical Officer, 2018; Howarth et al., 2021; Howarth & Donovan, 2019) and their current comprehensive Model of Personalised Care (Figure 2.2, Howarth et al., 2021; NHS England, 2019b).

Figure 2.2 outlines how social prescribing can provide universal, targeted, and specialist support based on the needs of service-users. Successful social prescribing schemes in the NHS involve appropriately trained Link Workers, multi-stakeholder collaboration to provide

community resources, support for community groups, streamlined referral processes, person-centred approaches, and the measurement of common outcomes (NHS England, 2022b).

Figure 2.2

Model showing a standard social prescribing scheme, developed by NHS and stakeholders (NHS England, 2019b)

Social prescribing is also a solution for tackling the loneliness epidemic impacting approximately 1.4 million people across the UK, with expectations for 2 million people to be impacted by loneliness by 2025/2026 (Age UK, 2021). Loneliness is defined as "a subjective, unwelcome feeling, or lack, or loss of companionship. It happens when we have a mismatch

between the quantity and quality of social relationships that we have and those that we want" (Coughtrey et al., 2019, p. 7). In 2018, the UK Government published a strategic framework to reduce loneliness entitled 'A connected society: A strategy for tackling loneliness – laying the foundations for change'. This framework identified social prescribing as a means to reduce loneliness (Coughtrey et al., 2019; HM Government, 2018). However, the implementation of social prescribing varies across different localities (Foster et al., 2021) which may lead to the marginalisation of the loneliness agenda in some areas.

To support the expansion of social prescribing, the NHS extended funding from 2020 to recruit Link Workers to primary care networks in their attempt to reach an additional 2.5 million people via social prescribing and achieve a target of referring 900,000 individuals by 2023/24 (NHS England, 2019b). The investment in social prescribing, including the addition of 1,000 Link Workers by 2021 (Bertotti et al., 2019), indicates a significant commitment and validation of personalised community treatment (NHS England, 2020). Therefore, social prescribing is deemed a priority initiative to be implemented in every GP practice by 2024 (Bertotti et al., 2019; Howarth et al., 2021; Husk et al., 2020).

Strengths and limitations of social prescribing

Research conducted in the 2020s indicates that social prescribing has been beneficial for various population groups, including young people (Bertotti et al., 2020c), early year caregivers (Mills et al., 2021), people with dementia (Giebel et al., 2022), and veterans (Yitka et al., 2022). Evaluations of social prescribing programs and national reviews have reported similar positive outcomes including reductions in smoking, addiction, depression, anxiety, and improved social relationships (Bertotti et al., 2020b; Chatterjee et al., 2018; Dayson & Damm, 2020; Dayson & Leather, 2020; Fleming et al., 2020; Gallagher, 2020; Jones et al., 2021; O'Connor et al., 2021; O'Hara, 2021). Of these nine evaluations, five found statistically significant results. The

remaining four evaluations provided descriptive statistics and did not comment on their significance (Chatterjee et al., 2018; Dayson & Damm, 2020; Dayson & Leather, 2020; Fleming et al., 2020) and reported qualitative data (Fleming et al., 2020). Bertotti et al. (2020b) found statistically significant improvements in life satisfaction, health, health-related quality of life, and mental wellbeing in service-users accessing a London based social prescribing service. Gallagher (2020) reported statistically significant improvements in participants' mood and wellbeing, compared to a control group in their randomised controlled trial of an arts intervention. Utilising a survey, Jones et al. (2021) evaluated the Bristol Ageing Better project, finding statistically significant improvements in social and emotional isolation, active engagement in social activities, wellbeing, health-related quality of life, and health. O'Conner et al. (2021) assessed survey and GP feedback data, finding statistically significant improvements in wellbeing in service-users accessing a Merton social prescribing service. Finally, O'Hara et al. (2021) conducted a mixed method study consisting of a pre-post design and semi-structured interviews. They reported statistically significant improvements in functional quality of life, depression, and engagement in leisure and work activities, alongside reductions in fatigue related distress in cancer survivors accessing social prescribing. Effect sizes were not discussed in any of these studies; however, the evidence suggests that social prescribing can lead to improved health and wellbeing outcomes.

Social prescribing also shows promise for reducing social isolation, loneliness, and reliance upon primary care (Alliance for Healthier Communities, 2020; Dayson et al., 2020; Giebel et al., 2022; Griffiths et al., 2022; Jones et al., 2021; Kellezi et al., 2019c; O'Connor et al., 2021), aligning with current health improvement goals (Wakefield et al., 2019). Several studies have found statistically significant reductions in loneliness and inappropriate GP appointments (appointments due to social rather than health determinants) among service-users (Foster et al., 2021; Jones et al., 2021; O'Conner et al., 2021). Qualitative data further revealed

improvements in self-esteem, confidence, wellbeing, increased long-term condition management, and reduced strain on healthcare services in service-user accounts (Chatterjee et al., 2018; Giebel et al., 2022; Kellezi et al., 2019c; Polley et al., 2017a; Thomas et al., 2021; White, 2020). However, reduced healthcare usage may only occur in service-users who fully engage with social prescribing, emphasising the need for person-centred approaches (Polley et al., 2017a). Despite these positive findings, there are some critiques of social prescribing including inadequate evidence for its effectiveness, limitations in addressing loneliness, barriers to engagement, and a lack of a comprehensive theoretical framework guiding social prescribing.

Unsatisfactory evidence for social prescribing

Current research into the effectiveness of social prescribing is unsatisfactory due to several methodological limitations and challenges (Costa et al., 2021; Bickerdike et al., 2017; Htun et al., 2023; Islam, 2020; Jani et al., 2020; Reinhardt et al., 2021). Quantitative evidence supporting social prescribing is lacking, with few randomised controlled trials and poor study designs that are prone to bias and confounding factors, suggesting that the enthusiasm for social prescribing may be premature (Bickerdike et al., 2017; Hermann et al., 2021). For example, quantitative investigations may lack a control group, have short follow-ups and missing data within investigations and written reports (Bickerdike et al., 2017; Hermann, et al., 2021; Husk et al., 2019; Percival et al., 2022). Systematic reviews echo these constraints alongside the methodological challenges of defining an appropriate control group, measuring multiple health and wellbeing outcomes, and gaining consent from multiple parties (Bickerdike et al., 2017; Husk et al., 2019; Pescheny et al., 2018a; Polley et al., 2017a; Thomas G. et al., 2021; Vidovic et al., 2021). The lack of quality quantitative evidence is discouraging, given the strength of the reported benefits in qualitative research, and is concerning given the mass rollout of social prescribing within the NHS. Efforts are being made to address these limitations, such as

ongoing randomised controlled trials and continued sustained National Institute for Health and Care Research funding (see Kiely et al., 2021a; Thomas et al., 2020).

Longitudinal research is also necessary to investigate the long-term benefits of social prescribing (McDaid et al., 2019) because most quantitative studies had focused on short-term outcomes of six months or less (Bickerdike et al., 2017; Vidovic et al., 2021). Research findings on the sustainability of benefits are inconclusive and hindered by a lack of inferential statistics in some studies. A cohort study by Bertotti and Temirov (2020) suggests that wellbeing increases for the first three months before stagnating at six-month follow-up. A lack of visibility and availability of social prescribing activities may challenge recruitment for research studies, leading to poor quality research (Husk et al., 2020; Islam, 2020; Pilkington et al., 2017). Difficulties in identifying social prescribing initiatives and insufficient community infrastructure to support and receive social prescriptions also impede evaluations of social prescribing (Alliance for Healthier Communities, 2020; Bickerdike et al., 2017; O'Callaghan, 2021; Simpson et al., 2021; Tierney et al., 2022). Given these limitations, future research should employ thoughtful approaches, including well designed randomised controlled trials and longitudinal studies to improve understanding of the effectiveness of social prescribing.

Barriers to engagement

Barriers to engagement in social prescribing are influenced by contextual factors that are crucial for successful engagement, including one's location in comparison to suitable and available community activities, availability of face-to-face interactions, and length of time spent with a service-user (Bertotti et al., 2018). The perceived time commitment required for social prescriptions can also hinder engagement because the scheme is often novel to service-users who need education and trust-building (O'Callaghan, 2021; Simpson et al., 2021; White et al., 2022). This may be off-putting to those invested in social prescribing, as tangible results may not be instantaneously visible (Islam, 2020), especially where a lack of service availability

is due to limited funding (Hamilton-West et al., 2020) and sustainability concerns impact who can be supported within an area (Bertotti et al., 2020a; Bertotti et al., 2020c, Islam, 2020; Jani et al., 2020; Kelly et al., 2021; Ladds, 2021). Whilst these issues are important, service-user disengagement may be more concerning.

Attrition poses a major challenge in social prescribing, with dropouts occurring at various stages. Limited engagement is observed with initial Link Worker appointments and social prescribing referrals in systematic and critical reviews (Bickerdike et al., 2017; Polley et al., 2017a), with one social prescribing scheme reporting that 5% of service-users referred to the service did not attend their Link Worker appointment, and 10% of service-users declined to access their social prescription (SPRING social prescribing, 2020). Six percent of these service-users were inappropriately referred to social prescribing with needs that could not be supported (SPRING social prescribing, 2020). Disengagement with either the Link Worker appointment or social prescription activity has been noted in eleven of 15 UK NHS-based social prescribing schemes, with four schemes showing a lack of engagement with both parts of the pathway (Bickerdike et al., 2017). Service-user anxiety, the need for support during access, and the risk of dependency on Link Workers contribute to disengagement (Brandling & House, 2009; Foster et al., 2021).

Other explanations for high attrition include a lack of suitable referrals into groups, service gaps in terms of activities available outside of working hours, and suitable referrals for specific groups, such as ethnic minority groups (Husk et al., 2020; Porter et al., 2022; Sandhu et al., 2022a; Tierney et al., 2022; Wildman et al., 2019a). These concerns are shared across the social prescribing literature. For example, Laing et al. (2017) reported that a lack of suitable referrals to Link Workers were day-to-day challenges. Unsuitable spaces for social prescribing assessments (Pescheny et al., 2018b) and slow integration of Link Workers into primary care (Chng et al., 2021), can increase the risk of dropout by impairing rapport building processes

e.g., between Link Workers and GPs and Link Workers and service-users. Effective relationships with GPs and service-users need to be built to support successful social prescriptions.

A lack of understanding of social prescribing among stakeholders further hampers engagement (Bickerdike et al., 2017; Brunton et al., 2021; Khan et al., 2022; Moore et al., 2022; Rhodes & Bell, 2021). Differing rates of onward referrals to secondary care (Grayer et al., 2008; Longwill, 2014; Polley et al., 2017a) may be due to inappropriate referrals into social prescribing limiting the support Link Workers can provide (Brown et al., 2021; Fixsen et al., 2020; Hamilton-West et al., 2020; Wildman et al., 2019a). How service-users access social prescribing may also impact attrition, with referred individuals more likely to engage than those who self-refer (Golubinski et al., 2020). Support throughout the social prescribing process and connection to suitable community resources are essential for encouraging engagement. Thus, understanding the reasons for disengagement is crucial, but accessing and studying disengaged service-users can be challenging. Since social prescribing aims to strengthen communities by increasing social connections, those who do disengage should not be ignored without understanding why.

Social prescribing's capacity to tackle loneliness

Vidovic et al.'s (2021) systematic review of 51 studies investigated social prescribing's ability to improve community wellbeing at the individual, system, and community level. They found that reducing loneliness, social isolation, and increasing trust and connectedness can lead to high wellbeing at each level. Improved individual health and wellbeing (individual level) contributes to increased community connectedness and social capital (community level), resulting in decreased demand for social prescribing and public services (system level). Statistically significant benefits in the review related to reduced loneliness, social isolation, increased wellbeing, and a sense of connectedness (Grant et al., 2000; Mercer et al., 2019;

Wakefield et al., 2022), although effect sizes were not discussed. Another review by Bild and Pachana (2022) identified increased social connection as one of the main benefits of social prescribing, attributed to decreased loneliness, improved belonging, and meaningful relationships. Despite these findings, concerns remain regarding social prescribing's capacity to effectively address loneliness due to inconsistency in measuring outcomes and a lack of standardisation on evaluating social prescribing schemes (Bild & Pachana, 2022; Vidovic et al., 2021).

A meta-synthesis of qualitative data from service-users who participated in a social prescribing scheme aimed at addressing loneliness and/or social isolation indicated that a lack of high quality randomised controlled trials impeded confidence in social prescribing's capacity to effectively reduce loneliness (Liebmann et al., 2022). Jones (2022) raised concerns about whether social prescribing provides sufficient support to overcome negative perspectives on social interactions, potentially leading to disengagement among lonely individuals who exhibit avoidant behaviours (Hawkley & Cacioppo, 2010; NIHR, 2021). Inappropriate referrals that do not meet the needs of lonely people may contribute to disengagement and reduced self-esteem (Jones, 2022). Likewise, loneliness is a subjective emotional state (Jones, 2022) and current measures of outcomes in social prescribing vary due to local need (Husk et al., 2019), complicating evaluations of successful social prescribing. Standardised outcome measures including a measure for loneliness have been proposed to address these issues (Herrmann et al., 2021; Vidovic et al., 2021) and refocus attention on social prescribing's potential to combat the loneliness epidemic in the UK.

Limited theoretical framework guiding social prescribing

Social prescribing has previously been criticised for lacking a formal theoretical framework (Bragg & Leck, 2017; Halder et al., 2018). The absence of a guiding theory may have contributed to the complexity and variability of social prescribing interventions. To address

this issue, Halder et al. (2018) proposed applying the Social Identity Approach to Health (SIAH) to social prescribing. This theory suggests that group memberships can act as a social cure for health concerns like loneliness. Vidovic et al. (2021) supported the use of this theory in showcasing community-level benefits, citing studies by Kellezi et al. (2019c) and Wakefield et al. (2022) as examples. These studies demonstrated the effectiveness of the SIAH in reducing primary care usage and loneliness through meaningful group memberships. Further information on these studies is provided in Chapters Three and Four which explores the SIAH and its importance for social prescribing in more detail.

Critics of social prescribing could suggest that health coaching models, such as the NHS health and wellbeing coach (NHS England, 2022b), offer evidence-based practice, however these cater to different needs and goals. These models primarily focus on managing long-term physical health concerns, setting health-promoting goals, and improving health-related quality of life through lifestyle behaviour changes (NHS England & NHS Improvement, 2020). This approach differs from the description of social prescribing and the Link Worker model described earlier in this chapter, which are a focal point in this thesis.

Chapter summary

To summarise, social prescribing is a widely endorsed health initiative that requires further research to establish the evidence base of social prescribing at a national and local level. Key components of successful social prescribing have been established, with the Link Worker model considered a critical feature. However, Link Workers require greater access to relevant training to adequately support them in their role. For social prescribing to effectively address the social determinants of health, including loneliness, there needs to be greater consistency in schemes regarding the outcomes they measure and the support they provide. Applying a theoretical framework that has universal implications to social prescribing and that supports

the provision of a good match that reduces loneliness, could strengthen the intervention's ability to support service-users and local communities, through evidence-based practice. One such theory is the SIAH. The SIAH has the capacity to identify facilitators of successful social prescriptions by understanding the impact of group experiences. The next chapter, Chapter Three provides a detailed overview of the SIAH, before the theory is applied to social prescribing in Chapter Four.

Chapter 3: The Social Identity Approach to Health

Chapter overview

Prior to applying the SIAH to social prescribing in Chapter Four, this chapter establishes the theoretical framework for understanding the health and wellbeing benefits of community group social prescriptions. It introduces the significance of group memberships in shaping our health and wellbeing. Our communities and social groups shape who we are and therefore, influence our health and wellbeing (Jetten et al., 2017). Meaningful group memberships that provide a sense of belonging and satisfy psychological needs offer the greatest health and wellbeing benefits because they foster group identification (Bowe et al., 2020; Greenaway et al., 2016; Haslam et al., 2021a; Jetten et al., 2012; Wakefield et al., 2019). Multiple group memberships increase these benefits (Jetten, 2014; Wakefield et al., 2019), especially during stressful situations such as life transitions (Iyer et al., 2009; Haslam et al., 2019b). However, not all group memberships benefit health and wellbeing (see Cohen, 2004; Kellezi & Reicher, 2012; Kellezi et al., 2019b), indicating that consideration is required when contemplating how social identification enhances our health and wellbeing. This chapter introduces the Social Identity Approach before outlining how social groups can provide a 'social cure'. The chapter finishes by exploring social identity-based interventions and the Social Identity Model of Behaviour Change.

Origins of the Social Identity Approach

Social psychologists queried the psychological reasoning behind the atrocities of World War II, such as the holocaust (Hornsey, 2008). Early theories considered irrational manifestations of prejudice (Dollard et al., 1939), where intergroup interactions (between group interactions) were viewed as a result of interpersonal processes (individual interactions), rather than separate processes (Hornsey, 2008). These conceptualisations remained until the late 1970's, where

debates surrounding group processes were in an "era of crisis" (Hornsey, 2008, p. 205). This crisis stemmed from a lack of confidence in how social psychological theory had progressed, with group process theorising being critiqued for being too narrow. During this crisis era, the Social Identity Approach (SIA) was developed, consisting of the Social Identity Theory and Self-Categorisation Theory.

Social Identity Theory

The Social Identity Theory was developed following Henri Tajfel's minimal group paradigm studies which found that social identification occurred in minimalistic groups, indicating that a meaningful connection between a person and a group was not necessary for group-based behaviour (Tajfel et al., 1971; Tajfel, 1972; Tajfel, 1978). Social identification refers to the psychological process of defining oneself as a member of a social category, such that one develops a psychological connection and sense of belonging to the category and adopts the categories norms, behaviours, and views (Tajfel, 1978).

The theory states that one categorises themselves and others into groups, constructing order within the social environment and shaping one's self-concept (Ashforth & Mael, 1989; Tajfel, 1978). Our self-concept is our understanding of who we are, which varies between our personal and social identity. Personal identity reflects one's sense of self as an individual where behaviour is defined by unique characteristics including attitudes, emotions, memories, and values (Tajfel, 1982). In contrast, social identity involves comparing shared qualities that make us similar to other group members, where behaviour is influenced by group norms, attitudes, and emotions rather than personal attributes (Postmes et al., 2005). Group norms refers to the values, beliefs, and actions pertinent to the purpose of the group (Brown & Pehrson, 2019; Steinel et al., 2010).

Categorisation involves inductive and deductive processes that shape one's understanding of themselves, and others based on the categories one belongs to, such as ethnicity, nationality, religion, or occupation (Tajfel, 1982). Inductively, individuals are assigned to a category based on an attribute that is perceived to be representative of an exemplary member of that category. Deductively, individuals are assigned an attribute based on being a member of that category. The attribute itself is context-dependent and varies depending on the saliency of a category (Tajfel, 2010).

When individuals perceive themselves as similar to other group members, they categorise themselves as ingroup members, creating a sense of "us," while dissimilar groups are categorised as the outgroup, "them" (Hornsey, 2008; Tajfel, 1982). Categorisation covers all social categories, including age, gender, and employment status (Tajfel & Turner, 1986) and one can identify with multiple groups simultaneously. Incorporating a group into one's social identity involves categorising oneself as a group member, where membership must hold some meaning or value (Haslam, 2004; Hogg & Abrams, 1989; Jetten et al., 2015).

Group memberships serve as a source of self-esteem and pride, leading to a motivation to achieve positive self-evaluation by differentiating one's group positively from others (Tajfel, 2010; Turner, 1982). Festinger's (1954) drive for social comparison supports positive evaluation in Social Identity Theory from an ingroup versus outgroup perspective. A desire for positive social identification increases the connection to groups that are considered to be representative of oneself. Simultaneously, the desire to distance oneself from dissimilar groups grows (Hornsey, 2008). Thus, positive differentiation involves enhancing similarities within the ingroup compared to an outgroup, and maintaining a positive self-concept, which reduces uncertainty, enhances self-esteem, and provides structure and meaning to one's life (Hornsey & Hogg, 2000; Trepte & Loy, 2017). Consequently, group members actively promote the ingroup to maintain a positive and distinct identity from relevant outgroups (Ashforth & Mael,

1989; Hornsey, 2008; Trepte & Loy, 2017). However, ingroup status can be threatened. The model of intergroup dynamics outlines the strategies one can engage in if one's group is threatened.

Model of intergroup dynamics

In situations where the ingroup lacks positive distinctiveness (perceptions that the ingroup is more favourable than relevant outgroups), due to identity threats or discrimination, group members may adopt one of three social mobility strategies based on their group identification and status (Spears, 2011; Spears et al., 2001; Wann & Branscombe, 1990). The choice of strategy depends on the permeability of group boundaries (whether one can easily move between groups).

When the ingroup is threatened and group boundaries are permeable, ingroup members may leave the threatened group and join a higher status group (social mobility strategy) to maintain positive distinctiveness (Hogg & Abrams, 1989; Abrams & Hogg, 1990; Jackson et al., 1996). When group boundaries are impermeable, ingroup members may engage in collective strategies that change the status of the whole ingroup (Abrams & Hogg, 1990; Jackson et al., 1996). Ingroup members may either confront outgroup members to change the status quo (Social change strategy) or find new positive dimensions of comparison to enhance ingroup distinctiveness (social creativity strategy, Abrams & Hogg, 1990; Jackson et al., 1996)

In summary, according to the Social Identity Theory, individuals categorise themselves and others into social groups, selectively comparing them to establish and maintain positive identification in relation to relevant outgroups. Group membership is internalised as a representation of the self, and the emotional connection and value attached to these group memberships influence both group and individual behaviour. In response to threats to positive identification, individuals employ various strategies to maintain individual positive

distinctiveness or enhance the positive distinctiveness of the whole ingroup. However, occasionally intragroup tensions (between the group memberships that one belongs to) occur, which are best explained by the second component of the SIA, the Self-Categorisation Theory.

The Self-Categorisation Theory

Turner et al. (1987) developed the Self-Categorisation Theory to refine the cognitive element of categorisation in Social Identity Theory, proposing that self-definition covers three levels of identity inclusiveness rather than an interpersonal-intergroup spectrum. These reflect human identity referring to one's self-concept as a human being compared to other species (superordinate level), social identity referring to one's self-concept as a member of a social group compared to other outgroups (intermediate level), and personal identity referring to the self as an individual compared to other individuals (subordinate level; Turner et al., 1987). The salience of a context influences which identity level is activated and the centrality (importance) of that identity which influences behaviour (Bosak et al., 2021; Hogg & Rinella, 2018; McLeish & Oxoby, 2011).

Salience

A social identity is salient when one perceives themselves to be a group member, with identity salience influenced by accessibility and fit (Hogg & Rinella, 2018; Oakes et al., 1991). Identity salience may also shift between identity levels when the salient identity is threatened (Jackall, 1978; Verkuyten & Hagendoorn, 1998). During social prescribing, the social context and stage of a social prescription may influence identity salience and whether a service-user sees themselves as an individual person accessing a service or a member of a group that they can access.

Accessibility and fit

Prior experience of categories influences the accessibility of a category for self-definition (Jetten et al., 2010; Turner et al., 1982). Fit has two forms outlining how social categories best reflect and represent differences in the real world (Turner et al., 1987). When the differences within a group are smaller than the differences between ingroup and outgroup members (comparative fit), there is greater sense of fit and stronger identification (Haslam et al., 2018; Turner et al., 1982). This interaction represents the meta-contrast ratio (Turner et al., 1987). The second form of fit (normative fit) refers to the extent that the behaviour of a social category reflects the expectations (stereotypes) for that category; greater fit occurs when the social behaviour of a group member matches stereotypical expectations of that group (Hornsey, 2008; Turner et al., 1987).

Salience and self-stereotyping

In Self-Categorisation Theory, high group saliency increases the likelihood of depersonalisation (Turner et al., 1987), which involves 'self-stereotyping' (Haslam et al., 2018, p.42) oneself as similar to and sharing a common fate with the average group member. One subsequently aligns themselves with the prototypical behaviour expected of group members, adopting the group norms (Hornsey, 2008; Leach et al., 2008). Group prototypes provide clear guidance on how members should behave to fit within the group, with greater prototypicality increasing the likelihood of norm adherence (Hohman et al., 2017; Turner et al., 1987), which boosts positive identification.

In summary, individuals categorise themselves as ingroup members when the social category holds value and is accessible in a given situation, leading to social identification. The salience of one's identity triggers depersonalisation, causing individuals to adopt group norms and think and behave as prototypes of the group. At this stage, individuals experience shared group

membership by focusing on salient similarities among ingroup members rather than the differences with outgroup members.

Towards a Social Identity Approach to Health

The SIA has been influential in explaining stereotyping (Haslam et al., 1992), crowd behaviour (Reicher, 1987), conformity and social influence (Turner, 1991), self-esteem (Abrams & Hogg, 1989), and group-based emotions (Smith, 1993). More recently, there has been a shift towards applying the SIA to understand the processes promoting health and the role of groups in health outcomes (Jetten et al., 2012).

Early research outside of the SIA highlighted the connection between social relationships and health (House et al., 1988). Research exploring social relationships and mortality showed that individuals with strong family and friend ties or those belonging to social or religious groups had lower mortality rates (Berkman & Syme, 1979), while those leading solitary lives had higher mortality rates (House et al., 1982). These findings suggested that strong social relationships have a protective effect on health and wellbeing.

A meta-analysis conducted by Holt-Lunstad et al. (2010) further supported the positive influence of social relations on health. Analysing 148 studies from mostly western, individualistic cultures, the researchers found that strong social relations were associated with increased life expectancy by up to 50% compared to poor social relations. The authors consider this finding to reflect similar effects to that of ceased smoking on mortality. While the existing research emphasises the individual perspective when examining health outcomes, there has been a neglect of the psychological importance of groups. The body of research investigating this dynamic between group memberships and health has been coined the ‘social cure’ (Jetten et al., 2012) approach, otherwise known as the Social Identity Approach to Health (SIAH). Before exploring the benefits of group memberships for health, the researcher acknowledges

that this approach may not be a universal remedy for all health ailments, particularly where medical intervention is required. Thus, a SIAH approach may be best integrated into existing medical frameworks to form a biopsychosocial approach to healthcare (Haslam et al., 2018) that comprehensively supports health and wellbeing.

The Social Identity Approach to Health

The SIAH challenges the traditional medical model of healthcare by recognising the influence that social factors have on health and wellbeing (Halder et al., 2018). Building on social identity research, this approach emphasises that group memberships can positively impact the health of individuals if they identify with the group (Dingle et al., 2021; Halder et al., 2018; Haslam et al., 2017; Jetten et al., 2014; Stevens et al., 2021; Wakefield et al., 2019) and engage with the group in a psychologically meaningful way (Jetten et al., 2015; Wakefield et al., 2022). Defining oneself in terms of group memberships influences how one perceives and copes with stressors, interacts with primary healthcare, and responds to social support, all of which influence health and wellbeing (Jetten et al., 2012).

The Transactional Model of Stress

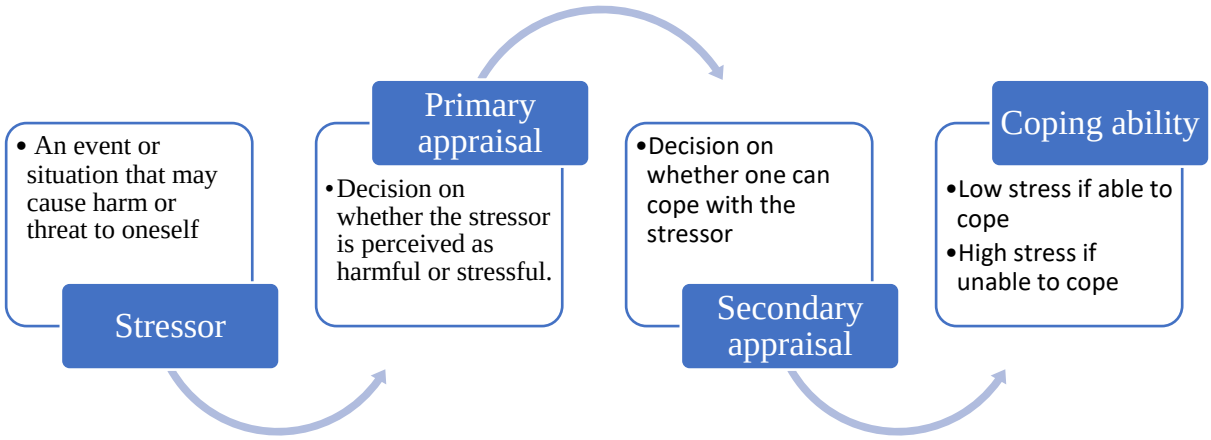
Early models of the social cure rooted in Folkman's and Lazarus (1984) transactional model of stress, propose that identifying with a group can influence one's perception of and response to stressors (Wakefield et al., 2019). Figure 3.1 illustrates this process: encountering a potentially stressful situation initiates a primary appraisal to determine if it is a threat, followed by a secondary appraisal to assess one's ability to cope.

Inappropriate coping strategies elicit a high stress response. Both in-group and outgroup processes and resources influence this process. Ingroup opinions play a crucial role in evaluating stressors (Haslam et al., 2004), as they are more trusted and influential during the primary appraisal stage. If a stressor is deemed threatening, individuals with stronger

identification are more likely to provide and receive support from other ingroup members during the secondary appraisal, compared to outgroup members (Folkman & Lazarus, 1984).

Figure 3.1

A diagram of the stress appraisal process (Folkman & Lazarus, 1984)



Social support, encompassing verbal and nonverbal communication, reduces uncertainty and anxiety related to stressors which enhance coping ability depending on the type of support received (Haslam et al., 2018; McNamara et al., 2021a; Sias & Bartoo, 2007). Social support can range from general day-to-day support to targeted support addressing specific issues, involving emotional, informational, or tangible assistance (Schaefer et al., 1981), with the type of support received dependent upon the strength of identification. For instance, Haslam et al. (2005) found that stronger group identification led to increased perceived social support, resulting in lower stress levels and higher life satisfaction ratings among individuals recovering from heart surgery or working in high-stress occupations. These findings remained consistent across various stressors, including traumatic situations. Kellezi et al. (2009) surveyed war

survivors and observed that those who perceived the war as affirming their national identity reported fewer mental health problems (e.g., anxiety, depression) compared to those who did not find the war identity affirming. Family support was found to moderate this relationship, highlighting the importance of both the meaning assigned to the experience and the social support received in influencing stress coping mechanisms. In a social prescribing context, this research suggests that there should be some meaning or value attached to a community resource and that social support should be provided for social prescribing to be effective at improving health and wellbeing. The following section explores the group dynamics necessary to facilitate and sustain social identification and subsequent improvements in health and well-being.

Group dynamics influence social identification

Limited research has focused on identifying the key group processes that facilitate social identification. Joining a group offers advantages such as increased social support, friendships, improved self-esteem, and opportunities to learn new skills. However, joining a group also has disadvantages including time, effort, and personal resources required to join (Hogg & Abrams, 1993), as well as potential anxiety or stress (Brown & Pehrson, 2019). The level of identification an individual has with the group influences their health and wellbeing by shaping their perception of receiving psychological resources from the group (Häusser et al., 2020). For social prescribing, the SIAH suggests that connecting service-users to community groups that facilitate social identification may provide the health and wellbeing outcomes that social prescribing intends to achieve, such as reduced healthcare usage and improved management of health and wellbeing in response to stressors (NHS England, 2019b; Public Health England, 2019).

This section delves into the intragroup dynamics crucial to forming, joining, and maintaining groups. These include psychological need satisfaction, accessibility, fit, shared similarities,

group cohesion, ingroup interactions, shared realities, and the presence of subgroups. The purpose of this section is to outline the intricacies in facilitating social identification and highlight the importance of these dynamics in fostering, developing, and sustaining social identity.

Accessibility and fit facilitates social identification

Groups form when a collection of people perceive themselves to share a common identity with each other, compared to relevant outgroup members (Hogg & Rinella, 2018). A group needs to be cognitively accessible to an individual for them to self-categorise as a group member (Hogg & Williams, 2000; Hornsey, 2008; Khan et al., 2020). Prior social experiences influence how accessible a group is perceived to be (Hogg & Williams, 2000; Hornsey, 2008; Jetten et al., 2010; Oakes et al., 1991). Greater accessibility increases a person's readiness for categorisation, which influences perceptions of fit (Hogg & Rinella, 2018). Accessibility can be influenced by one's current aspirations, goals, and motivations for joining a group (Tarrant et al., 2020). The more one's values, beliefs and actions fit or reflect the group's identity, the stronger the perceived sense of connectedness to the group will be, strengthening social identification over time (Çelebi et al., 2017; Kyprianides et al., 2019). Consequently, fit supports group identification by promoting a cognitive switch between perceptions of being in a group, to having an intertwined fate with the group.

Groups satisfy psychological needs and improve wellbeing

People are more likely to join and stay in groups that satisfy basic psychological and emotional needs such as self-esteem, belongingness, meaningful connections, a sense of control, competence and relatedness (Greenaway et al., 2016; Haslam et al., 2021a; Jetten et al., 2017; Kyprianides et al., 2019; Williams, 2009). Groups that hold personal value or meaning are more likely to foster social identification, which satisfies these psychological needs and provides access to curative psychological resources such as social support (Draper & Dingle,

2021; Greenaway et al., 2016; Jetten et al., 2015) and autonomy (Kounderberg et al., 2017; Kyprianides et al., 2019).

Shared similarities facilitate social identification

When individuals consider joining a group, they assess the degree of similarity between themselves and other group members (Brown & Pehrson, 2019). This assessment is influenced by numerous factors, including personal traits, gender, social motives, and prior group experiences. It is crucial that groups initially hold some interest, meaning, or value for prospective members (Jetten et al., 2012). Groups that do not hold meaning or value to an individual may be uncomfortable for people to engage with, as experienced by social prescribing service-users in Stuart et al.'s (2021) interview study exploring why lonely and isolated people do not engage with social prescriptions.

Meaningful group identification has positive implications for health and wellbeing, granting individuals greater access to psychological resources such as social support and autonomy (Jetten et al., 2017; Koundberg et al., 2017; Kyprianides et al., 2019). Social support is thought to drive the relationship between social identity and health (Freak-poli et al., 2021; Sani, 2012), with increased social support both directly impacting health improvement via reduce blood pressure, and indirectly via buffering the negative impacts of stress through enhanced coping abilities (Häusser et al., 2020; Sani, 2012). Groups that foster a sense of belonging and provide greater access to social support encourage social integration through the adoption of normative behaviours associated with the group (Jetten et al., 2012; Thoits, 1983).

Group cohesion maintains social identification

Maintaining group membership reflects a commitment to the group (Levine & Moreland, 1994). Self-Categorisation Theory suggests that commitment to a group depends on greater prototypicality between group members, creating ingroup cohesion (Hogg & Turner, 1987;

Sani et al., 2009). Ingroup cohesion involves trust, with trust being built through self-categorisation processes. Trust involves having confidence in the goals, intentions, and sincerity of others (Tanis & Postmes, 2005), which is necessary for enabling interactions and developing a sense of connection among group members (Haslam et al., 2018; Tarrant et al., 2020). A lack of trust can lead to suspicion regarding the provision of social support, limiting the curative benefits of group membership.

Trust can also be an outcome of group identification. When shared group membership is salient, expectations of reciprocity and support foster trust among ingroup members (Tanis & Postmes, 2005). Greater similarity between ingroup members increases the presence of trust (Brown & Perhson, 2019; Ferguson & Peterson, 2015). This suggests that once someone self-categorises as a group member, the individual should trust the group. However, identity salience and conformity to group stereotypes can influence the degree to which trust is present within a group (Abrams & Hogg, 1998).

Ingroup interactions maintain social identification

Trust between group members also supports maintained social identification and engagement with a group. The more visible one's involvement and commitment to the group is, the more trusted and valued that person's contributions become. This can enable a more positive standing within the group, even for in-group critics, who are considered less threatening and more constructive to the group, if they are perceived to be a valued exemplar of the group (Hornsey, 2006). This is because perceived member prototypicality influences the groups commitment to support a member and a member's commitment to the group. Strength of commitment can change over time, due to shifts in the group prototype or the categorisation process defining the prototype (Brown & Pehrson, 2019). Specific dynamics that improve group cohesion and promote trust include similarity, physical proximity, successful

cooperation towards a shared goal (Brown & Pehrson, 2019), and autonomy on choosing to belong to the group (Turner, 1984).

Shared realities facilitate and maintain social identification

Our social need to verify our experiences can be achieved by seeking shared realities with similar others (Hogg & Rinella, 2018). Greater similarity to ingroup prototypes strengthens group identification through a stronger sense of shared reality. This shared reality enhances a sense of shared connection within a group (Hogg & Rinella, 2018), reflecting shared interests among members. Shared realities also bolster the provision of social support (Jetten et al., 2014). When group members collaborate to achieve shared goals, it reinforces their sense of belonging and helps them define their roles within the group, leading to sustained commitment (Tarrant et al., 2020). One group type that fosters shared realities are dieting groups, such as Slimming World. Pallister et al. (2009) found that dieting groups promote close social relationships and a shared responsibility for maintaining the diet together. Furthermore, the health benefits extend not only to individual members but also to their families, suggesting that strong relational ties can influence health behaviour in both individuals and their wider social networks (Pallister et al., 2009). Social prescribing ethnography research further attests to the health benefits of dieting groups such as Slimming World becoming a shared family project (Moffat et al., 2023).

Fulfilling shared goals can also increase the perceived effectiveness of the ingroup, empowering individuals to manage and cope with stressors (Relke et al., 2021), thereby enhancing their sense of control. Exploring a group-based programme for managing morbid obesity in the UK, Tarrant et al. (2017) interviewed 20 participants engaged in the programme. Participants reported that they were encouraged to interact with each other and share experiences, fostering trust and cohesion between group members due to a sense of similarity between group members that was strengthened through shared experiences. The shared

experiences fostered social support between group members, which fostered commitment towards a shared goal of managing obesity through a collective commitment to lifestyle change (Tarrant et al., 2017).

The more one engages with group members and participates in activities reflective of the group's norms, the more prototypical one becomes which increases positive social identification, self-esteem, and self-worth (Code & Zapryniuk, 2010; Newman & Newman, 2001). The desire to maintain positive distinctiveness further influences this process. Experimental research by Kyprianides et al. (2019) demonstrated that group identification enhanced positive mood, outlook on life, and life satisfaction, due to the strong feelings of connectedness and self-worth groups provided.

The risk of subgroups when maintaining social identification

Where a group responds to new members in a warm, sharing way that introduces members to group norms, these dynamics can be enhanced (Brown & Pehrson, 2019). However, the formation of cliques or subgroups within a group could deter new members from joining if they feel excluded or perceive themselves to be outsiders (Cole, 1954; Martin et al., 2014; Parker, 2014). Cliques often have distinct norms and boundaries separate from the wider group and tend to be more homogeneous, representing a subset of members who have formed a closed friendship within the wider group (Adler & Adler, 1995; Cohen, 1977; Dunphy, 1963). Cliques can disrupt the formation of a shared social identity (Martin et al., 2014; Parker, 2014) as clique members interact more with each other than with the wider group (Adler & Adler, 1995; Cohen, 1977). Therefore, it is important to closely monitor intragroup dynamics and discourage cliques to ensure new members feel welcomed, valued, and able to interact with and develop a sense of belonging to the group they join. Social prescribing research outlines how strong personalities within support groups and cliques within larger groups can deter service-users

from feeling a part of the group they are connected to (Stuart et al., 2021), increasing the likelihood of disengagement.

In summary, when individuals join a group, they must perceive that the group is accessible, that they fit the group, and that it fulfils their psychological needs and provides psychological resources. Simultaneously, prospective members themselves must be ready and willing to engage with the group. The group must be welcoming, offering a meaningful connection based on shared interests or similarities, with prospective members actively choosing to participate. When these dynamics are met, new members are more likely to feel a sense of belonging and connection to the group. This motivates adherence to group norms and engagement in prototypical behaviours, reinforcing the sense of belonging and the perception of available support. Sustained engagement in prototypical behaviour and group activities helps provide new members with purpose and meaning. The salience of shared commonalities between prospective and existing members further sustains the sense of belonging through shared realities. Over time, these factors contribute to the development of social identification within the group.

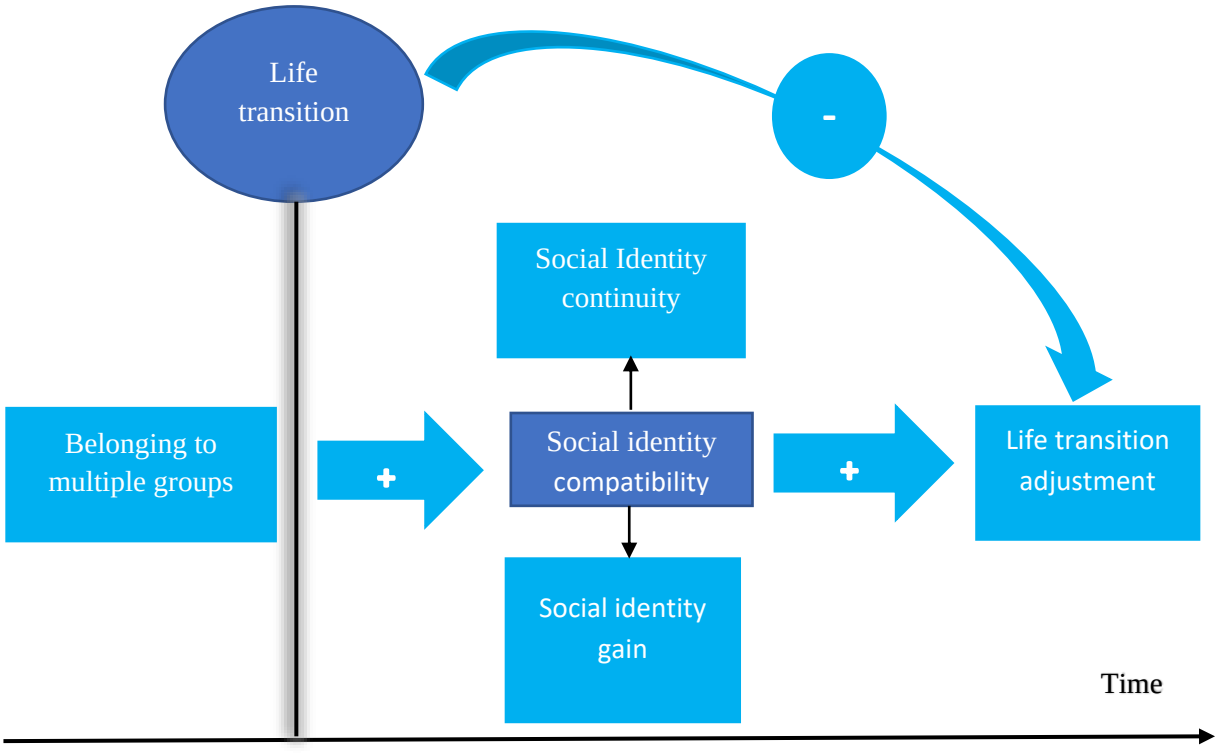
Multiple group memberships and health and wellbeing

Group memberships have a cumulative effect on health, with multiple memberships providing access to beneficial groups, psychological resources, and health benefits (Brown & Pehrson, 2019; Haslam et al., 2019b; Putnam & Feldstein, 2004; Stevens et al., 2021; Wakefield et al., 2019). Identifying with multiple group memberships positively impacts health behaviour and mental health (Miller et al., 2015; Sani et al., 2015a; Cruwys et al., 2013; Sani et al., 2015b), with variety of social groups rather than frequency of contact being associated with a lower risk of heart disease and mortality (Barefoot et al., 2005).

Multiple group memberships are particularly beneficial during life transitions, as they support identity maintenance or gain pathways that protect health and wellbeing (Haslam et al., 2008; Iyer et al., 2009; Jetten, 2014; Wakefield et al., 2019; Cruwys et al., 2020b; Haslam et al., 2021a). Whether maintaining existing groups or developing new group memberships supports health and wellbeing, depends on the context of the transitional event and the compatibility of one's existing social identity with the prospective group identity (Haslam et al., 2019b). The Social Identity Model of Identity Change (SIMIC, Haslam et al., 2021b) outlines when identity gain and identity continuity improves health and wellbeing during life transitions. Figure 3.2 displays the SIMIC, the shaded life transition line represents a period of uncertainty that may compromise one's social identity through identity change or loss of central group memberships (Iyer et al., 2009, Haslam et al., 2019b; Seymour-Smith et al., 2017; Wakefield et al., 2019).

Figure 3.2

The Social Identity Model of Identity Change representing the life transition of retirement (Haslam et al., 2019b)



The identity continuity pathway reflects how maintaining existing group memberships during life transitions negates the harmful impacts associated with membership loss, improving health and wellbeing (Cruwys et al., 2020a; Haslam et al., 2021a; Jetten et al., 2015; Seymour-Smith et al., 2017). Maintaining existing group memberships provides increased access to psychological resources supporting individuals through life transitions and maintains self-continuity, a continuous sense of self across one's past, present, and future (Sedikides et al., 2018).

The loss of central group memberships during transitions is associated with negative mental health outcomes (Haslam et al., 2019b; McNamara et al., 2021b; Seymour-Smith et al., 2017; Wakefield et al., 2019). A study by McNamara et al. (2021b) found that firefighters attributed their occupational role as a central part of their self-concept, which was lost when they entered retirement, resulting in a loss of meaning in life that was associated with reduced health and wellbeing. Acquiring new group memberships through the identity gain pathway in Figure 3.2, can compensate for the loss and add meaning and support to one's life (Cruwys et al., 2014a; Haslam et al., 2019b; Haslam et al., 2021b; Jones et al., 2012; McNamara et al., 2021b).

Acquiring new group memberships is thought to enhance the repository of support that is provided when one belongs to multiple social groups (Boden-Albala et al., 2005; Jetten et al., 2008; Jetten et al., 2015; Miller et al., 2015). Where one cannot maintain existing group memberships, having multiple central group memberships prior to a life transition can support people in acquiring new group memberships (Haslam et al., 2019b). When new groups are compatible, support self-continuity, and add meaning or value to a person's life, they become more central to one's social identity. Social prescribing's dedication to person-centred care should support service-users to acquire new group memberships that are tailored to their interests and needs, adding value to a person's life (NHS England, 2019b). Lonely service-users may best benefit from interventions that support them to acquire new compatible group

memberships (Cruwys et al., 2021; Dingle et al., 2021, given that loneliness is defined in social identity terms as a lack or loss of group memberships and identities (Hayes et al., 2022).

Prior social experiences influence the compatibility of new or existing group memberships during life transitions. Memory loss, e.g., due to dementia, can disrupt self-continuity and hinder the acquisition of new group memberships (Jetten et al., 2010). Similarly having preconceptions of certain health conditions, such as diabetes, could threaten the compatibility of existing or new group memberships due to stigma (perceived negative social appraisal of diabetes) and lifestyle changes (having to use injections, dietary changes etc.) during health-based transitions (Schabert et al., 2013). Maintaining supportive existing group memberships can increase one's coping capabilities, however acquiring new group memberships with others sharing the conditions (creating reduced stigma) may better support one through the transition. Initiatives and group-based interventions have been developed based on the SIMIC to support the acquisition of new group memberships as discussed in the next subsection.

Interventions designed to facilitate identity gain and maintenance

Haslam et al. (2019b) utilised the SIMIC to develop Groups4Health, a social health initiative designed to alleviate the stress of social disconnectedness during life transitions. It helps maintain and build compatible group memberships, fostering group connections and protecting health and wellbeing (Haslam et al., 2018; Haslam et al., 2019b). The program contains five modules: schooling, scoping, sourcing, scaffolding, and sustaining (Haslam et al., 2016). A key component is the creation of a social identity map which allows one to reflect on the compatibility of their existing group memberships. This helps one to recognise the positive and negative aspects of their group memberships and work towards building more positive connections.

Studies investigating the effectiveness of Groups4Health have shown significant improvements in health and wellbeing among non-clinical (Haslam et al., 2016) and clinical populations (Cruwys et al., 2021; Haslam et al., 2019a). It has been found to be as effective as cognitive behaviour therapy for supporting depression, and slightly more effective than cognitive behaviour therapy in addressing loneliness in young people during a three-month trial (Cruwys et al., 2021). A large effect size (d = -1.07) was reported at 12-month follow-up for improved loneliness, indicating significant long-term benefits. However, further research is required to assess the intervention's effectiveness in different populations.

Expansions of the Groups4Health programme have included the Groups2Connect and the Groups4Belonging intervention. Groups4Belonging is tailored for individuals recovering from substance use disorders, adapting and extending the original program to address specific challenges faced in substance abuse treatment (Dingle et al., 2021; Ingram et al., 2020). It incorporates mindfulness-based cognitive-behavioural therapy elements to target addiction-related barriers to supportive social connections (Dingle & Sharman, 2022). Initial findings suggest that Groups4Belonging is a feasible intervention with promising demand, acceptability, and participant satisfaction (Ingram et al., 2020). A feasibility trial is currently ongoing (Dingle et al., 2021).

Alternatively, Groups2Connect is a condensed version of Groups4Health designed as a short 15-minute activity to support and sustain positive online group connections, particularly during the COVID-19 pandemic (Bentley et al., 2021). It aims to increase awareness of various group memberships and provides a structure for setting social connectedness goals. Preliminary evidence indicates that Groups2Connect is a feasible intervention that improves social connectedness, health, and wellbeing (Bentley et al., 2021), with effect sizes (d) ranging from .15 - .74.

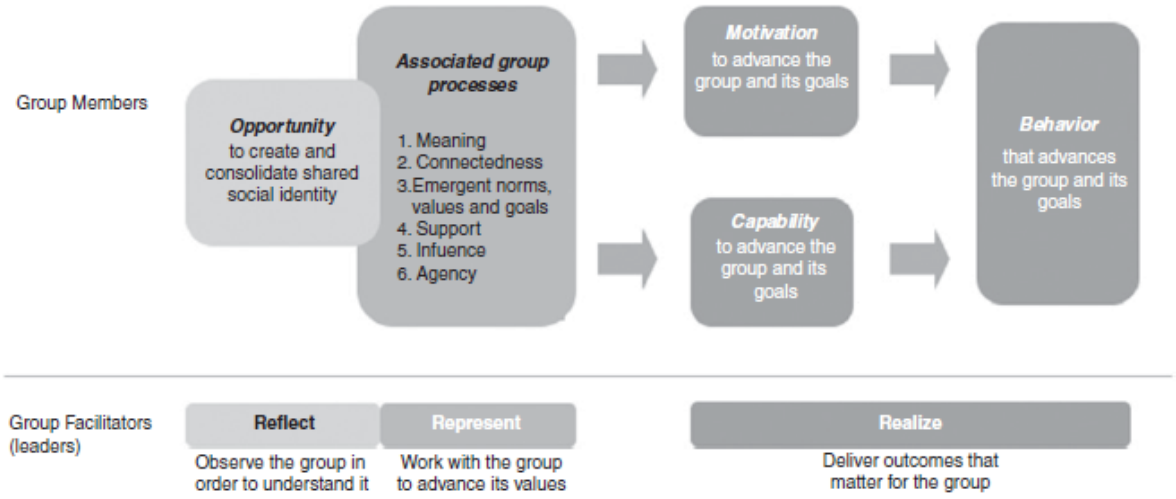
While these interventions show promising results, larger scale randomised controlled trials are necessary to establish their true effectiveness at improving health and wellbeing through increased social connections. To support the development of group-based interventions that utilise group processes to foster health-related behaviour change. Tarrant et al. (2020) have proposed a Social Identity Model of Behaviour Change (SIMBC), discussed below.

The Social Identity Model of Behaviour Change

Utilising six hypotheses proposed by Haslam et al. (2018), Tarrant et al. (2020) developed the SIMBC (Figure 3.3). The hypotheses intended to support behaviour change through promoting a shared social identity and included the meaning hypothesis, the connection hypothesis, the support hypothesis, the norm enactment hypothesis, the influence hypothesis, and the agency hypothesis (Haslam et al., 2018).

Figure 3.3

The Social Identity Model of Behaviour Change (Tarrant et al., 2020)



SIMBC aims to support researchers and practitioners to design group interventions that consider contextual factors such as the target population, the desired behaviour to change, and the intervention setting, by utilising social identity principles to promote behaviour change (Tarrant et al., 2020). Promoting behaviour change is relevant to social prescribing as the initiative aims to promote continued engagement with the group, so that service-users can be supported to change their behaviour (NHS England, 2019b; NHS England & NHS Improvement, 2020). To self-manage one's health and wellbeing, service-users are encouraged and supported to make lifestyle changes that promote healthier behaviours that are maintained (NHS England & NHS Improvement, 2020).

According to the SIMBC, three leadership processes facilitate the development of a shared and positive social identity during an intervention: identity reflection, identity representation, and identity realisation. These processes involve the group leader encouraging members to reflect on their collective values and goals, clarifying the group's identity, and promoting actions that reinforce the group's importance. The intervention leader(s) should foster a group environment that encourages members to perceive themselves as part of a collective by addressing readiness, fit, and depersonalisation. However, the utility and effectiveness of this model in supporting desired behaviour changes during group interventions still requires further evidence, with a manualised version of the model currently being feasibility tested to explore its capacity to support positive behaviour change in group-based interventions targeting obesity in the UK (Swancutt et al., 2022).

Chapter summary

The SIA outlines how people categorise themselves and others into groups based on similarity, fit, and accessibility, leading to psychological connection and a sense of belonging. The SIAH expands on this by highlighting how group identification provides access to psychological

resources that promote individual health and wellbeing. Multiple group memberships enhance access to these benefits. Facilitating and maintaining identification involves various group processes, such as accessibility, fit, connectedness, shared realities, trust, cohesiveness, need satisfaction, belonging, and social support. Interventions based on the SIAH have shown effectiveness in promoting positive health and wellbeing, particularly by addressing psychosocial factors like reducing loneliness through increased social connection. The SIAH thus offers a theoretical framework that could support social prescribing in addressing psychosocial factors, by supporting service-users to reconnect and identify with their community. The next chapter explores the relevance of the SIAH for social prescribing, why it appears to be a better fit to other theories currently being applied to social prescribing such as occupational science (Doble & Santha, 2008), and how social identification can support successful social prescriptions to community groups.

Chapter 4: Social prescribing as a social cure

Chapter overview

This chapter focuses on applying the SIAH to social prescribing, examining the social cure mechanisms that contribute to its potential effectiveness. It explores key group processes such as accessibility, fit, psychological need satisfaction, and shared similarities, and argues that these are crucial for promoting social identification in social prescribing. The chapter presents evidence from studies highlighting the group processes underlying the health and wellbeing benefits of social prescribing (Kellezi et al., 2019c; Wakefield et al., 2022), as well as instances where these processes may not be curative (Stuart et al., 2021). Furthermore, it outlines the group processes relevant to the Link Worker assessment and referral to a community group, emphasising how these processes are addressed in a Community Prescribing Toolkit based on the SIAH. The Toolkit intends to assist Link Workers in facilitating social identification through social prescriptions to appropriate community groups. The chapter justifies the pivotal role played by Link Workers in fostering group identification. It also discusses and evaluates existing toolkits and their limitations in contrast with the proposed Community Prescribing Toolkit. Lastly, the chapter introduces the research environment of the PhD program and provides a summary of its relevant key features.

Does social prescribing align with a Social Identity Approach?

Social prescribing policies aim to reduce loneliness, health inequalities, and barriers to engagement in community resources, and promote health and wellbeing by connecting people to community groups that foster a sense of belonging (NHS England, 2019c; NHS England, 2020; Public health England, 2019). Link Workers provide personalised support to empower service-users in managing their health and well-being, as well as assess and enhance community capacity to meet their needs (NHS England, 2019a; NHS England, 2022b).

The outcomes of social prescribing according to designers, commissioners, and deliverers of social prescribing schemes include improved resilience, self-confidence, self-esteem, mental health, quality of life, reduced primary care utilisation, improved community resilience, and decreased isolation (Polley et al., 2017b). Link Workers aim to facilitate these outcomes by adopting a person-centred approach, using active listening and motivational interviewing techniques (person-centred conversations that promote acceptance and compassion) to promote positive behavioural changes through shared decision-making and reflective listening (Anstiss, 2021; Lee et al., 2022; NHS England, 2019c; Resnicow & McMaster, 2012). The SIAH outlines that group belonging can improve health and wellbeing by satisfying psychological needs and providing access to social support (Greenaway et al., 2016; Kyprianides et al., 2019), which aligns with social prescribing's aim to improve health and wellbeing by connecting people to community groups that foster belonging (NHS England, 2019b). Although, it is unclear from Greenaway et al. (2016) whether group identification satisfies the full range of psychological needs, such as autonomy, relatedness, and competence, that could also be met through identification. Despite this, social identification within groups has been found to reduce isolation, improve self-confidence and self-esteem, and provide opportunities for community involvement (Greenaway et al., 2016; Kyprianides et al., 2019; Steffens et al., 2016). Given that Link Workers assess service-users' needs and aim to connect them with suitable community groups (not always successfully as noted in Chapter Two), they are ideally situated to provide social prescriptions that facilitate group identification. The following section explores the existing evidence for the SIAH as a theoretical framework for social prescribing.

Social cure mechanisms for social prescribing's success

Chapter Two introduced Kellezi et al. (2019c) and Wakefield et al. (2022) as leading researchers applying the SIAH to the same social prescribing scheme. In Kellezi et al. (2019c) the team of researchers report a mixed-method study involving interviews with healthcare staff and patients, as well as a longitudinal survey with 630 service-users at a four-month follow-up. The study explored whether social cure processes captured the experiences of healthcare staff and patients, and whether those processes explained the effect of the social prescribing pathway on healthcare usage. Patients expressed the benefits of receiving social support from community groups, including reduced anxiety, decreased isolation, increased motivation, and a sense of being understood. However, some patients reported facing challenges in joining these groups due to anxiety related to meeting new people. Consequently, the Link Worker role was highly valued by patients for their support, empathy, and consideration. Quantitative findings demonstrated that community belonging mediated the relationship between increased group memberships and reduced primary healthcare usage through decreased loneliness at four-month follow-up. These findings outline how social prescriptions to community groups might improve wellbeing, by presenting multiple group memberships and community belonging as mechanisms that can improve wellbeing.

The team of researchers in Wakefield et al. (2022) further expanded on this evidence by examining the longitudinal impact of social cure processes on service-users' quality of life during a social prescription. Data from three time-points were analysed and included 632 service-users at baseline, 178 service-users at four-month follow-up, and 63 service-users at six-nine-month follow-up. Quality of life positively correlated with increased group memberships examined across engagement with the social prescribing pathway, social support, and community belonging, while negatively correlating with loneliness at baseline. The number of group memberships at baseline predicted quality of life at a 4-month follow-up,

indicating a positive influence of group memberships on long-term wellbeing. This relationship was not reciprocal (Wakefield et al., 2022), implying that the number of groups a person belongs to predicts their future health rather than their health predicting group membership. Mediation analysis further revealed that increased group memberships positively predicted quality of life by fostering community belonging, social support, and reducing loneliness. These improvements in health and well-being were maintained at a later follow-up, even though group memberships declined. These findings underscore the importance of community belonging, social support, and reduced loneliness as active group processes influencing the effectiveness of social prescriptions.

The results from both Kellezi et al. (2019c) and Wakefield et al. (2020) suggest that promoting a sense of belonging is a crucial aspect of social prescribing and may explain the improved health and well-being outcomes, including reduced loneliness. Therefore, social prescribing schemes that prioritise fostering a sense of belonging may yield optimised benefits for service-users. These findings have implications for the development of social prescribing programs, as variables such as community belonging, social support, loneliness, health-related quality of life, and group memberships may be overlooked depending on the type and purpose of the social prescribing scheme and its target population. Therefore, focusing on developing tools and knowledge on how to nurture processes of social identification during social prescribing appears to be a logical extension of this research, enhancing our understanding on how and why social prescribing is effective, and when it is not.

Social prescriptions that do not facilitate a social cure

Stuart et al. (2021) conducted longitudinal qualitative research as part of a larger social prescribing project with Age UK Exeter, focusing on understanding why certain lonely and isolated individuals who are not receptive to group-based activities do not engage with community groups. The study involved eleven participant interviews with older adults and

highlighted how social identification processes can act as barriers to joining a group. Some service-users mentioned personal barriers relating to past traumas, lack of social experience, shyness, and prior health problems, which made group settings uncomfortable for them (Stuart et al., 2021). Service-users who had negative experiences with groups may require additional time and support to find a suitable community group. The Community Prescribing Toolkit is aiming to increase the likelihood of connecting service-users with groups they can identify with by taking the necessary time to align the group to the service-user's social identity and needs, and vice versa. Consequently, insights from group-based interventions (Haslam et al., 2019b) and social prescribing service-users (Stuart et al., 2021) suggests that social connections may need to be scaffolded to encourage service-users to attend and join groups. However, time constraints within social prescribing services may hinder the provision of such scaffolded support, especially for services offering short-term rather than long-term assistance (Islam, 2020).

Likewise, engaging and maintaining participation in groups posed challenges for some service-users in Stuart et al. (2021), including difficulties fitting in, social anxiety, low self-esteem, and discomfort in social settings. Unwelcoming or unaccommodating groups further exacerbated these issues. Chapter Two previously acknowledged how anxiety can be a barrier to attending social prescribing and subsequent social prescriptions (Dayson & Leather, 2020). Thus, service-users experiencing shyness, anxiety, or low self-esteem may require ongoing support to encourage their engagement. In their SIMBC model, Tarrant et al. (2020) recommended assessing identification at various time points throughout an intervention due to its complex and time-consuming nature. Consequently, the Community Prescribing Toolkit includes acknowledgment of the time required to facilitate group identification.

Scaffolded support (Haslam et al., 2019b) can involve assessing the fit between the service-user and potential groups (Turner et al., 1987), considering factors such as similarity to other

group members and alignment with the service-user's sense of identity as suggested by Stuart et al. (2021) and Tarrant et al. (2020). Stuart et al. (2021) also acknowledged that barriers may accumulate over a lifetime, resulting in complex needs that are challenging to address within a single group setting. Thus, social prescribing should cater to the needs of individuals who are not inclined to join groups due to long-standing preferences. Some service-users may feel obliged to participate in unsuitable groups, emphasising the importance of offering options that meet their specific requirements, such as open spaces, non-pressured socialisation, escape routes, and mental health support. Supporting service-users in this way may help improve sustained long-term engagement in group social prescriptions which has been highlighted as a concern in prior research by Halder et al. (2019). Services that provide support for six to twelve weeks, which is the recommended standard for most NHS-based social prescribing schemes, may not allow sufficient time for the development of group identification and social cure processes. Such time limited social prescriptions may impact participants' perceptions on the presence of group processes and the utility of a toolkit to support Link Workers to facilitate social identification if they are not given adequate time to support service-users through a social prescription.

Facilitating social identification during social prescriptions

Given the focal role of the Link Worker in social prescribing for supporting service-user engagement with social prescriptions (Halder et al., 2019), it is essential to consider how Link Workers can best be supported to connect service-users to groups that can become curative through identification. A theoretically informed toolkit that applies the SIAH and wider group processes from the SIA to the social prescribing referral process could support Link Workers to provide curative social prescriptions. A toolkit was considered optimal over a training course because of its reviewability, flexibility, and utility in various settings (Hempel et al., 2019;

Theole et al., 2020). Toolkits support the implementation of evidence-based interventions or best practice (Hempel et al., 2019), and can be easily accessed repeatedly in comparison to training courses that may be accessed solely during the time of the course. Repeated access to a toolkit combined with its flexibility to be utilised in differing contexts, with differing service-users, is particularly beneficial for supporting Link Workers to facilitate social identification during the variable social prescribing schemes (Ladds, 2021). However, there are no guidelines, definitions, or standard approaches towards creating toolkits (Davis et al., 2017; Hempel et al., 2019; Theole et al., 2020), with some toolkits failing to outline how to implement toolkit guidance into real world practice (Theole et al., 2020).

As stated in Chapter One, this programme of research aims to create a SIAH based toolkit, which Link Workers can use to increase the likelihood of service-users being matched to community groups they can identify with. This toolkit will contain real-world examples of how to apply the guidance into practice, to overcome some of the existing limitations associated with the creation of toolkits (Theole et al., 2020). As indicated in Kellezi et al. (2019c) and Wakefield et al. (2022), a service-user's health and wellbeing is more likely to improve if they are connected to community groups that they can develop a sense of belonging with, one of the key components of social identification (Leach et al., 2008). Shared group identification is likely to facilitate access to social support from other group members, whilst potentially satisfying psychological needs for belonging, self-esteem, and self-efficacy (Greenaway et al., 2016). These dynamics may potentially support the social prescribing outcomes of reduced loneliness, improved confidence, and self-esteem (Polley et al., 2017b), and may improve health and wellbeing. How this can be achieved is explored next by focusing on the group dynamics relevant to the Link Worker assessment and group connection processes of a social prescription.

Social identity processes during a social prescription

Service-users can be referred into social prescribing through their GP, other non-health and healthcare professionals, and where possible, through self-referral (Garside et al., 2020) as outlined in Chapter Two. Once a Link Worker receives a service-user, they typically conduct an initial introductory phone call, before organising a time and date for a face-to-face assessment (Wildman et al., 2018). Service-user's users then experience two parts to social prescribing, 1) the Link Worker assessment process and 2) the referral to a community resource process (Runacres, 2022) once a service-user has selected a group to attend. These two processes will be the focus of the Community Prescribing Toolkit as these processes are where identity-based information can be discussed and then matched against the available resources in the community.

The Link Worker assessment process

Chapter Two provided an overview of the Link Worker model in social prescribing, emphasising the importance of the interaction between Link Workers and service-users in facilitating appropriate referrals to community resources. Link Workers use motivational interviewing techniques during conversations with service-users to encourage self-disclosure of their needs and goals (Anstiss, 2021; NALW, 2019a). Link Workers then match this information against the available community resources, such as local community groups (Anfilogoff, 2020b; Wildman et al., 2019a). However, barriers to engagement can arise when referrals do not consider factors such as interests, perceived accessibility (e.g., mobility, capability, similarity to others, etc.), and cultural needs (Wildman et al., 2019a; 2019b). To address this, Link Workers should consider identity-based information, including cultural identities, gender, age, interests, hobbies, shared similarities, and psychological needs when suggesting community groups (Greenaway et al., 2016; Hogg & Rinella, 2018; Tajfel & Turner, 1986).

Prior experiences also play a crucial role in shaping one's readiness to identify with a group (Jetten et al., 2010; Tarrant et al., 2020). For some social prescribing service-users in Stuart et al.'s (2021) interview study, a lack of prior positive social experiences in childhood prevented them from identifying with groups during adulthood due to a persistent feeling of being an outsider. Link Workers should gather information about prior experiences during the assessment process to understand a service-user's needs and preferences. Drawing on social identity research, positive experiences contribute to group engagement and social identification, whilst negative experiences hinder group engagement and identification (Abrams & Hogg, 1989).

The Community Prescribing Toolkit intends to support Link Workers in providing a good fit by highlighting the types of social identity-based information (e.g., prior experiences, age, shared similarities, potential barriers, group experiences) they can discuss during their conversations with service-users. A conversational framework in the toolkit should support Link Workers to discuss such topics and match them against the available community groups to recommend the most suitable options. When suggesting potential groups, Link Workers should provide detailed information about the group. Providing such descriptions increases the level of personalisation necessary for service-users to understand why a group can benefit them and for finding the right fit (Aughterson et al., 2020).

The referral to a community resource process

Having chosen a potentially suitable community group, the service-user needs to be supported to access the group. Community groups need to be welcoming to new group members to optimise the likelihood for social identification (Kraut et al., 2012; Tarrant et al., 2020) and facilitate maintained engagement with a social prescription (Stuart et al., 2021). Responding positively to new members by welcoming them into the group and teaching them the group norms can facilitate a sense of belonging (Kraut et al., 2012), whilst an unwelcoming group

could foster disengagement as seen with social prescribing service-users in Stuart et al. (2021). Group leaders can help service-users feel welcomed into the group by being friendly, displaying a positive attitude, empathising with service-users, and encouraging group member interactions (Borek et al., 2019b). A Nottinghamshire social prescribing evaluation by Halder et al. (2019) outlines how being welcomed into a group by the group leader was perceived to support a positive group experience for service-users that encouraged maintained engagement with a social prescription. Furthermore, service-users are more likely to consider the group beneficial for satisfying their needs if they have a positive group experience. Borek et al. (2019b) developed the mechanisms of action in group-based interactions framework (MAGI), applying it to health-based support groups. This framework outlines key action mechanisms that facilitate social identification and positive behaviour change. Within this framework and Tarrant et al.'s (2020) SIMBC model, group leaders are considered influential for fostering positive group processes that facilitate social identification. These action mechanisms include facilitating member introductions, setting group goals, communicating clearly with members, presenting, and adhering to the group norms and providing members with group roles. Encouraging group discussions and interactions is also beneficial for providing social support and fostering group identification. Group leaders who are relatable or considered peers are more effective at facilitating social identification (Borek et al., 2019b). The Community Prescribing Toolkit thus considers these action mechanisms, including the need to be welcoming in a guidance document for group leaders supporting social prescribing. Aside from the Community Prescribing Toolkit developed during this PhD Programme, to the researcher's knowledge at the time of writing this thesis, there were only two theoretically informed toolkits created for utilisation in social prescribing. These toolkits are not universally utilised and are explored below.

Supporting Link Workers to promote a social cure

Two toolkits have been created that present similarities to the Community Prescribing Toolkit developed throughout a series of studies described in this thesis (see Chapters Seven to Nine). The first toolkit, underpinned by occupational science, is the Salford Social Prescribing Toolkit introduced in Chapter Two. The second toolkit, The Social Psychology of Social Prescribing Toolkit is underpinned by the SIAH and is designed to support the general operation of social prescribing.

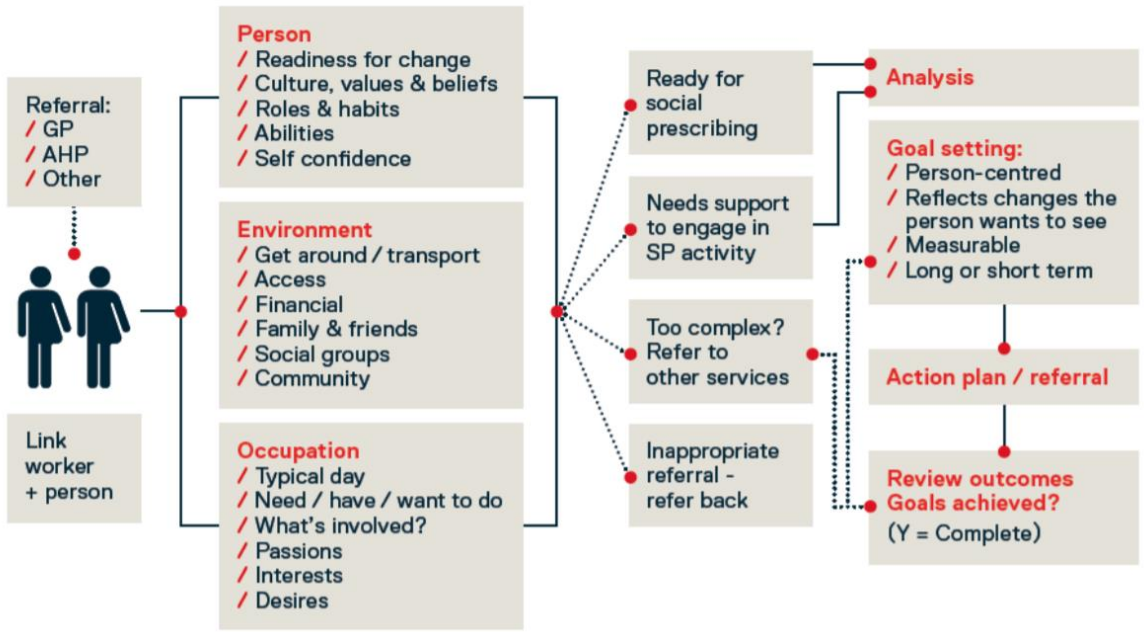
The Salford Social Prescribing Toolkit

The SSPH developed a licensed, person-centred assessment and planning toolkit informed by occupational science, the field of study guiding the practice of occupational therapy (Clark et al., 1991; Doble & Santha, 2008), to improve the outcomes of social prescribing for Link Workers and service-users (Bodell et al., 2019; SSPH, 2020b; 2020c). The Salford Social Prescribing Toolkit was developed based on the understanding that person-centred outcomes during social prescribing are related to how one feels about the activities they engage with (Polley et al., 2018; SSPH, 2020c). Occupational science was chosen as the theoretical framework because it focuses on human participation in meaningful and purpose-led activities (Bodell et al., 2019; SSPH, 2020b; 2020c), and can explain why social prescribing outcomes occur and improve consistency in social prescribing effectiveness. In occupational science, meaningful and purpose-led activities refer to those that reflect one's sense of capacity, values, interests, and spirituality (Clark et al., 1991; Doble & Santha, 2008; Kielhofner, 2008). Specifically, the toolkit utilises the Person, Environment, and Occupational (activity) Framework (Figure 4.1) of occupational science (Kielhofner, 2008; SSPH, 2020c), which is considered useful for understanding what a person does and how it makes them feel.

Effective social prescribing is thought to require careful alignment of the person, their environment, and the prescribed activity (Bodell et al., 2019; SSPH, 2020c). Figure 4.1 depicts a service-users journey through social prescribing using occupational science as a theoretical framework. The Link Worker considers the person, their environment, and the potential occupation to explore what support the service-user needs. Using this framework, Link Workers are then able to refer complex cases onto to other services who may be able to support the service-user (SSPH, 2020c).

Figure 4.1

The Person, Environment, and Occupation Model of occupational science applied to social prescribing in the Salford Social Prescribing Toolkit (Bodell et al., 2019)

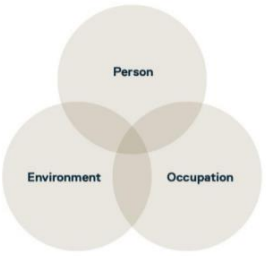


The toolkit was co-produced with social prescribing stakeholders (Link Workers, managers, and commissioners), and consists of a conversation framework, process flowchart, analysis framework, and an action plan (Bodell et al., 2019; SSPH 2020a; 2020c). These resources are accessible following training in the toolkit which includes a one-year license to use the toolkit. Consequently, precise details on each of the resources in the toolkit cannot be provided due to

the training requirements. However, Bodell et al. (2019) provided insight into the conversation framework (Figure 4.2). The conversation guidance was developed to help Link Workers co-design an action plan that is meaningful and useful to the service-user (SSPH, 2020c), relating to the wellbeing conversations that Link Workers have with service-users. The conversation guidance was intended to increase consistency of this process, following little documentation on how the conversation occurs in practice (SSPH, 2020c).

Figure 4.2

Examples of occupational science-based questions Link Workers can ask service-users using the Salford method (Bodell et al., 2019)



Person

Things to consider
/ Readiness for change
/ Culture, values & beliefs
/ Roles & habits
/ Abilities
/ Self confidence

Example questions
/ Why are you here?
/ What are you good at?
/ What roles/responsibilities do you have?
/ What's important to you?
/ What are the things you find difficult?
/ How do you feel about being part of a group?
/ Do you believe you can be successful?
/ What's stopping you from doing what you want?
/ How satisfied are you with your life?

Environment

Things to consider
/ Get around / transport
/ Access
/ Financial
/ Family & friends
/ Social groups
/ Community

Example questions
/ Where do you go regularly, how do you get about?
/ What makes it difficult for you to access certain places or services?
/ Who do you see or have contact with (and how often)?
/ Are you part of any groups?
/ Who/what around you makes you feel safe/content?
/ How satisfied are you with your environment?

Occupation

Things to consider
/ Routine
/ Choice
/ Control
/ Passions
/ Interests

Example questions
/ Describe a typical day/week
/ How do you feel about your [daily/weekly] activities?
/ How much choice do you feel you have in what you do?
/ How satisfied are you with what you do?
/ What do you love doing?
/ What keeps you going / makes you happy?
/ How would you like things to be different?

The conversation guidance was developed to help Link Workers co-design an action plan that is meaningful and useful to the service-user (SSPH, 2020c). The conversation guidance was intended to increase consistency of this process, following little documentation on how the conversation occurs in practice (SSPH, 2020c).

The topics covered in Figure 4.2 may also be relevant within a social identity-based toolkit. For example, when considering the person within the Salford toolkit, one question that may be asked is "How do you feel about being part of a group?" From a SIAH perspective, this question explores prior experiences of groups and whether someone would be ready to attend a group. According to Tarrant et al. (2020), perceiver readiness (see Chapter Three) to attend a group is important when engaging with group-based interventions. Those who are not ready may be more likely to decline or stop engaging with a group. When considering one's environment within the Salford toolkit, a Link Worker may ask "Who do you see or have contact with?" to explore a service-user's existing social network. Maintenance of existing social networks can be beneficial for health and wellbeing (Haslam et al., 2019b). Understanding one's existing social relationships is important for understanding whether identities can be maintained or whether identity gain needs to be explored (Haslam et al., 2019b). Finally, when considering a service-users occupation within the Salford toolkit, Link Workers may ask "What do you love to do?" From a SIAH perspective, this question may elicit responses on a service-user's interests and skills, which can be matched to groups that have shared characteristics.

According to the SSPH website, their toolkit was being pilot tested (SSPH, 2020c), and to the researcher's knowledge at the time of writing this thesis in 2023, there are no formal publications detailing the development or pilot of the toolkit. However, insight from participant interviews in Chapter Seven suggests that the toolkit was distributed to some social prescribing services in Nottinghamshire, with some participants reporting they had received training in it.

Whilst occupational science focuses on what *is* meaningful to an individual, the SIAH focuses on what can *become* psychologically meaningful to an individual, and *why* it is meaningful using psychological insights (Haslam et al., 2018; Wakefield et al., 2019). For a community group to become psychologically meaningful, one must identify with the group. Facilitating group identification is a complex process involving considerations of need satisfaction

(Greenaway et al., 2016), fit and accessibility (Hogg & Williams, 2000; Turner et al., 1987), shared similarities with group members and the group prototype (Brown & Pehrson, 2019; Hogg & Rinella, 2018), and existing group dynamics, including ingroup cohesion (Hogg & Turner, 1987), trust (Ferguson & Peterson, 2015), being welcoming (Brown & Pehrson, 2019), and managing subgroups (Parker, 2014).

Whilst the Salford toolkit appears to be a well-defined package undergoing efficacy testing, the full process of social prescribing may have been overlooked. For example, the Salford toolkit focuses on the Link Worker assessment process to provide service-users with a more meaningful referral (SSPH, 2020c), due to the utilisation of occupational science as their theoretical framework. However, occupational science is typically individualistic and neglects considerations of sociocultural and group-based contexts that influence health (Gallagher et al., 2015; Hocking & Whiteford, 2012; Phelan & Kinsella, 2009). Failing to account for social factors that inform behaviour and engagement in activities is concerning because social factors are considered the greatest predictors of health and wellbeing (Steffens et al., 2016). The SIAH on the other hand does account for sociocultural factors and emphasises the importance of group memberships in the improvement of health and wellbeing (Jetten et al., 2012; Steffens et al., 2016; Wakefield et al., 2019). Therefore, the SIAH may offer a more comprehensive theoretical account as to why and when social prescribing is effective.

The Salford toolkit also does not consider the community group that the service-user is referred to. Considering the groups that service-users are connected to is important because a service-user could disengage with the group if they are not received positively (e.g., if they feel judged or unwelcomed; Husk et al., 2019; Stuart et al., 2021), as noted earlier. A Community Prescribing Toolkit, guided by the SIAH, can take account of sociocultural factors and a groups response to service-users during a social prescription. In doing so, service-user disengagement with social prescribing should be minimised, particularly when identification is facilitated,

because the group will imbue the service-user with psychological resources that enrich their life (Wakefield et al., 2019). An alternative toolkit developed by Kellezi et al. (2019a) that utilises the SIAH is explored below.

The Social Psychology of Social Prescribing: A Toolkit

The toolkit was designed using the SIAH and insights from Kellezi, Wakefield, Bowe, Stevenson et al., as a resource for those considering becoming involved in or developing social prescribing schemes (Kellezi et al., 2019a). However, it does not specifically focus on the Link Worker referral process. Five tools offering best practice guidance and links to additional resources are included in the toolkit (Kellezi et al., 2019a). Each tool has a theoretical section outlining the available evidence and relevance of social psychology to social prescribing. This information varies depending on the purpose of the tool and whether it is for developing, commissioning, or running schemes. For example, Tool 1 offers a resource list (including Dayson & Bashir (2014), Kellezi et al. (2019c), NHS England (2019b), and Wakefield et al. (2019) discussed across Chapters Two, Three and Four), which directs readers to the social evidence base if they are interested in more information. Tool 2 helps readers identify if social prescribing is right for their needs. This is achieved by asking readers to describe elements of their intervention and compare them to examples of a social prescribing-based scheme. If the elements match, then a social prescribing approach could be useful to them and their intervention. Tool 3 offers insight into what social psychological factors should be considered during social prescribing, by presenting statements and descriptions of why that factor should be considered. One recommendation includes ensuring that the social prescription fosters a strong sense of connection with other group members, becoming meaningful to the patient, which is considered important for accessing the health benefits of a social prescription through group identification (Kellezi et al., 2019a). Tool 4 provides understanding on how and why social prescribing works, using Kellezi et al. (2019c) as a case study. Finally, tool five offers

insight into how to evaluate and monitor a social prescribing service or group (Kellezi et al., 2019a). This involves considerations of why social prescribing should be evaluated, how it can be evaluated quantitatively or qualitatively, and how one can present their evaluations for clarity.

Whilst most tools within this toolkit provide guidance and advice on why utilising social psychological principles during social prescribing is beneficial, the toolkit does not explore how Link Workers can specifically utilise this guidance in practice. For example, Tool 3 explains why ensuring a social prescription is meaningful to the service-user is important from a SIAH perspective but does not explain how a Link Worker can provide a social prescription that has the potential to become meaningful to the service-user. As it takes time for social identification to develop (Çelebi et al., 2017; Doosje et al., 2002), guidance on how group identification can be developed is imperative for increasing the likelihood of service-users gaining access to the health and wellbeing benefits resulting from social identification. In comparison, the Community Prescribing Toolkit can provide detailed guidance on how a social prescription to a community group can become psychologically meaningful to a service-user. For example, the Community Prescribing Toolkit will consider how Link Workers can gather social identity-based information about the service-user during conversations with them, and then apply and compare that information to the available groups in the area that may support the service-user's needs.

Consequently, the Community Prescribing Toolkit aims to maximise the likelihood of social prescriptions to community groups improving health and wellbeing by facilitating group identification, through negating the shortfalls of existing theoretical toolkits. The Community Prescribing Toolkit will consider both the Link Worker assessment process and the connection to a group process, overcoming the missed opportunity in the Salford Social Prescribing Toolkit. The Community Prescribing Toolkit will also do more than outline why facilitating

social identification is important during a social prescription as with Kellezi's et al.'s (2019a) toolkit, by offering guidance on how Link Workers can utilise the theory in practice and facilitate social identification during a social prescription. The next section introduces the research context underpinning this PhD programme.

Setting the research scene: Social prescribing during COVID-19

During the COVID-19 pandemic in the UK, various restrictions were imposed to control the spread of the virus, including national and local lockdowns, social distancing measures, and stay-at-home orders (Gov UK, 2021a). The first national lockdown began in March 2020 and ended on the 23rd of June 2020; local lockdowns (city-based lockdowns) with four tiers of severity were imposed in England on the 4th of July 2020 (HM Government, 2021; Institute for Government Analysis, 2022). A second national lockdown occurred between the 5th of November to the 2nd of December 2020, followed by reduced restrictions over Christmas and a third national lockdown which lasted between the 6th of January to the 19th of July 2021 (Institute for Government Analysis, 2022). During the third national lockdown, the UK Government in England implemented a roadmap to recovery which involved the strategic relaxation of pandemic restrictions, until all legal restrictions were lifted in February 2022 (HM Government, 2022). At this stage, the UK was claimed to have entered a 'recovery period' from the coronavirus pandemic which involved a commitment to social reintegration through the Emerging Together policy (Gov UK, 2021b). Emerging Together focused on supporting recovery from COVID-19 by promoting social connection using local and place-based approaches that tackle loneliness in young and older people and improving digital inclusion (Gov UK, 2021b).

These restrictions had significant implications for the delivery of social prescribing services. Initially social prescribing shifted from face-to-face interactions to remote modes of support

provision including email and telephone communication (Bertotti & Temirov, 2020; Melam & Sanderson, 2020; O'Connor et al., 2021; Tierney et al., 2020). Ongoing doctoral research and commentaries suggest that remote working was beneficial for increasing staff flexibility and reducing social pressures for service-users with mental health issues (Etheridge, 2020; Lawrence et al., 2021), however, it also posed challenges in fully understanding service-users' needs and was seen as contradictory to the ethos of social prescribing (Bertotti & Temirov, 2020; British Red Cross, 2020; Fixsen et al., 2021; Lawrence et al., 2021). The pandemic further increased Link Worker workload following a surge in the complexity of cases seeking loneliness and mental health-based support (Bertotti & Temirov, 2020; British Red Cross, 2020; Carpenter et al., 2021; Lawrence et al., 2021; Vidovic et al., 2021), due to the pandemic widening health inequalities and weakening economies (Fixsen et al., 2021; Spencer et al., 2021; Spencer et al., 2022). The social distancing restrictions imposed during the pandemic was thought to increase loneliness, particularly for those already vulnerable to these issues (Gov UK, 2021b), and this became a critical public health concern (McQuaid et al., 2021).

Social distancing measures also resulted in the temporary closure of community groups, limiting social interactions and the availability of typical community resources (Carpenter et al., 2021; Grotz et al., 2020; Howarth & Leigh, 2020b; Lawrence et al., 2021; Ogden, 2020). Link Workers adapted by providing crisis support, (e.g., accessing medication and food shopping), rather than linking to community groups (British Red Cross, 2020; Etheridge, 2020; Fixsen et al., 2021; Tierney et al., 2020). Some community groups attempted to address the limitations of social distancing by offering online sessions and interactions such as videoconferencing, emails, and social media (Carpenter et al., 2021; Grotz et al., 2020; Ladds, 2021). However, this digital shift presented challenges for service-users experiencing digital exclusion (Broomhead & Mackin, 2020; Carpenter et al., 2021; Lawrence et al., 2021) and reduced the value of interpersonal contact (British Red Cross, 2020; Williams et al., 2022),

potentially increasing social isolation and loneliness. Consequently, there was a perception that face-to-face services could not be replaced (British Red Cross, 2020; Lawrence et al., 2021).

From the end of 2021 onwards, social prescribing and communities were considered important for social recovery from the pandemic (Brown et al., 2021; Cunningham et al., 2022; Howarth & Leigh, 2020b; Vidovic et al., 2021). However, concerns were raised regarding the capacity of Link Workers and community groups to provide long-term support, given the anticipated economic, psychosocial, and health consequences of the pandemic (Brown et al., 2021; Mak, 2021; Rice, 2020). The VCSE sector, including community groups and charities, faced difficulties due to austerity measures, such as funding cuts and the inability to fundraise during COVID-19 (British Red Cross, 2020; Carpenter et al., 2021; Hamilton-West et al., 2020; Mahase, 2020; Razai et al., 2020). Despite the allocation of £5 million supporting local community groups to respond to COVID-19 in England, the VCSE sector was reported to be in crisis (Brown et al., 2021), struggling to bounce back from the forced closures during the initial stages of the pandemic (Mahase, 2020). Overall, the pandemic profoundly impacted the delivery of social prescribing services, necessitating remote support provision and a shift in the types of resources available. The challenges posed by the pandemic highlighted the importance of social prescribing and community support for social recovery, but also underscored the need for sustained resources and capacity-building in the face of ongoing uncertainties.

Chapter summary

This chapter applied the SIAH to social prescribing to understand how and why social prescribing can reduce loneliness, barriers to community group engagement, and improve health and wellbeing, belonging, and social connection (NHS England, 2020). The SIAH was found to be useful for addressing inappropriate referrals to social prescribing by facilitating group identification, an active ingredient that promotes health and wellbeing benefits during

social prescribing (Kellezi et al., 2019c; Wakefield et al., 2022). The group processes of accessibility, fit, psychological need satisfaction, and shared similarities, alongside time, facilitate social identification during social prescribing.

Existing resources were critically evaluated, revealing limitations in supporting Link Workers to facilitate connections to groups which will lead to the development of valuable social identification during a social prescription. The Salford Social Prescribing Toolkit overlooked the important role that group leaders have in supporting a successful social prescription, while the Social Psychology of Social Prescribing Toolkit did not provide practical guidance for Link Workers in fostering group identification. Therefore, the development of a Community Prescribing Toolkit that specifically supports Link Workers to facilitate social identification was deemed necessary, particularly given the reported increases in loneliness during the pandemic (British Red Cross, 2020; Lawrence et al., 2021). The methods utilised to develop the toolkit during the research programme detailed in this thesis are discussed in Chapter Five.

Chapter 5: Methodology

Chapter overview

The previous chapter applied the SIAH to social prescribing and introduced the social environment that this research was conducted in. This chapter begins by providing a brief overview of the research conducted during the PhD programme, before outlining the philosophical stances guiding the research and detailing the collaborative and mixed methods research utilised. The methodologies utilised in this mixed method research are then discussed, followed by the analytical methods. A reflection on my influence on the research is then presented before discussing ethical considerations. The chapter concludes by summarising the key methodological decisions guiding the four studies reported in the consecutive chapters, and what a mixed method approach will offer.

The research within this thesis

This thesis aimed to answer the overarching research question: How can the application of the SIAH improve the social prescribing referral process to community groups? To answer this research question, the development of a Community Prescribing Toolkit was explored. Four studies supported the development of the toolkit, responding to four research questions and six research aims detailed in Table 5.1. Social prescribing stakeholders including Link Workers, community group leaders and service-users were recruited for this research.

Mixed methods

A mixed methods design from a pragmatist paradigm was utilised during this research programme. Pragmatism states that knowledge is both constructed through the actions and interactions of people and based on the reality of the world we experience and live in (Allemang

et al., 2022), and that experience of the world is necessary to ascribe meaning to an event (Allemang et al., 2022; Shannon-Baker et al., 2016).

Table 5.1

The research questions and aims underlying the four studies documented in this thesis.

Research Question	Research Aim	Study and Method
What would Link worker, community group leader, and service-user stakeholders include in a SIAH based Community Prescribing Toolkit that supports social prescriptions to community groups?	Aim one: To gain link worker, service-user, and community group leader perspectives on the community group referral process to inform toolkit development. Aim two: To gain Link Worker, service-user, and community group Leader perspectives on the presence and their understanding of possible group processes that facilitate or prevent social identification during social prescriptions to community groups.	Study One (Chapter Six), in-depth interviews analysed using Reflexive Thematic analysis (N = 22 participants; n = ten Link Workers, n = seven group leaders, n = five service-users; two males, 20 females)
How would social prescribing stakeholders refine the Community Prescribing Toolkit?	Aim three: To collaboratively develop the Community Prescribing Toolkit for social prescribing stakeholder use.	Study 2a and 2b (Chapter Seven), online focus groups and qualitative questionnaire, analysed using thematic analysis (N = eight Link Workers, N = three group leaders, all female)
Can social prescribing and communities practically support a feasibility trial of the Community Prescribing Toolkit, whilst recovering from the ongoing impacts of the COVID-19 pandemic?	Aim four: To explore the possibility of conducting a feasibility trial of the Community Prescribing Toolkit.	Study Three (Chapter Eight), online qualitative and quantitative questionnaire, analysed with descriptive statistics, paired sample t-tests, and qualitative content analysis (N = 70 Link Workers; 60 female, eight male, one prefers not to say)
How can the experiences of service-users who disengage or decline to engage with recommended community groups, inform understanding of the barriers and facilitators to engagement with social prescribing?	Aim five: To deepen understandings on why service-users may decline or disengage with recommended group activities. Aim six: To further explore the potential facilitators that may encourage service-user engagement with community groups.	Study Four (Chapter Nine), in-depth semi-structured interviews, analysed with phenomenological reflexive thematic analysis (N = five service-users; two males, three female)

Pragmatists utilise the most appropriate research methods to investigate real-world problems, supporting the use of multiple sources of data and knowledge to answer research questions (Allemang et al., 2022; Creswell, 2014; Hall, 2013; Shannon-Baker, 2016). As such,

pragmatism supports mixed methods research by perceiving differing methodologies to be useful tools that aids one's understanding of the world (Allemang et al., 2022; Shannon-baker, 2016). Pragmatism's ethos that reality and knowledge are socially constructed from individuals' experiences (Zoztmann et al., 2022) supports the use of social psychological theory to understand and ascribe meaning to an experience, such as the framework offered by the SIAH applied throughout this research programme.

This research employed an exploratory, sequential mixed methods design, prioritising qualitative data collection and using quantitative data to complement and expand upon the initial qualitative findings (Clark, 2019; Creswell & Plano Clark, 2007; 2018). Link Workers and Group Leaders in Study One could take part in Study Two. Prioritising qualitative research was beneficial for tailoring the toolkit to the needs of Link Workers, group leaders, and service-users (Creswell & Plano Clark, 2018; McKim, 2017), which aligns with the pragmatic goal of using human experience to build knowledge and understanding of the world (Allemang et al., 2022; Morgan, 2014). Pragmatists further believe that one's experiences and actions occur within specific historical, social, and cultural contexts (Allemang et al., 2022; Maarouf, 2019), making the use of mixed methods research to explore multiple worldviews of social prescribing throughout this research programme appropriate (Creswell & Plano Clark, 2007; Johnson & Onwuegbuzie, 2004; Levitt et al., 2018). Pragmatism recognises that one's ability to use prior experience to predict future actions is limited, thus pragmatists engage in careful, reflective decision making before using the scientific method (Morgan, 2014). Such careful consideration of an experience makes it a useful approach to understanding the world through applied and collaborative research as described in this thesis (Allemang et al., 2022).

The research program consisted of three research phases. The first phase (starting September 2020 and ending June 2021) involved a two-step process of toolkit development. The first step involved a qualitative exploration of social prescribing, focusing on stakeholder perceptions

and understandings of group processes during social prescriptions to community groups (Study One). The outcomes of Study One informed the development of a draft toolkit based on the SIAH, which was then qualitatively refined to support both Link Workers and group leaders in the second step of toolkit development (Study Two) . The second phase (starting August 2021 and ending October 2021) aimed to conduct a quantitative feasibility trial of the toolkit, but due to the ongoing impacts of the COVID-19 pandemic (Gov UK, 2022; HM Government, 2021), it became necessary to assess the practicality of conducting a trial within a pandemic-affected working environment. Thus, the initial aim to explore the feasibility of the Community Prescribing Toolkit in practice with social prescribing Link Workers was changed to explore the possibility of conducting a feasibility trial of the Community Prescribing Toolkit. A quantitative and qualitative questionnaire was used to explore the practicality of conducting the trial (Study Three), revealing that a trial was not feasible due to bottlenecks in social prescribing schemes and limited community capacity. This led to the identification of the under-researched population of disengaged service-users (Wildman et al., 2019b), and the final qualitative phase of toolkit development (starting March 2022 and ending February 2023) exploring service-user experiences of disengagement with recommended community groups (Study Four). To comply with university regulations during the coronavirus pandemic (Nottingham Trent University, 2021) and ethical permissions, all data collection took place remotely.

Ontology

This section discusses ontology, the philosophical study of reality (Tubey et al., 2015). One makes ontological assumptions about what they believe is real and how they know it is real (Kivunja & Kuyini, 2017). Ontology thus shapes the way a researcher perceives and studies their research subjects, such as social prescribing stakeholders, informing choices on what and

how to research (Saunders et al., 2015). The main ontological assumption guiding this thesis is realism. Realists believe that there is one true reality that exists independently of the researcher's and other's minds (Al-Ababneh, 2020; Ryba et al., 2022; Saunders et al., 2015; Sobh & Perry, 2006). One's perception offers a window into reality, however because people operate interdependently in the real world, there are multiple worldviews of that reality (Al-Ababneh, 2020; Sobh & Perry, 2006). Multiple worldviews of a single reality make realism compatible with a pragmatist paradigm due to pragmatism's belief that there are different experiences of one reality (Allemang et al., 2022; Guyon et al., 2018; Maarouf, 2019). Consequently, realists believe that the real world is probabilistically apprehensible (Braun & Clarke, 2021b; Michell, 2003; Sobh & Perry, 2006; Williams, 2003), acknowledging differences between the real world and their view of it. The aim of research for realists is to create a family of answers that capture a complex, single reality (Sobh & Perry, 2006). Since there is an external reality, realists acknowledge that others would have researched or experienced aspects of that reality previously and support the use of theory in understanding people's perceptions of reality (Emmel et al., 2018; Sobh & Perry, 2006; Williams, 2003). As such, the SIAH is applied to social prescribing throughout the research, recognising that participant's experiences reflect real phenomena that can be interpreted using prior knowledge of reality.

Realists thus attempt to construct differing views of this reality using triangulation of quantitative and qualitative methodology that is appropriate for the research context (Al-Ababneh, 2020; Michell, 2003; Ryba et al., 2022; Sobh & Perry, 2006), making it appropriate for mixed method research combining quantitative and qualitative methodologies. Quantitative methodologies such as questionnaires and inferential statistics enable realists to explore the prevalence and severity of a phenomenon (Ryba et al., 2022; Sobh & Perry, 2006), such as the types of social prescriptions provided over a set amount of time. Thus, the exploratory

questionnaire used in Study Three was appropriate for a realist approach, as the quantitative and qualitative data was triangulated to explore the practicality of trialling the Community Prescribing Toolkit during a social prescribing environment impacted by the coronavirus pandemic (Al-Ababneh, 2020; Madill et al., 2000; Ryba et al., 2022; Sobh & Perry, 2006).

Qualitative methods and analyses are appropriate for realist research because they support the exploration of the nature of reality from multiple and individual perspectives (Braun & Clarke, 2021b; Ryba et al., 2022; Sobh & Perry, 2006), such as a service-user's experience of receiving a social prescription. Thus, the semi-structured interviews in Study One and Four and the focus groups and qualitative questionnaire in Study Two were appropriate in capturing participant's experiences of social prescribing (Study One and Four) and participant's experiences of the Community Prescribing Toolkit (Study Two). Realism also aligns with qualitative data analysis that utilises theory to support understanding of participant realities, such as Reflexive Thematic Analysis utilised in Study's One and Two (Braun & Clarke, 2021b). Realism also aligns with the Reflexive Thematic Analysis using a hermeneutic phenomenological lens utilised in Study Four. Phenomenology refers to "the study of human experience and the way in which things are perceived as they appear to consciousness" (Langdridge, 2007, p.10). Using a phenomenological lens, one reflects on a person's understand and meaning associated with an experience (Finlay, 2011; Ho et al., 2017; Westland, 2010; Willig, 2013), recognising that one experience is not truer than another aligning with realists' recognition that there are differing perceptions of reality (Braun & Clarke, 2021b; Michell, 2003; Sobh & Perry, 2006; Williams, 2003).

Epistemology

Epistemology is the philosophical study of knowledge concerned with how we acquire knowledge and what qualifies as knowledge (Fazlıoğulları, 2012; Kivunja & Kuyini, 2017).

Our epistemological stance governs what forms of knowledge generation are considered legitimate for our research (Saunders et al., 2015). This research within this thesis adopts a contextualist epistemology which perceives knowledge of reality to be contextually situated, partial, and perspectival (Braun & Clarke, 2021b; DeRose, 1999; Madill, 2000). Contextualism acknowledges that participants cannot be separated from their context, allowing for multiple versions of reality without privileging one over another (DeRose, 1999; Lloyd, 2023), aligning with realist ontology that there may be multiple worldviews of one reality (Braun & Clarke, 2021b; Michell, 2003; Sobh & Perry, 2006). Theoretical interpretation is necessary to understand the meaning of data, thus supporting the application of the SIAH to connect participant data with the broader social context of social prescribing. Acknowledging that there are multiple accounts of reality (Braun & Clarke, 2021b; DeRose, 1999) supports the utilisation of semi-structured interviews in Study's One and Two. Contextualism further supported the utilisation of focus groups and a qualitative questionnaire in Study Two, and an exploratory quantitative and qualitative questionnaire in Study Three, by considering the broader social, political, and theoretical context of participants (Braun & Clarke, 2021b; DeRose, 1999; Madill, 2000).

A contextualist approach was also deemed appropriate for the analytical approaches conducted in each study. The capacity to interpret and situate participant responses to the wider contextual situation, utilising the SIAH supported the Reflexive Thematic Analysis in Study's One and Two, and the qualitative content analysis in Study Three (Bengtsson, 2016; Braun & Clarke, 2021b). A hermeneutic phenomenological lens was utilised to guide the reflexive thematic analysis in Study Four, in a comparable manner to Mitchell et al. (2020) who conducted their research from an interpretive phenomenological stance. Introduced in the ontology section, a phenomenological lens for this study was considered necessary to capture the idiographic nature of service-users' lived experiences of disengagement, given the variability in social

prescribing schemes (Ladds, 2021). A phenomenological lens supported a contextualist approach by pursuing an interpretative account of a participants experience that considers the context surrounding shared meaning making (Ho et al., 2017; Ozuem et al., 2022; Willig, 2013).

Stakeholder engagement

This research aimed to collaboratively develop a Community Prescribing Toolkit that facilitates social identification during social prescriptions to community groups. Stakeholder engagement was crucial in tailoring the toolkit to Link Workers and group leaders to ensure its relevance for social prescribing (Goodman & Thompson, 2017). Several social prescribing organisations, clinical commissioning groups, local councils, and national platforms such as the NALW were contacted to support the research via dissemination and participation. Monthly Microsoft Teams meetings were held with a local council member to support distribution and recruitment for Study One. Relationships were further developed through maintained contact with the council member and follow-up meetings conducted over six-months to generate interest in trialling the toolkit. Through the council member, a working relationship was developed with a social prescribing service willing to trial the toolkit. Microsoft Team Meetings were held to generate interest in a trial, via presenting a research plan to the prospective social prescribing services. These meetings spanned several months but ceased in February 2022 when it was deemed impractical to trial the toolkit following Study Three and high demands on the interested social prescribing service. Such involvement is reflective of patient and public involvement research involving stakeholders outside of the research context (e.g., Gedling Borough council members and a social prescribing service manager). Involving patients and the public in research increases the relevance, appropriateness, and potential benefits of research outputs (Greenhalgh et al., 2019; Holmes et al., 2019; Morgan et al., 2016;

Rivas et al., 2019), including the Community Prescribing Toolkit. Involvement of the council members and service manager was considered necessary at the time, to ensure that a planned feasibility trial of the toolkit was considerate of their needs, wishes, and capacity to support research (Greenhalgh et al., 2019; Rivas et al., 2019).

Despite the inability to trial the toolkit, insights from Link Workers, community group leaders, and service-users informed the creation and refinement of the toolkit in Studies One and Two, and its further development following Study Four. The variability of social prescribing across the UK meant that attempts were made to understand local contexts of stakeholder engagement, such as in Study Four. However, low recruitment motivated a shift towards a national sample in Study One, whilst a national sample was sought in Study Three to best capture the impact that COVID-19 had on social prescribing's capacity to support a trial of the toolkit. Such changes between localised and national recruitment were necessary to engage participants in the research.

Engaging stakeholders aligns with realism and contextualism as multiple worldviews are accounted for (Madill, 2000; Shannon-Baker, 2016). Lai's (2011) literature review into collaborative learning characterises collaborative interactions as shared goals, negotiation, interactivity, and interdependence, with the level of collaboration varying in research depending on the purpose of stakeholder engagement (Morgan et al., 2016). Symbolic participation (Goodman & Thomspon, 2017) was the type of stakeholder engagement employed in this research, which aligns with the newly refined definition of stakeholder consultation in Thompson et al. (2021, p447):

"Researchers ask community residents and/or patients for advice on important elements of a project or activity. The provided feedback informs the research, but the researchers are

responsible for designing and implementing projects with no help expected from the people who were consulted."

Participants in this research provided recommendations that were incorporated into a toolkit and tailored to effectively apply the SIAH to the social prescription process. Such involvement of stakeholders as informative research participants in Study One to create the toolkit and collaborative research participants in Study Two to refine the toolkit are somewhat reflective of Delphi research which seeks expert consensus on a topic over multiple iterations of feedback (Fink-Hafner et al., 2019). However, as detailed in Chapter Seven, unlike a Delphi study which restricts who is considered an expert to professional qualifications (Fink-Hafner et al., 2019), this research perceives those stakeholders who have direct experience of providing, supporting, or receiving a social prescription as experts of social prescribing.

Semi-structured interviews

Semi-structured interviews were employed in Study's One and Four to address the research questions. This approach allowed for in-depth exploration and follow-up on participant responses through a combination of open and structured questions (Adams, 2015; Doody & Noonan, 2013). The use of an interview schedule ensured comprehensive coverage of the topic area in each study while allowing flexibility to delve deeply into participant thoughts and experiences of social prescribing (Adams, 2015; Dejonckheere & Vaughn, 2019; Kallio et al., 2016). Key topic areas, such as the process of social prescriptions, the role of group leaders in welcoming service-users, and barriers faced by service-users in attending recommended groups, were informed by previous literature on social prescribing and the SIAH.

Sample sizes for semi-structured interviews can vary based on the information sought and the targeted population. Hard-to-reach populations, characterised by factors like stigma, digital exclusion, reduced literacy, desire for anonymity, and distrust, often pose recruitment

challenges and may result in smaller sample sizes (Raifman et al., 2022; Wilkerson et al., 2014). In Studies One and Four, sample sizes were estimated using Malterud et al.'s (2016) concept of information power, as recommended by Braun and Clarke (2021a) for Reflexive Thematic Analysis. Smaller sample sizes were deemed appropriate due to the narrow research aims, specific target populations, utilisation of theory-based analysis on a rich dataset, and comparison of participant responses. Consequently, a small sample of ten participants per stakeholder group (to ensure a larger multi-perspective sample) was planned for Study One, and a small sample of 15 participants was planned for Study Four.

Focus groups

Online focus groups were utilised in Study Two as part of a two-step process to elicit consensus and feedback on the content and refinement of the Community Prescribing Toolkit. This approach involved introducing Link Workers to a draft version of the Toolkit that was created following Study One, before facilitating online group-based interactions where participants shared their individual and collective views on the toolkit (Kamberilis & Dimitriadis, 2011; Morgan, 1996), allowing for active discussion and the generation of group perspectives that supported the refinement of the toolkit. Online focus groups were chosen to facilitate discussions across different geographical locations and encourage wider participation (Morgan, 1996; Stewart & Shamdasani, 2017).

A focus group schedule was employed to guide the discussions (Kamberelis & Dimitriadis, 2011) keeping participants focused on the toolkit's content. This directed approach helped maintain topic relevance and minimise the risk of participants deviating from the main subject or influencing the data based on unequal engagement or pre-existing relationships (Laenen, 2021). To maintain a balance between researcher control and participant autonomy, the focus groups were semi-structured (Kamberilis & Dimitriadis, 2011; Laenen, 2021). This allowed

participants to provide their own insights and responses to set questions regarding the toolkit's content and structure, promoting collaborative discussions.

For Study Two, a target sample of eight Link Workers from Study One was divided into two focus groups, aligning with previous literature suggesting that two to three focus groups (Guest et al., 2017), involving six to eight participants for about one and a half hours (Finch et al., 2013) would be sufficient for data coverage. Participants were not acquainted with each other prior to the focus groups to ensure unbiased discussions. The researcher minimised their own input to encourage participant led discussions. The researcher only commented to provide clarification, encourage all participants to engage, and to progress the focus group to cover all relevant topics.

Online questionnaires

Online questionnaires were employed in Study Two and Study Three. In Study Two, group leaders were invited to choose the method for reviewing the draft toolkit. Allocating choice of methodology to group leaders was considered necessary to increase the likelihood of recruitment and accommodate group leader availability. After a majority vote, an online questionnaire which utilised open-ended questions derived from the focus group schedule in Study Two was selected. In Study Three, Link Workers answered qualitative and quantitative questions to assess the practicality of conducting a trial of the toolkit post-pandemic.

The social distancing requirements during the COVID-19 pandemic (Gov UK, 2021a) necessitated the use of online questionnaires, as opposed to face-to-face data collection methods, to ensure the safety of participants and the researcher. Online questionnaires offered flexibility, affordability, and the ability to overcome geographical limitations (Ball, 2019; Braun et al., 2021; Evans & Mathur, 2018), making them a cost-effective means of gathering diverse perspectives from Link Workers and group leaders.

Both studies employed descriptive exploration of the research questions using open-ended questions as recommended by Braun et al. (2021), Nayak and Narayan, (2019), and Zuell et al. (2015). Single-item questions were used to minimise participant burden and overcome the lack of known validated measures that suited the studies' purposes and objectives. Containing both quantitative and qualitative questions in Study Three, the questionnaire was long. Using single-item questions where possible helped to reduce the number of questions a participant was required to answer, reducing the physical and psychological burden of completing the questionnaire (Nayak & Narayan, 2019; Riggle et al., 2005; Zuell et al., 2015). Nevertheless, single-item questions can be subject to misinterpretation, such as reading a question wrong and not answering the question provided (Van Oort et al., 2011), and open-ended questions may have higher non-response rates (Braun et al., 2021; Riggle et al., 2005; Zuell et al., 2015).

Determining an appropriate sample size for questionnaires can be challenging. For qualitative questionnaires a sample size ranging between 20 to 100 participants can be obtained depending on the study's scope (Braun et al., 2021). In Study Two, which attempted to recruit as many participants as possible from Study One, a sample size calculation was not necessary. Alternatively, for quantitative questionnaires, a power analysis is recommended to determine sample size unless the research is exploratory (Haile, 2023). Exploratory research that does not test hypotheses does not require power analysis (Haile, 2023), thus sample size can be determined using alternative methods. Since the exploratory questionnaire in Study 3 did not seek to test hypotheses, sample size was instead calculated based on a known estimated population of participants, utilising a population table published by Israel (1992; Table 5.2) as recommended in Nanjundeswaraswamy and Divakar (2021). Using an NHS population target to recruit 1,000 Link Workers by 2021 (Bertotti et al., 2019), a standardised confidence level of 95%, and a standardised variability of 50% (Israel, 1992; Lakens, 2013; Singh & Masuku,

2014), a sample of 286 participants was calculated for the questionnaire based on a 5% precision level, 95% confidence level and 50% variability.

Table 5.2

Calculated sample sizes from Israel (1992), based on population size, a 95% confidence level and 50% variability.

Sample size for 5% and 10% precision levels where confidence level is 95% and variability 50%.		
Population Size	Sample Size (n) for precision	
	5%	10%
500	222	83
1,000	286	91
2,000	333	95
3,000	353	97
4,000	364	98

Analytical methods

As noted in Table 5.1, the analytical methods utilised during the research programme were Reflexive Thematic Analysis, phenomenological Reflexive Thematic Analysis, qualitative content analysis and paired samples t-tests.

Reflexive Thematic Analysis

Reflexive Thematic Analysis was chosen as the analytical method for Studies One, Two, and Four due to its ability to generate a comprehensive understanding of shared experiences whilst accounting for individual perspectives of that experience. This approach allows for both inductive (themes generated from the dataset) and deductive analysis (themes driven by the researcher's theoretical framework and questions), as well as semantic (closely reflecting participant responses) and latent coding (reading between the lines, searching for the hidden meaning), providing theoretical flexibility (Braun & Clarke, 2019; 2021b). The six phases of Reflexive Thematic Analysis are outlined in Table 5.3. The process of reflexivity is essential

in Reflexive Thematic Analysis, enhancing transparency and promoting the researcher's development and understanding of the method (Braun & Clarke, 2014; 2021b).

Study One employed a multi-perspective approach, combining inductive and deductive analysis with latent coding to explore group processes during social prescribing. A multi-perspective analysis explores the similarities and differences between different perspectives (Kendall et al., 2009), making it appropriate for understanding group processes throughout the social prescription process. Study Two utilised an inductive, semantic approach to analyse the novelty of reviewing a draft toolkit.

Table 5.3

Braun and Clarke's (2021b) six phases of Reflexive Thematic Analysis.

Phase	Description
1) Familiarisation	Data is repeatedly re-read and listened to, to support deep immersion with the content of the dataset. Brief notes are made on insights relating to data items and the whole dataset.
2) Coding	Segments of data that appear interesting or meaningful for the research question are systematically identified. Sections of data are analysed and meaningfully coded at the inductive or deductive level, depending on the research purpose. Theory remains important regardless of coding level.
3) Generating initial themes	Codes are condensed and clustered around shared core concepts that meaningfully answer the research question, beginning a process of identifying shared patterns of meaning across the data set. Once potential themes are identified all data relevant to each potential theme is collated.
4) Developing and reviewing themes	The initial fit of potential themes is assessed by checking that they make sense in relation to the coded extracts and the whole dataset. Radical revision may be necessary if a potential theme does not tell an important pattern of shared meaning related to the dataset and research purpose. Themes may be collapsed or split into new themes as relationships between themes are considered.
5) Refining, defining, and naming themes	The analysis is fine tuned to ensure that each theme is clear and built around a strong core concept relating to the research question. A brief synopsis of themes detailing their story and how it fits the research question is written.
6) Writing up	Written notes are finessed into a narrative to produce a persuasive story that answers the research question. This involves writing the introduction, method, and conclusion sections.

In Study Four, an inductive, latent Reflexive Thematic Analysis was conducted from a phenomenological perspective, as outlined in the ontology and epistemology sections. While alternatives such as Interpretative Phenomenological Analysis (IPA) could have been

considered, the choice was made to focus on understanding the shared meaning-making process rather than individual experiences. IPA has limitations in explaining why an experience occurs and is perceived to be incompatible with theories of cognition. The application of the SIAH in this research, which has cognitive underpinnings, overcomes these limitations, and provides insights into the experience and its causes (Bowe et al., 2020; Cruwys et al., 2014b; Hogg, 2000; Turner et al., 1987; Wakefield et al., 2022). The flexibility of thematic analysis enables the application of the SIAH under a phenomenological lens in this study (Braun & Clarke, 2021b; Ho et al., 2017).

Qualitative content analysis

In Study Three, qualitative content analysis was employed instead of Reflexive Thematic Analysis to analyse the open-ended questions. This choice was made because qualitative content analysis is better suited for handling copious amounts of qualitative data (Beck et al., 2010). It allows for the portrayal of multiple perspectives by categorising responses into frequently occurring categories that require contextual consideration to avoid misinterpretation (Bengtsson, 2016). Qualitative content analysis involves analysing the meaning and relationships within textual data in a replicable and systematic manner (Bengtsson, 2016; Erlingsson & Brysiewicz, 2017). Its aim is to produce a condensed yet comprehensive description of the phenomenon under investigation (Bengtsson, 2016; Elo & Kyngäs, 2008; Erlingsson & Brysiewicz, 2017). The analysis can be inductive or deductive and may employ either manifest (semantic) or latent coding (Bengtsson, 2016). In Study Three, an inductive, manifest content analysis was conducted due to the novelty of the information being sought (Lauri & Kyngäs, 2005). At the time of Study Three, there was little information regarding how Link Workers and community groups were operating during the pandemic and the pandemic recovery period, including whether social prescriptions to community groups were

occurring. Such information was necessary to determine if a trial of the toolkit could occur during 2022.

To ensure the trustworthiness of the qualitative content analysis, the process should be systematically and clearly reported from start to finish (Elo et al., 2014). Bengtsson (2016) outlines four steps involved in this analysis: decontextualisation, recontextualisation, categorisation, and compilation. Decontextualisation involves familiarising oneself with the data by repeatedly reading participant responses and breaking them down into smaller units of two to six words that capture the content. Recontextualisation compares these meaning units against the research aim and the original text to ensure their accuracy and relevance. Any unmarked text is reviewed for inclusion and excluded if irrelevant to the research aim. Categorisation condenses the meaning units into codes that retain the content, which are then clustered into subcategories and categories based on similarities. The categories are refined until they are internally consistent and externally diverse. The compilation stage involves writing up the analysis once the categories have been established (Bengtsson, 2016).

NVivo Pro-12

The NVivo Pro-12 qualitative data analysis software was utilised to organise, sort, and synchronise the qualitative data into a single location (Oliveria et al., 2016; Zamawe, 2015). Data can also be imported, coded, and collated into themes in NVivo, using a node system (Oliveria et al., 2016). The software was also methodologically flexible meaning it supported the conducted Reflexive Thematic Analyses (Castleberry & Nolan, 2018; Zamawe et al., 2015) and the qualitative content analysis (Bengtsson, 2016).

Quantitative analysis: paired sample t-tests

Quantitative questions in Study Three were analysed descriptively, with three sets of related questions being analysed through paired samples t-tests. Paired sample t-tests were considered

appropriate for Study Three because they compare the mean differences between related variables (Kim, 2017; Park, 2009) in studies where all participants have answered all questions (Field, 2013; Nardi, 2018). Comparing the mean differences was considered important for exploring any potentially significant changes within the data that could be relevant for informing whether a trial of the toolkit was practical. For example, comparing the mean differences in social prescriptions to community groups before and after the pandemic, could be beneficial in exploring if there were significant changes in service-users being connected to groups. Community groups would need to be open and receptive of service-users for a trial of the toolkit to take place. Alternative analyses, including the Analysis of Variance have been considered superfluous in situations where there are only two group comparisons (Emerson, 2017). As Study Three only contained two comparable variables, paired sample t-tests were considered the most appropriate statistical analysis.

Reflexivity

In this section I reflect on how my interest in social prescribing and my experiences have shaped the progress and analysis of the studies conducted during the research programme. Qualitative analysis necessitates that I situate myself in relation to my research and increase transparency on how I conducted qualitative analysis (Braun & Clarke, 2021b). I developed a deep-rooted interest in social prescribing during my MSc course because I valued its ability to improve health and wellbeing without a pharmaceutical prescription. Throughout my academic background specialising in psychopathology and wellbeing, I have considered pharmaceuticals to be supplementary to wider therapies that address root problems. My beliefs align more closely with the nurture perspective in that, I believe that experiential or social factors largely shapes one's sense of self and behaviours, including health and wellbeing, rather than biological factors (Eagly & Wood, 2013). Such alignment is reflective of contextualist

epistemology where one's knowledge of reality is dependent on wider social contexts (Braun & Clarke, 2021b; Lloyd, 2023). Although, given my mental health background, I do acknowledge that both nature and nurture (Eikemo & Øversveen, 2019; Tabery., 2014) can influence one's behaviour in certain instances. I also largely side with the view that one can change across the lifespan (Block & Robins, 1993; Eikemo & Øversveen, 2019; Roberts et al., 2006), which aligns with social prescribing's intention to empower service-users to change how they manage their health and wellbeing. Therefore, I consider myself to be an advocate for social prescribing to support one's health and wellbeing without pharmaceuticals unless it is necessary such as in the management of long-term conditions and mental illness. Such personal investment could introduce bias into the research process by neglecting participant voices who are less enthusiastic about social prescribing or community groups in general. Careful reflection upon the qualitative analyses that I conduct will be required to reduce this risk of bias.

As a white female in my late twenties from a working-class background, I have witnessed family and friends struggle with their mental health and wellbeing. As a result, I often provided space for family and friends to share their struggles, which has fuelled my interest in services that are person-centred. Consequently, I believe in working with people to understand their experiences and opinions, which aligns with a realist ontology that seeks to understand people's worldviews of reality (Al-Ababneh, 2020; Sobh & Perry, 2006). However, in my attempt to understand another's experience, I may have asked leading questions to participants based on information I had gathered during a previous participant interview. For example, during Study Four I had asked one participant whether they would like a group to be closer to their ethnic background and age range, rather than simply asking them to describe what type of group would better suit their needs. I was aware of this tendency and improved my interview skills over time. Alongside leading questions, I may have influenced the relationship between the

participants and myself in Study One. Introducing myself as a student researching social prescribing, Link Workers may have considered myself an insider (someone knowledgeable about social prescribing) resulting in reduced descriptions on what they do (Adu-Ampong & Adams, 2020; Dunn, 2019). Alternatively, community group leaders and service-users may have considered me to be an outsider, with differing consequences to the subsequent interactions (Adu-Ampong & Adams, 2020; Dunn, 2019). Community group leaders may have assumed that I was naïve to the operations of community groups, providing me with detailed insight into their group. Alternatively, service-users may have considered me unknowledgeable about their experience and been wary of discussing their experiences with me due to the authority and power associated with academic institutions (Adu-Ampong & Adams, 2020). As a result, I found it easier to build rapport with Link Workers and group leaders and discuss their roles. Alternatively, I found service-users to be less talkative about their experiences which required me to utilise additional prompts to encourage further discussion during interviews. Consequently, Link Workers and group leaders had the longest interviews whilst service-users tended to have shorter interviews in Study One, increasing in length by Study Two due to developed interview skills over the course of the research programme.

Ethical approval and considerations

The Business, Law and Social Sciences Research Ethics Committee at Nottingham Trent University provided ethical approval for all four studies documented in this thesis. The research also abides by the British Psychological Society's (BPS) ethical requirements for human-based (BPS, 2021a) and online research (BPS, 2021b). Considerations around gathering informed consent, minimising harm to participants, protecting anonymity and confidentiality, and transparency in the collection, transportation, utilisation, and storage of participant data were required (BPS, 2021a; 2021b). For example, participants were required to sign a consent form for Studies One, Two, and Four to indicate that they understood the nature of the study and

were providing informed consent to take part (BPS, 2021a). For Study Three, informed consent was gathered through a consent page, which was preceded by a detailed information page (in accordance with BPS, 2021a; BPS, 2021b). Regarding confidentiality, participants in studies who provided qualitative data were informed that full confidentiality could not be guaranteed in case of self-identification in any published reports of the data (BPS, 2021a). Participant anonymity to each other was also compromised during focus groups (BPS, 2021a; 2021b), which participants were made aware of when consenting to take part. To further protect participant anonymity, participants who provided qualitative data were pseudonymised (BPS, 2021a; 2021b).

Data management

A data management plan was developed and updated accordingly in line with BPS (2021a; 2021b) recommendations. All data was stored in line with open science principles which increases the transparency of the research process including conceptualisation, design, data collection, and analysis (Allen & Mehler, 2019). Collected data was initially stored on the researcher's password protected, organisational cloud-based OneDrive and accessed from their password protected laptop. The researcher contacted potential participants and obtained informed consent for Studies One, Two and Four from their encrypted university email. Interviews and Focus groups were audio recorded using a password protected audio recording device. Each recording was transferred into a secure folder on the OneDrive. All audio-recordings were deleted at the end of each study, due to the presence of identifiable information that was anonymised during transcription. Transcripts were created in Microsoft Word and saved on the OneDrive. Identifiable information utilised to share research documents with participants was temporarily stored in a password protected file on the OneDrive. The storage of identifiable information (including email addresses, phone numbers etc.,) is considered appropriate for research purposes of obtaining consent (BPS, 2018).

All identifiable data was deleted at the end of each study. Participants were informed that their anonymised data would be retained for ten years for research purposes. To comply with open science principles, whilst retaining the confidentiality and anonymity of participants the following research data was made available:

- Anonymised transcripts with sensitive information withdrawn.
- An analysis log containing information on how data was analysed.
- Participant information sheet, consent forms, and debriefs.
- Interview schedules, focus group schedule, and questionnaire questions.
- Raw data for the questionnaire study, with identifiable data removed (I.e., IP addresses).
- The data management plan.

Please see page 303 for a data assessment statement.

Chapter summary

This chapter provided an overview of the upcoming research conducted for a PhD, highlighting the realist ontological and contextualist epistemological positioning of the researcher within a pragmatist paradigm. The involvement of stakeholders within an exploratory sequential mixed-methods research design was considered essential for developing the toolkit using social prescribing stakeholder experiences and opinions. Semi-structured interviews, focus groups, and an online questionnaire supported the development of the toolkit by increasing understanding of group processes during the social prescription process. The use of qualitative data analyses such as Reflexive Thematic Analysis and quantitative analysis such as paired sample t-tests were justified, before reflexively positioning the researcher within their research and wider psychological literature. Ethical approval and considerations were also discussed, ensuring participant and researcher safety. The following chapter, Chapter Six, introduces the first study of the described research programme.

Chapter 6: Exploring the presence of social identification processes during the social prescription referral process to community groups

Chapter overview

Following the methodology chapter, this chapter presents the first study in the research program exploring the social prescribing referral process to community groups, perceptions of group processes, and their relevance to social prescriptions to community groups. Knowing which, if any, group processes are present and understood during the Link Worker assessment and connection to a community group stage of a social prescription is important for improving future social prescriptions to community groups to minimise disengagement. Semi-structured interviews were conducted with three groups of social prescribing stakeholders and analysed using Reflexive Thematic Analysis (Braun & Clarke, 2021b). Three themes were generated during analysis and are discussed before outlining how they were utilised to create a draft Community Prescribing Toolkit informed by the SIAH.

Introduction

As of May 2023, social prescribing research has focused on the effectiveness of social prescribing schemes and the barriers that may impact its effectiveness (Bickerdike et al., 2017; Frostick & Bertotti, 2019; Moffat et al., 2017; Wildman et al., 2019a), as indicated in Chapter Two. Bickerdike et al. (2017) outlined how a lack of engagement with Link Worker appointments and social prescriptions were barriers to social prescribing's success. Inappropriate referrals into social prescribing (Laing et al., 2017), and to community groups that do not suit a service-user's needs (Wildman et al., 2019a; 2019b) may increase disengagement. Moreover, the variability in social prescribing schemes (Halder et al., 2018) and the absence of a unifying theoretical framework (Stevenson et al., 2020a) have made it challenging to understand how and why social prescribing works.

The SIAH, outlined in Chapter Three, has been applied to social prescribing (see Chapter Four) to overcome this theoretical limitation (Halder et al., 2018; Stevenson et al., 2020a). Social prescriptions that are valuable to a service-user, foster community belonging, provide social support, and reduce loneliness are more likely to improve service-user health and wellbeing (Kellezi et al., 2019c; Wakefield et al., 2022). Likewise, drawing on the Social Identity Approach, community group social prescriptions should also be accessible (cognitively and practically) and reflect shared similarities between the service-user and ingroup members (Hogg & Rinella, 2018; Wakefield et al., 2019).

However little research has investigated what occurs during a social prescription to a community group and Link Workers understanding of the group processes outlined above, during a social prescription. Understanding these processes is crucial for developing effective social prescriptions that facilitate social identification. One approach to achieve this is through the development of a psychoeducational toolkit that considers how Link Workers can utilise group processes during social prescribing and the role that community groups have in supporting a successful social prescription. Focusing on these aspects will help overcome the short fallings of existing toolkits such as the Salford Social Prescribing Toolkit (SSPH, 2020c) and the Social Psychology of Social Prescribing Toolkit (Kellezi et al., 2019a).

From a social identity perspective, the complexity of facilitating group identification (Tarrant et al., 2020), underscores the importance of considering how Link Workers can facilitate it during social prescriptions. This involves helping Link Workers to maximise the chances of referring service-users to a context where group processes might develop and facilitate social identification. Failure to recognise the importance of social identification may result in missed opportunities to optimise the health and wellbeing of service-users. Therefore, this study aimed to gather perspectives from Link Workers, service-users, and community group leaders on 1) the community group referral process, and 2) the presence and their understanding of possible

group processes that facilitate or prevent social identification during social prescriptions to community groups. The study also sought to answer the additional research question: 'What would Link Worker, community group leader, and service-user stakeholders include in a SIAH based Community Prescribing Toolkit supporting social prescriptions to community groups?' The findings from this study will offer insight into where and how awareness of group identification facilitation is needed throughout the social prescription journey. These insights can then be used to create a draft Community Prescribing Toolkit outlining how social identification can be facilitated during a community group social prescription pathway.

Method

Design

Semi-structured interviews were conducted online over Microsoft Teams or over the telephone between October 2020 and March 2021, supporting the in-depth exploration of multiple Link Worker, group leader, and service-user perspectives of social prescribing (Doody & Noonan, 2013). To contextualise participant responses, the SIAH was utilised to aid interpretations of participant responses.

Participants

In total, 22 participants (two males, 20 females, aged between 20 - 78 years) were recruited, involving ten Link Workers, seven community group leaders and five service-users. Table 6.1 details participant demographics. Participants reported their age, ethnicity, and experience in their role through open-text responses. Multiple choice questions were utilised for gender, marital and employment status.

Table 6.1

Participant demographics

Participant Type	Age (years)	Gender	Ethnicity	Marital status	Employment status	Experience in role/service
Link Worker 1	36	Female	White British	Unknown	Employed	10 months
Link Worker 2	44	Female	White British	Cohabiting	Employed	9 months
Link Worker 3	44	Female	White British	Married	Employed	6 months
Link Worker 4	25	Female	White British	Single	Employed	5 months
Link Worker 5	26	Female	White British	Single	Employed	14 months
Link Worker 6	45	Female	White British	Married	Employed	14 months
Link Worker 7	60	Female	White British	Married	Employed Part Time	6 months
Link Worker 8	26	Male	White British and Irish	Single	Employed Part Time	2 years
Link Worker 9	46	Female	White British	Cohabiting	Employed	2 years
Link Worker 10	27	Female	White British	Cohabiting	Employed	1 year
Group leader 1	54	Female	White British	Married	Self- Employed	5 years
Group leader 2	52	Female	White British	Cohabiting	Employed	5 years
Group leader 3	61	Female	White British	Married	Retired and volunteering	11 years
Group leader 4	57	Female	White Multiracial	Married	Employed	22 years
Group leader 5	74	Female	White British	Married	Retired	50 years
Group leader 6	55	Female	White British	Married	Employed Part Time	4 years
Group leader 7	72	Female	White British	Married	Retired	10 years
Service-user 1	78	Female	White British	Married	Retired	Unknown
Service-user 2	70	Female	White British	Divorced	Retired	8 years
Service-user 3	33	Male	British South Asian	Single	Employed Part Time	Unknown
Service-user 4	20	Female	Mixed Race Caribbean	Single	Unemployed	3 months
Service-user 5	52	Female	White British	Married	Employed	2 years

Although the sample size in this study was lower than the intended 30 participants, it was considered sufficient. The use of information power as defined in Chapter Five (Malterud et al., 2016), justified the small sample because the research focused on a narrow aim and specific target population, and employed a theory-based analysis on a rich data set in a cross-case analysis.

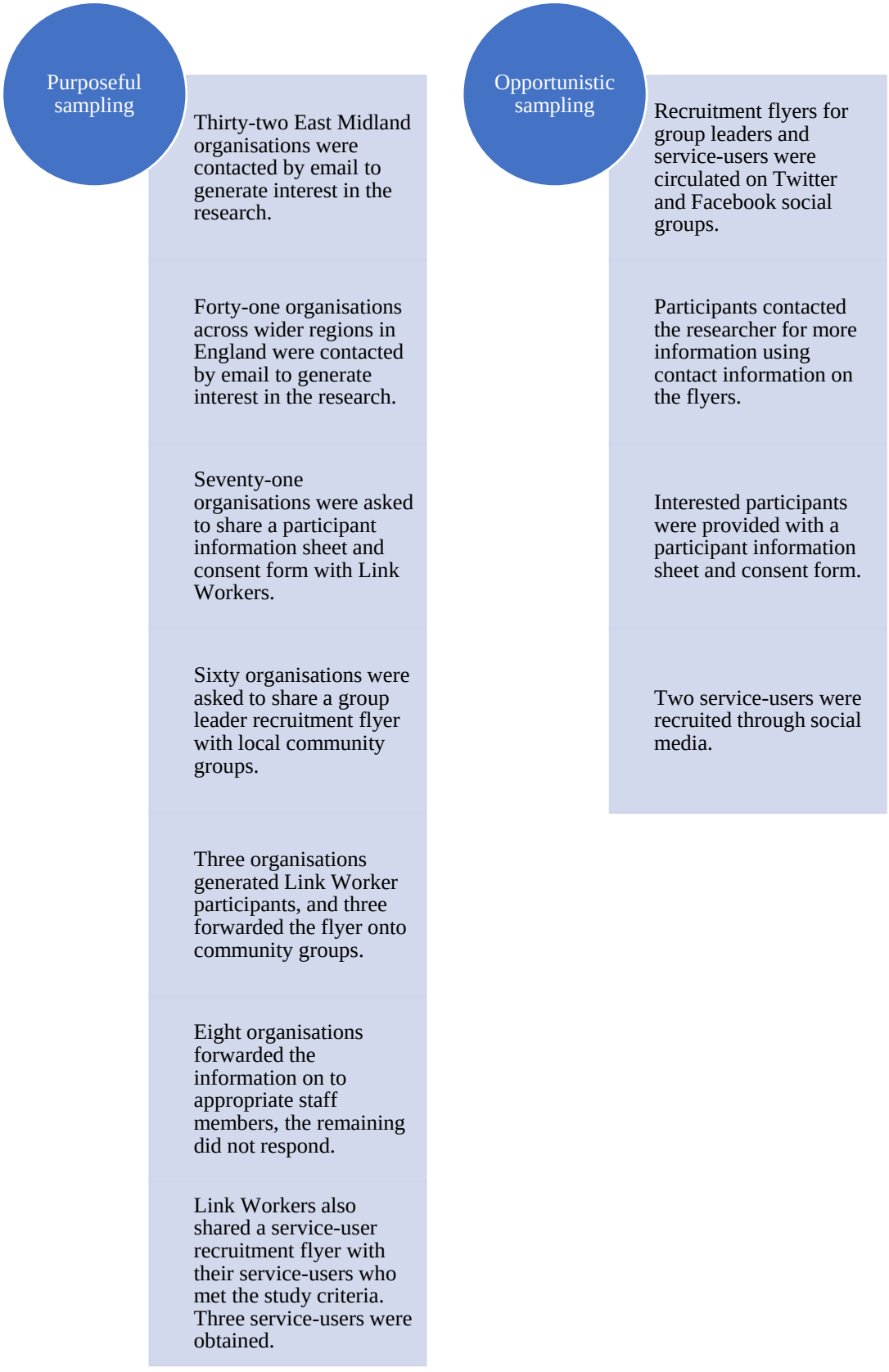
Recruitment initially targeted the East Midland counties of Derbyshire, Lincolnshire and Nottinghamshire but was later expanded to encompass the whole of England to encourage successful recruitment. Link Workers and group leaders were recruited between September 2020 and March 2021, and service-users between November 2020 and March 2021. Purposeful and opportunistic sampling methods were utilised in this study, as outlined in Figure 6.1. Additionally, snowball sampling was conducted with Link Worker participants to recruit group leaders, service-users, and other Link Workers, by asking existing participants to share the research opportunity. It was unclear which recruitment strategy had generated group leader participants.

Semi-structured interviews

Three individually tailored semi-structured interview schedules (see Appendix A) were utilised with Link Workers, community group leaders, and service-users respectively. Semi-structured interviews were appropriate for a contextualist approach as they supported the in-depth exploration of multiple experiences (Dejonckheere & Vaughn, 2019), as indicated in Chapter Five. The interview schedules explored current practice surrounding a social prescription to a community group, the group processes involved in successful social prescribing referrals, and whether stakeholders appreciated and understood group processes. A series of questions were derived from the SIAH, with follow-up questions prompting further clarification or exploration of responses. For example, the SIAH recognises the importance of providing a positive and welcoming group experience (Grant et al., 2017; MacIntosh & Law, 2015).

Figure 6.1

Recruitment processes for Link Workers, group leaders, and service-users



Welcoming group structures have been found to be a motivating factor for joining groups (Grant et al., 2017) and maintaining group memberships in qualitative research (MacIntosh & Law, 2015). These findings suggest that how a group responds to prospective members is important for encouraging people to join and maintain group membership. Consequently, the SIAH literature supported the addition of questions including: "What sort of atmosphere are you looking for?", "How do you ensure that new members feel they can join the group and feel part of the group?", and "How did the group make you feel", for Link Workers, group leaders, and service-users respectively.

Procedure

Informed consent was obtained, and interviews were arranged over email. During the interview, participants provided demographic information, were reminded of the study's purpose, and answered the interview questions. Afterwards, participants were debriefed, provided with their shopping voucher and a list of supportive resources to access if needed. The voucher was given regardless of whether a participant withdrew from the study. Participants could withdraw from the study at any point up until two weeks after their interview using a unique identifier they created during informed consent. All interviews were audio-recorded.

Ethics

Participants in the study may discuss sensitive topics, such as Link Workers sharing information about service-users from their caseloads. To protect privacy and minimise the risk of privacy violations, all identifiable information about participants and the individuals they discussed were anonymised during transcription (BPS, 2021a). Furthermore, the audio recordings containing non-anonymised information were deleted at the end of the study. Participants were also compensated for their time, in line with recommendations (BPS, 2021a),

with a £10 Shopping voucher due to the expectation to dedicate between 45 minutes to one hour to the study.

Data analysis

A hybrid, deductive-inductive, multi-perspective, Reflexive Thematic Analysis was conducted using the guidelines provided by Braun and Clarke (2021b, see Chapter Five) and NVivo pro-12. A multi-perspective analysis supported the consideration of differing stakeholder experiences of a community group social prescription (Kendall et al., 2009), whilst Reflexive Thematic Analysis supported the detection of shared patterns of meaning across the data (Braun & Clarke, 2019).

A hybrid analysis "reflects a balanced, comprehensive view of the data", because it can fully capture participant's views through inductive analysis, whilst also contextualising participant accounts through theoretical interpretations (Xu & Zammit, 2020, p.3). A hybrid approach was deemed necessary to capture the complexity of factors associated with social identification during a community group social prescription, in line with the study's aims..

Analytic procedure

Interviews were transcribed into a word document. No notes were taken during or after the interviews. A deductive analysis guided by the social prescribing, the SIAH, and the SIA literature was conducted first. Following deductive theme generation, the data was analysed inductively to fully capture novel stakeholder perspectives that could relate to group processes during a social prescription. For both inductive and deductive analyses, the six steps to Reflexive Thematic Analysis outlined by Braun and Clarke (2021b) in Chapter Five were followed. First, transcripts were familiarised through repeated reading and listening to the audio-recordings in accordance with step one. Data was analysed per stakeholder group with Link Worker data analysed first, followed by group leaders, then service-users. Following

familiarisation, initial coding occurred which involved generating semantic codes that provided explicit coding labels to sections of data forming step two. This initial list of semantic codes was then refined to remove duplicate codes.

Semantic codes were then analysed via latent coding, seeking the meaning within the data by using theory to inform interpretations. Similar codes with shared concepts were clustered together, forming initial themes in step three. Step four involved continuously reviewing, expanding, collapsing, or removing themes and subthemes, with feedback from a supervisory team, to refine the core concept of the theme in line with the data. Themes were labelled to highlight the core concept once refined. This iterative process continued until the themes adequately captured the essence of relevant parts of the dataset in relation to the research objectives as recommended for step five. Final themes included data from all participant groups, where relevant. Inductive analysis followed the same procedural steps for generating, reviewing, and finalising themes as deductive analysis, without searching for latent meanings relating to group processes. Instead, the data was searched for accounts of processes that could influence the community group referral process, an example of inductive coding is presented in Table 6.2.

Once inductive themes were generated, they were compared and combined with the deductive themes to create a hierarchical order of themes and subthemes. In accordance with step six, these themes were formally reported. Three themes were generated consisting of inductive and deductive subthemes, detailed in Table 6.3 and a thematic map in Figure 6.2. Themes were inclusive of the Link Worker assessment process and the group connection process within social prescribing, with subthemes referring to these processes based on the stakeholder perspective being analysed.

Table 6.2

An inductive coding example reflecting the semantic, latent and subtheme labelling of a data extract from a Link Worker participant.

Extract	Semantic code	Latent code	Subtheme	Main theme
"Well, I think first of all, the person who you are ref-connecting them to want-needs want to be connected. I think sometimes you know, we take referrals, or we get referrals and, when we actually speak with people, they're not really ready to be going to things. They need a bit more confidence building." (Link Worker 7, female)	Need to be ready	Readiness to attend a group is important for attendance	Are you ready yet? Willingness to engage with group prescriptions	Identification dynamics during the referral process

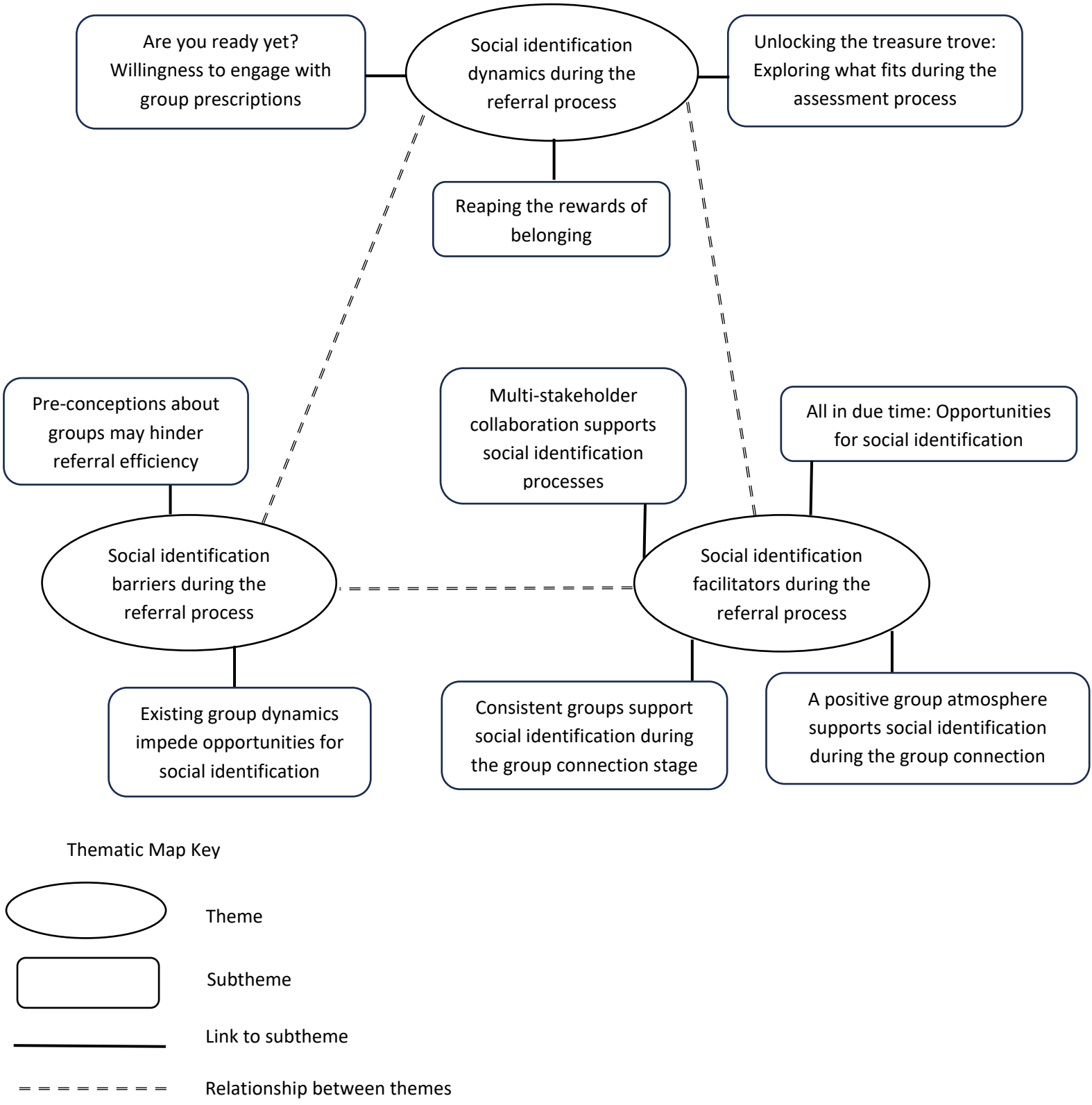
Table 6.3

Thematic table detailing the generated themes and subthemes

Theme	Subtheme	Inductive/deductive
Theme 1: Social identification dynamics during the referral process	1.1: Are you ready yet? Willingness to engage with group prescriptions	Inductive
	1.2: Unlocking the treasure trove: Exploring what fits during the assessment process	Deductive
	1.3: Reaping the rewards of group belonging	Deductive
Theme 2: Social identification facilitators during the referral process	2.1: Multi-stakeholder collaboration supports social identification processes	Deductive
	2.2: All in due time: Opportunities for social identification	Deductive
	2.3: Consistent groups support social identification during the group connection stage	Inductive
	2.4: A positive group atmosphere supports social identification during the group connection stage	Deductive
Theme 3: Social identification barriers during the referral process	3.1: Preconceptions about groups may hinder referral efficiency	Deductive
	3.2: Existing group dynamics impede opportunities for social identification	Deductive

Figure 6.2

Thematic map of the generated themes and subthemes of Study One.



Analysis and discussion

The following section details the three generated themes in Table 6.3 and Figure 6.2.

Theme 1: Social identification dynamics during the referral process

All participants demonstrated inherent knowledge of group dynamics that were present throughout the referral process. This theme covers three subthemes, 'Are you ready yet? Willingness to engage with group prescriptions,' 'Unlocking the treasure trove: Exploring what fits during the assessment process,' and 'Reaping the rewards of group belonging.'

1.1: Are you ready yet? Willingness to engage with group prescriptions.

Link Workers and service-users discussed readiness for group engagement in this inductive finding reflecting the importance of service-users being ready to engage with the recommended groups. Most Link Worker participants discussed a service-user's readiness to engage with a group from the context of them being motivated or willing to attend a group when describing how they would connect a service-user to a group:

> "Well first of all making sure that the client is ready to engage, for a start. So, this is- a client journey is key. And err there's one lady that erm I worked with for many months erm who was adamant at first…no, no, I'm not going to counselling... So, working with her over a period of time and erm she went to counselling… So, this is relevant in any groups I mean, somebody has to have the intention and the, the will and the drive and the motivation and all the other things that, you know inspires and encourages action to engage." (Link Worker 9, Female)

According to this sample, service-users may require time to find the motivation or readiness needed to attend a recommended community group via social prescribing. This focus on individualistic motivation and readiness to attend groups, as described by Link Worker 9 may be influenced by training in patient activation. Link Workers in this sample reported being trained in the PAM (Hibbard et al., 2004; NHS England, 2019c) to help them provide social

prescriptions. This measure assessed an individual's skills, needs, and confidence in managing their own health and wellbeing, with higher levels of activation indicating greater self-management ability that requires less support to engage social prescribing (Hibbard et al., 2004; NHS England, 2019c). Link Workers using this training recognised the importance of building service-user confidence to engage with a group, and that this process could not be forced:

> "I'm not going to force you to go to any groups, I'm not going to make you do anything you don't want to, and I'm always very sort of clear with that with people. It's a case of you know, it's what you are wanting, if you're not in the right place yet to be wanting this or you're not wanting to change that, absolutely fine that's your choice and I respect that." (Link Worker 10, Female)

When suggesting potential groups to service-users, Link Worker 10 emphasised the choice that service-users had when selecting the group/s they wished to attend. As such, Link Worker 10 was supporting service-users to have greater voice in their social prescribing journey towards improving their health and wellbeing. For most Link Workers, promoting empowerment through personal choice complies with the person-centred nature of social prescribing (NALW, 2019a), supporting service-users to actively decide to engage with a group, rather than passively accepting a suggested group. Service-user 5 reflects on the beneficial impact of empowerment for their own health and wellbeing:

> "I think the fact that it was- I wasn't referred as such. I just rang up. Erm, I mean I'm not saying don't refer people, cause sometimes that's beneficial, but you know it was, I think because I'd done it. Rather than somebody else. And I suppose that's the start of me taking control of my own destiny and my own life" (Service-user 5, Female)

After finding a leaflet at their doctors advertising an arts group, service-user 5 contacted the group to find out more information. For them, the act of choosing to contact the group themselves was empowering and they experienced increased agency through their action of

reaching out for support. From a social prescribing perspective, this action could be considered another success story for Link Worker training advocating empowerment and readiness to change. However, applying insights from the SIA literature, a service-users agency to manage one's own health and readiness to engage in health improving social relations is dependent on social categorisation processes and intergroup attitudes (Hogg & Reid, 2006) which could influence the cognitive accessibility of a recommended community group. Prior social experiences, such as whether one has previously been passive or active in accessing support, could influence a service-user's readiness to attend groups, by influencing the cognitive accessibility of a group (Hogg & Williams, 2000; Tarrant et al., 2020; Turner & Haslam, 2001). By considering a service-user's prior experiences and social interactions when empowering them to choose a recommended group, Link Workers should increase the likelihood of the service-user selecting a group they can identify with. Furthermore, social identities can satisfy a psychological need to exert control over one's actions (Greenaway et al., 2016), which could increase service-user agency to manage their health and wellbeing. Therefore, redefining how Link Workers understand empowerment and a service-user's readiness to engage in groups could increase the effectiveness of social prescriptions in facilitating valuable social identification. The next two subthemes explore deductive insights relating to group processes during a social prescription.

1.2: Unlocking the treasure trove: Exploring what fits during the assessment process.

A service-user's willingness to attend a group cannot facilitate the positive outcomes of group identification alone. For social identification to occur, a group must hold some initial value, attraction, or purpose to a prospective group-member (Abrams & Hogg, 1989), such as satisfying a service-user's needs or the presence of shared commonalities (Hogg & Rinella, 2018) between a service-user and other group members. Shared commonalities can include hobbies, interests, skills, and demographics, such as age or gender. Community group leaders

and Link Workers were aware of the importance of considering how a service-user's needs fit the available community groups:

> "So, you need to kind of find out- match both the criteria. So, what is the individual looking for, because they might be lonely and isolated but they're twenty-two years old. Well going to the local church group for people who are isolated may have attracted people who were sixty plus, and that might not be a good fit. But the individual may want to socialise with older people, so you really need to find out what the person is really looking for" (Link Worker 6, Female)

Link Worker 6 outlined the complex yet crucial task of matching a service-user to a community group that fits them. Matching the needs of a service-user to the criteria of a group should increase the chances of a social prescription facilitating group identification, because fit and shared commonalities are important group dynamics that foster social identification (Hogg & Turner, 1987; Oakes et al., 1991). Both dynamics help individuals to compare their level of similarity to others in the group (Jetten et al., 2017; Turner, 1984). Service-users placed similar importance on their being a right match between themselves and others within the group:

> "At first, I was erm sceptical like, will any other service-users in this group who have been labelled, or do you know- are supposed to be- have mental health difficulties, will I be able to relate to them? Will I be able to sympathise, and you know talk to them in a group environment" (Service-user 3, Male)

Service-user 3 expressed scepticism about their ability to empathise with and perceive themselves as similar to other group members. Their scepticism indicates that they are questioning their prospective level of fit with the group and whether they share characteristics and experiences with other members. In the SIA, high levels of fit and need satisfaction are likely to foster depersonalisation and the development of a shared group identity (Haslam, 2004; Hogg & Reid, 2006). The ease of comparing fit may be influenced by the extent to which

a Link Worker matches a group to a service-user's needs and interests. Community group leaders also expressed concerns about Link Workers providing appropriate matches to their groups, based on prior experiences of inappropriate referrals:

> "Well, I mean I can't say every referral was wrong but [organisation] were really working on the mentally handicapped[1] people… and you know I've got nothing against that at all. But they were pushing- we had one or two meetings, especially at the garden, when we met in the community garden. And erm these people with real- erm were mentally handicapped people with learning difficulties, and they were coming and disrupting us and one of our ladies is a retired social worker. And she said I really can't keep coming if- with how, you know, we've got to give help to these people" (Group leader 5, Female)

For group leader 5, the changed inclusivity of group boundaries (accepting people with learning difficulties) strained existing member's sense of belonging to the group by providing a barrier to engaging with the group. Referrals perceived to be inappropriate for a group can disrupt group cohesion and the strength of social identification amongst existing members (Levine & Moreland, 1994), causing existing members to disengage with the group if they perceive that it has changed or no longer fit their needs. To minimise this risk, the consideration of fit and what is valuable to a service-user could be matched to the purpose and demographics of the proposed community group. To practically implement this level of consideration, there will need to be effective relationships between Link Workers and group leaders to provide a thorough understanding of a group and who they can support. Some group leaders provided examples of how they supported prospective member's assessment of fit with the group:

> "If somebody is thinking about bringing somebody, erm a support worker of some sort, then I would have a chat and get a little bit of information over, such as like wh- what interests that

[1] This quote is from a verbatim transcript and the author recognises that this language is outdated and inappropriate. The quote is retained for authenticity and with the consideration that others may not understand or be aware that such language use is now outdated.

person has. Erm and then erm, well I mean- well in the past erm I might've… I might have made sure that we have an activity that was appropriate to that person going on" (Group leader 2, Female)

Group leader 2 appealed to prospective members interests by tailoring session activities for their arrival. This action supported assessments of fit by increasing perceptions of shared similarities between the prospective member's and wider group's interests. The provision of accessible activities to prospective members that match their interests, may also generate a sense of inclusion by encouraging engagement in group activities.

Consequently, the assessment process conducted by Link Workers plays a crucial role in shaping the provision of suitable groups that can facilitate social identification for service-users. Group identification is more likely to occur when service-users fit the group and share similarities with other group members. When this happens, service-users are more likely to remain engaged with the group because the group activities are desirable, beneficial, or enjoyable for them. Groups can support this process by tailoring activities to the interests or skill level of prospective members, which fosters feelings of inclusion and belonging (Ashforth & Mael, 1989; Tajfel & Turner, 1979) and facilitates social identification. Once a service-user feels a sense of belonging, they are more likely to experience the psychological benefits associated with group membership as explored in the next subtheme.

1.3: Reaping the rewards of group belonging.

Once a service-user becomes an ingroup member, The SIAH outlines that they should have increased access to the psychological resources that groups provide (Greenaway et al., 2016; Kyprianides et al., 2019). All participants commented on the benefits of belonging to a group, including improved confidence, health and wellbeing, self-esteem, and the provision of social

support. Most Link Workers showed tacit understanding of the importance of group belonging for service-users:

> "Yeah, I mean if the person doesn't feel included or they feel like there's ingroups, that you know, if your face doesn't fit… if you feel that you don't belong and you're made to feel you don't belong then you're not going to be motivated to be involved in any way shape or form, so those things are really important" (Link Worker 3, Female)

Feeling included and accepted by a group motivates maintained group engagement. Research indicates that those who are included in group activities are more likely to be perceived as ingroup members (Berkman & Glass, 2000; Putnam, 2000), and receive social support (Haslam et al., 2009; Jetten et al., 2009). Where service-users do not feel included, either due to poor fit or the presence of subgroups (explored in subtheme 3.2), then they are unlikely to experience the health benefits associated with group belonging. Group leaders recognised the importance of including new members:

> **"**They need to feel included, it's- it's really important that they feel part of that group, rather than the kind of you know, the new boy or girl on the side-lines. Erm and that's why I need to be really sure about that, that I think that physically, mentally they could be integrated into that group, because if they can't, then it's just going to be miserable for them and also miserable for other people" (Group leader 1, Female)

Group leader 1 expressed the importance for new service-users to practically and psychologically fit the group so that they would be included. Perceived similarities between a service-user and other group members are likely to lead to the group including them in group activities (Haslam et al., 2018; Levine et al., 2005). When a social prescription does result in social identification, the outcomes can be significant as outlined by service-user 5:

> "**I:** Okay, and what has changed for you then personally since you actually started to go to that group?

> **P:**…Erm I just feel like I'm a complete person now. Whereas before I was just so broken, I didn't ever see myself as anything other than a service-user… I've never felt that I've had an identity or purpose. Erm and this has given me that. This has giving me my identity and my purpose, which is priceless. Erm when I talk about thriving, not just surviving, that's the key difference." (Service-user 5, Female)

After joining an art group at one of their lowest moments of their life, service-user 5 discovered a new purpose in life. The process of joining and integrating into the group, and developing a sense of belonging, provided them with a new sense of identity. Group membership had furnished them with psychological benefits that provided them with the agency to thrive in life rather than just survive. This example shows how social prescriptions that facilitate social identification can result in the empowering health benefits that social prescribing was intending to provide.

Overall, group dynamics relating to a service-users willingness to attend a group based on prior experiences of social categories (cognitive accessibility), fit, need satisfaction, inclusion, and belonging can be found during social prescriptions to community groups. Each of these dynamics impact the development and maintenance of social identification and the potential health benefits associated with group membership. These findings provide valuable insight into aim two, with this theme outlining where these group dynamics may be present throughout the community group referral process providing insight into aim one. However, as noted in Chapters Three and Four, facilitating social identification is complex. The following two themes outline this complexity in greater detail, starting with factors that can support group identification during the referral process in theme 2.

Theme 2: Social identification facilitators during the referral process

All participants reflected on factors that could facilitate social identification during the referral process. Evidence of this span four subthemes 'Multi-stakeholder collaboration supports social

identification processes,' 'All in due time: Opportunities for social identification,' 'Consistent groups support social identification during the group connection stage,' and 'A positive group atmosphere supports social identification during the group connection stage.'

2.1: Multi-stakeholder collaboration supports social identification processes.

Effective social prescribing is reliant on collaboration between various sectors (NHS England & NHS Improvement, 2019). Goal-directed collaboration can influence collective, intergroup behaviour (Abrams & Hogg, 2006). In social prescribing, Link Workers collaborate with other stakeholders such as community groups and service-users, to connect service-users to community groups. Collaborative discussions between Link Workers and group leaders are essential for developing mutual understanding of the available groups in an area, increasing a Link Workers repertoire of resources they can utilise when determining which group/s may facilitate social identification. All Link Workers described collaborative discussions with group leaders when mapping their communities:

> "I've been liaising with her over the phone and through email and just sort of getting to know her and sort of wanting to know, you know, who are you expecting at your groups, what are you going to be discussing, what are you going to be talking about, what's- you know, what- what can I tell patients when I'm sort of suggesting this." (Link Worker 10, Female)

Link Worker 10 outlines the importance of communication in building an effective working relationship with group leaders, to determine what a group offers and who they support. This information can provide insight into a group's boundaries and their identity, particularly for smaller groups (Postmes et al., 2005). Link Workers may be cued to key information provided by the service-user, that they can match to a suitable group because they have developed a mutual understanding of who a group can best support. Within the interviews, service-users

and group leaders recognised the importance of this collaboration, with group leaders indicating that Link Workers should visit the groups to get a better feel for who they are:

> "I think you would need to make really, really sure that that person you know, the club that you were recommending them to join was going to be the right sort of place. Somebody would have to- somebody should meet up with somebody there and make sure that it most definitely was" (Group leader 6, Female)

Visiting the group should provide further insight into how the group operates, and whether it could be a good match for a service-user. This type of collaboration may be beneficial in supporting the provision of a right match, as indicated in subtheme 1.2. Visiting a group can also build intergroup trust which strengthens the collaborative relationship between a Link Worker and community group (Aughterson et al., 2020; Cakal et al., 2021). Therefore, intergroup trust between Link Workers and community groups is important for building trust in the social prescribing process and recommended community resources (Aughterson et al., 2020; NALW, 2019a).

Group leaders and Link Workers both endorsed the need to visit local community groups, despite this opportunity being constrained by social distancing guidelines during the interviewing period (Institute for Government Analysis, 2021). Some Link Workers further outlined how contact with groups further established collaborative communication opportunities between themselves and group leaders:

> "We get permission from the client to talk a little bit about whatever challenges they are experiencing and then we can chat that through with the group leader. If there's anything around any sort of physical disability or communication needs again, we would sort of talk to the group leader to make sure that they felt that they could accommodate that person sort of comfortably and safely, before we would then you know link the person to actually go along to the group" (Link Worker 1, Female)

Pre-group contact is highly valued by Link Worker 1 as it helps assess the suitability of referrals and increases the chances of connecting a service-user with a group they can establish a connection with. From a SIA perspective, this communication facilitates the evaluation of fit (Postmes et al., 2005) and helps align service-user and group expectations. It also minimises any risks to the group that may arise when recruiting new members. Pre-group contact makes the joining process smoother for both prospective and existing group members by providing reassurance that new members are likely to be like-minded individuals who do not pose a threat to the group's structure (Levine et al., 2004; Zander, 1976). Effective collaboration within social prescribing involves input on referral suitability from all stakeholders, and the use of feedback mechanisms can further enhance the process by addressing potential barriers to group attendance, integration, and social identification:

> "It can be a learning point as well for both of us and their feedback is helpful as well, because if erm, if there's a barrier or particular situation that happened, if I log it in my head and then there's someone else I'm thinking of signposting or referring to them and it might happen again, I might have a better understanding" (Link Worker 5, Female)

Where communication occurs with Link Workers on the progress of a referral, it can provide Link Workers with a greater understanding on how a group operates and who they support. From this, Link Workers can become more informed about failure or success. Likewise, feedback opportunities can also help address any issues that may occur during a social prescription to community group. Link Worker 10 reflects on how they collaborated with a group following negative feedback from a service-user who attended a second group session alone, following a positive first impression:

> "Because she had me to sort of- who was following up and sort of like, "oh how did things go, how was it, what did you get up to you?" And she's like "oh, really not good", and it's like oh my goodness why?... "Should we look at sort of trying to sort this out, would you like to you

> know, go back and give it another go? I'll have a chat with some of the volunteers, we can maybe you know, get you sat down in a different part of the [group]"… erm and through being able to have that you know- that sort of working relationship with the volunteers and obviously this lady, we was able to sort of get her back into that group" (Link Worker 10, Female)

The capacity for the service-user to feedback to Link Worker 10 on the group experience, and the subsequent capacity to collaborate with that group to resolve the negative experience, aided service-user integration into the group. Without this level of feedback, the service-user supported by Link Worker 10 may have disengaged from their social prescription due to the negative group experience. The cause of this experience is explored in subtheme 3.2, and the importance of having a positive first experience of a group is outlined further in subtheme 2.4.

Overall, collaboration between stakeholders supports opportunities for social identification, through facilitating trusting relationships between stakeholders. Trusting relationships can improve collaborative intergroup communications between stakeholders which can aid in both assessing initial fit between a service-user and community group, and for supporting service-users to attend and integrate into a group. These findings provide further insight into the complexity of balancing group dynamics during a social prescription and how important collaborative communications are throughout the social prescribing referral process. However, these processes take time to complete as outlined in the next subtheme.

2.2: All in due time: Opportunities for social identification.

Social identification is a complex and time-consuming process involving various group dynamics (Abrams & Hogg, 2006; Cruwys et al., 2020b; Tarrant et al., 2020). In social prescribing, it can take time for service-users to explore their needs and reach a point where they are ready to attend a group (Frostick & Bertotti, 2019). Additional time is required if a service-user needs assistance in accessing and integrating into the selected group/s (Hari,

2018). This suggests that the process of accessing suitable groups, integrating into them, and developing a sense of belonging cannot be rushed and requires appropriate support. Tarrant et al. (2016, 2020) recommend considering group identification over several time points, as an intervention and context progresses. Link Workers acknowledged the time it takes to complete a community group social prescription:

> "I worked with a young lad who was agoraphobic. Erm and when I first met him initially, he was not leaving the house for anything, not even to go to the shop or anything. And over time we sort of worked up a relationship to the point where, we were actually getting to the shop and back and to a point where he was actually going on his own. And actually, to a point where we went to some of these groups" (Link Worker 10, Female)

Link Worker 10 reflects on the time required to build a collaborative relationship with their service-user. The opportunity to develop a trusting relationship that was supportive and empowering, provided the service-user with the confidence to venture outside of their home and access local groups. In social prescribing, service-users may require multiple conversations with a Link Worker before they agree to attend a selected group or activity:

> "I found that I've had maybe six phone calls with someone before they go actually, yeah, I'd love the befriending service now. I think that's something that could work for me." (Link Worker 4, Female)

Some service-users may require six conversations with a Link Worker before they feel the suggested group or activity would be beneficial for their needs. As these phone calls may be weeks apart, this account provides further insight into the time service-users may need to reflect on and process their needs until they are ready to act on them. Depending on the social prescribing service, this could occupy most of the allocated time a Link Worker has for a service-user, particularly if they are in a 12-week scheme (Pescheny et al., 2018a). Service-user 1 further outlines the time it took them to act on a suggested group referral:

> "Amongst other things that the GP suggested, was joining the group, which I didn't actually do immediately, it was a couple of months. And then by chance I looked on erm [organisation website] what's on list and discovered that [organisation name] do a community group in [city], which bizarrely was held in our church… so I went along as a visitor because you can go as a visitor, and decided yes it was for me and so I joined" (Service-user 1, Female)

For this service-user, the suggested group was not enacted upon until months later when they had found out more information about the suggested group themselves. This suggests that Link Workers may want to disclose as much information about a group to a service-user, to encourage a timelier uptake of group social prescriptions. Link Workers and Group leaders also recognised service-users may need time to integrate into their group:

> "…so, we did have a lady that started to come. Erm she wouldn't speak to anybody, erm she wouldn't do anything…for about three weeks, she'd just sit next to me, not speak to anybody and knit squares. But slowly she started to get I think a little bit confident about the surroundings and now, well now she- but then she became one of the group" (Group Leader 2, Female)

Group leader 2 describes the slow integration of a group member who was not confident to interact with and integrate into the group. People may need time to take in new surroundings and observe a group before feeling confident enough to interact with group members. Group observations develop understanding of the group's norms and promote beneficial interactions with group members that support social identification (Oakes et al., 1991). Research indicates that time spent interacting with other group members on group-based activities, such as group singing, positively predicts the development of psychological connection with the group (Bullack et al., 2018; Pearce et al., 2016). Therefore, whilst the group concept should be of interest to a service-user when looking to join a group, time to observe and interact with other group members on shared activities may be more important for facilitating psychological connection during group integration. Group leader one supports this:

> "I've seen it happen so many times, when you've had somebody that you know, the- the rugs been pulled out you know from underneath, and they've got nothing left. They're just miserable, they've got no purpose, no point to their lives and then they- they, I don't know they come along to a [group] and then they cry the first two times, because they feel so pathetic[2] and miserable and lonely and then gradually, they get integrated and gradually they feel stronger, and gradually they make friends and gradually those friends may all come join the theatre group" (Group leader 1, Female).

From experience, group leader 1 outlines how gradual integration into the group due to time spent with other members increased people's psychological connection to the group, which resulted in improved wellbeing and social relationships. Social identification developed over time, by gradually becoming an active group member. The benefits of identification are then recognised by group leader one as increased agency, self-esteem (Foster et al., 2021; Greenaway et al., 2016), and increased social relationships (Kellezi et al., 2019c; Wakefield et al., 2022). Consequently, social prescriptions designed to foster and facilitate social identification cannot be rushed if one wants to achieve the subsequent health and wellbeing benefits associated with a group referral. These findings highlight the time sensitive nature of social prescribing for supporting service-users to act on a social prescription, deepening understanding of aims one and two and the potential time required to provide a community group social prescription and support new group member integration into a group that facilitates social identification. The next subthemes explore supportive factors relevant to joining and integrating into a group during the group connection stage of the referral process.

[2] This quote is from a verbatim transcript and the author recognises that this perception of a service-user's feelings of self-worth may not be representative. The quote is retained for authenticity and in recognition that this group leader used to be a Link Worker and may have had a service-user express these feelings to them.

2.3: Consistent groups support social identification during the group connection stage.

Consistency was an inductive finding considered important for facilitating group engagement. Link Workers and group leaders reflected on the practical elements of group consistency, such as the timing and location of a group. Link Workers noted how a disruption in routine could increase disengagement:

> "If something changes within the group, people who decide they no longer want to go, so maybe the environment changes. Maybe erm how the sessions run change, maybe there's less- maybe a break moved to a different time. But erm, people are creatures of habit, so if they're used to a group being on erm a certain time, certain place, and it changes time from 11 till 12 for example, people might just stop going" (Link Worker 6, Female)

Link Worker 6 acknowledges that people are habitual creatures that can become reluctant to maintain group engagement when the group environment changes. Thus, a lack of practical group consistency, e.g., timings, locations etc., may disrupt people's capacity to maintain group identification. For group leaders, practical consistency helped them to create a space where their members could develop a sense of connection to the group:

> "I think why people come to my class is because I'm just there. I'm not- you see they know about my family; they know about my background, and I think my class feel very secure and it's not an open class. So, the people that come every week, they know, they start to get to know each other… people don't come and go… every week they see most of the same people, so you get a bond between people" (Group leader 4, Female)

For group leader 4, the consistency of their sessions provided group members with a space to bond and supported the development of consistent relationships between group members. Providing space for group members to interact with each other is important for developing a sense of belonging with and between group members (Code & Zapryniuk, 2010). A lack of

practical group consistency within a group may prevent prospective members from developing a sense of belonging with the group, as experienced by service-user 4:

> "Erm yeah. I think that not having- because it was not like a regular thing, I didn't- yeah, I didn't have like- I couldn't really have like a connection to anyone or, I don't really have a connection to the group. Like it was quite easy for me like, when I like stopped going because it was just like erm. Yeah... it helped me like for a period of time and then afterwards, it wasn't, it wasn't that helpful." (Service-user 4, Female)

Service-user 4 struggled to develop and maintain any beneficial social connections to others in the recommended group they chose to attend. The lack of consistency in how the group operated and who attended the group meant disengagement was easy as they did not feel committed to the group or its members. Whilst the group was perceived as initially beneficial, the inability to maintain consistent relationships with other group members hindered service-user 4's capacity for group identification and they disengaged. Therefore, ensuring there is practical consistency regarding group locations and timings, as well as consistency in member interactions, is important for supporting social identification. These novel findings outline the reliability required from community resources to support a successful social prescription to a community group (exploring aim one) and that provides opportunities for service-users to experience consistent interactions with other group members that facilitate social identification, e.g., (exploring aim two). The final subtheme explores the need for providing a welcoming experience for service-users to support group identification.

2.4: A positive group atmosphere supports social identification during the group connection stage.

Welcoming group members into a group can be seen as an inclusion tactic. The importance of inclusion for group identification was outlined in subtheme 1.3, however use of such positive tactics can help service-users to feel they are genuinely desired and appreciated by the group

(Levine et al., 2004). Providing a positive group atmosphere may aid social identification through providing a positive first impression of the group. The social identity literature suggests that a positive group atmosphere is polite, respectful, open, and friendly (Borek et al., 2019a). All participants recognised the importance of being welcoming and inclusive to prospective members, with group leaders outlining how and for whom they were welcoming:

> "We are a community space erm for all variety. We have people- we have asperger's, autism, erm bipolar, borderline personality disorder and people that have got anxiety or are just feeling a little bit isolated" (Group leader 2, Female)

For group leader 2, providing a welcoming and inclusive atmosphere meant providing a safe space for people managing various mental health diagnoses to come together and form a community. The utilisation of the word community indicates the presence of a shared social connection between group members. Shared social connections may reflect shared realities, which can foster social identification due to shared similarities between group members (Hogg & Rinella, 2018). Most group leader's understanding of being welcoming aligns with the theoretical description thought to support social identification (Borek et al., 2019a). Group leaders would personally introduce themselves to a service-user, ask if they would like anything to drink (if relevant), and then connect them with other group members so they could interact with the group. One welcoming tactic used by some group leaders, and recommended by some Link Workers was a buddy system, which involved matching a prospective member to an existing group member, who would support their integration into the group:

> "We were sort of thinking of…making sure that the groups that we're referring to have a sort of champion within them. That we- that met new people and made sure they were comfortable and made sure they were happy being there and that they weren't sort of pushed into the corner while everybody else carried on chatting" (Link Worker 7, Female)

Link Workers recognised the importance of a community group for being supportive and welcoming to service-users attending the group. A buddy system minimises the risk of a prospective member being excluded from group activities and would provide existing group members the opportunity to interact with prospective members and teach them the group norms (Borek et al., 2019a; Levine et al., 2004).

Some service-users attributed the welcoming nature of a group to effective group leadership skills. Group leader effectiveness is thought to influence the development of a shared social identity because they facilitate and manage group interactions (Borek et al., 2019a). The SIMBC model outlines that shared identity can be facilitated by encouraging group members to reflect on their collective values, clarifying the group identity, and promoting actions that reinforce the group's importance (Tarrant et al., 2020). For service-users a good leader is welcoming, friendly, approachable, and listens to their group members:

> "I think the facilitator at the first instance, like he said take a seat. He was very welcoming, he had a good attitude, his personality was very erring down to Earth. And I think he had the right characteristics to you know, to work err with mental health. So, he was a very good listener… I think it was just that facilitator, that group dynamics and the way that he could pull things together and his skill and his ability made the group successful" (Service-user 3, Male)

Good leadership skills helped to create a smooth integration experience for service-users. Service-user 3 was made to feel comfortable within the group. When groups are not welcoming, service-users may disengage and seek support elsewhere. This is explored further in subtheme 3.2. Community groups that help prospective members experience a positive impression by being welcoming, inclusive and supportive can minimise the risk of them disengaging with the group by increasing perceptions that they are valued, providing valuable insight into aim one and two.

Theme 3: Social identification barriers during the referral process

Consistent with previous research, all participants indicated practical barriers to accessing a group to be a concern, such as transport, costs, mobility, motivation, and service locality (Husk et al., 2019; Moffat et al., 2017; Wildman et al., 2019b). These types of barriers could impact opportunities for social identification, by limiting a service-users ability to access the group. However, stakeholders also provided novel insights into barriers that could impede group identification. Two subthemes reflect these barriers, 'Preconceptions about groups may hinder referral efficiency' and 'Existing group dynamics impede opportunities for social identification'.

3.1: Preconceptions about groups may hinder referral efficiency.

Preconceptions of groups can significantly influence a service-user's likelihood of attending and psychologically connecting with a group, according to Link Workers and service-users in this sample. Prior group or service experiences can shape the cognitive accessibility of a group, due to preconceived expectations of that group (Oakes et al., 1994) impacting the likelihood of one categorising themselves as a group member (Levine & Moreland, 2004). Positive experiences can increase motivation, while negative experiences can be demotivating (Levine & Moreland, 2004). In social prescribing, prior experiences of services can influence the social prescription process. For instance, Link Workers may have personal preferences for community groups which may introduce bias in their community resource recommendations:

> "I think you do kind of really pick out somethings that you think yeah, some real good works going on there erm and that probably influences. I think that's influenced me sometimes and it's maybe something I worry about as well, of almost like that prejudice in you just because… I think it's a really good thing, peer support and I feel like maybe I incorporated that- not just asking everyone do you wanna do this, but maybe my questioning angled things to, do you feel

> if you had someone to talk to regularly about that, or could hear from other people going through a similar thing." (Link Worker 8, Male)

Link Worker 8 acknowledges that their preference for peer support may have influenced their interactions with service-users. While their preconception is positive, it can have a negative impact on service-users. Service-users may unintentionally agree to attend a group that is not suitable for their preferences, resulting in a mismatch between the service-user and the group, which hinders the likelihood of social identification. This occurred with Link Worker 10 who demonstrated implicit biases by repeatedly recommending a specific group to their service-users based on their perception that anyone would feel welcome there. However, their preconception led to an inappropriate social prescription to that group:

> "We went to the [group name], and he- he went there, and he found it really nice, really welcoming but he was so anxious and so worried, and it wasn't his thing… it's like okay, this doesn't work for ya, that's- that's absolutely fine but at least you tried it. There's no ties to this, you don't have to commit to coming here, we're just coming to see what's it about… Erm and we actually found a different group in town called erm [group name]." (Link Worker 10, Female)

Link Worker 10's preference for a specific group may have caused oversight in ensuring that the group was a good fit that the service-user was willing to attend. If the first group experience is not perceived to be a good fit, service-users may struggle to develop a sense of connection and disengage with the group. Alternatively, negative preconceptions that make group memberships seem unattainable due to incompatibility with existing identities can also prevent engagement with groups. Research by Frings et al. (2020) outlines that when existing identities are considered incompatible with prospective identities, it can result in negative outcomes. In social prescribing, negative preconceptions that make group status seem unattainable due to incompatibility with existing identities, may result in service-users disengaging with

potentially beneficial group referrals that could facilitate group identification. Service-user 5 outlines how their preconceptions of art-based groups did not align with the group memberships defining their sense of self:

> "Yeah because (pause) arts for arty farty people, it's for posh people. You know, it's not for somebody who was on benefits, whose kids look after them. Erm, you know it's not for the bog-standard person, it's for people with money, it's for people who can appreciate it." (Service-user 5, Female).

Service-user 5 held preconceptions about art being associated with affluence and distinct from their perceived social status of being "on benefits" and as someone in the care of their children. These preconceptions meant they had never attempted to engage with art prior to attending the art group where they gained a new sense of purpose in life, as outlined in subtheme 1.3. If this service-user had allowed their preconceptions to guide their actions on attending the group, they may not have experienced the benefits they received from belonging to the art group. Consequently, preconceptions of services may impact the likelihood of service-users engaging with groups they can socially identify with. In either case, preconceptions may need to be considered and addressed carefully throughout the social prescription process to prevent them from hindering opportunities for group identification during the referral process to community groups. This inductive finding further supports aims one and two by outlining the influence that prior social experiences may have on service-user engagement with a social prescription and the subsequent opportunity to facilitate group identification. The last subtheme outlines how existing group dynamics can prevent prospective group members from developing a sense of belonging to the group.

3.2: Existing group dynamics impede opportunities for social identification.

Existing group dynamics, such as the existence of subgroups within a group, were considered a potential barrier for new members looking to join and integrate into the group. Subgroups, referred to as "cliques" by some participants, represent a proportion of group members that have formed close friendships within the larger group (Adler & Adler, 1995; Cohen, 1977). Groups with cliques reduce opportunities for personal relations between all group members (Abrams & Hogg, 2006), and may neglect to welcome and interact with prospective members due to perceptions that they are not ingroup members (Cole, 1954; Martin et al., 2014). Link Workers and group leaders acknowledged that subgroups could be barriers for service-users looking to join a group, with Link Worker 10 recalling an incident that occurred with one of their service-users:

> "I spoke to her the day after she went to the group, and she said I went and nobody even talked to me. And I was sort of like, nobody talked to you? She's like yeah, I- I went to go speak to some of the ladies that I spoke with the other week, but they were sort of in their own conversation and I didn't feel like, they was trying to sort of encourage me to be involved in the conversation." (Link Worker 10, Female)

The experience described by Link Worker 10 explains the situation in subtheme 2.1, where a service-user provided negative feedback of a social prescription following a first positive experience. When the service-user attended the group alone, members of the group they initially interacted with neglected to include the service-user, suggesting that those group members may not have perceived the service-user to be an ingroup member. Where subgroups discourage prospective member attendance, opportunities for group identification are hindered. Group leader 1 notes an instance where subgroups have impeded continued engagement with the group:

> "I accompanied someone to an arts group once and she wasn't really welcomed in. I don't know whether they just thought well Sally's with her, so we don't really need to talk to her, but she

> kind of was on the edge and she so she didn't feel part of the group. That should have been a wonderful experience for her, but they didn't kind of you know welcome her in, they didn't chat to her and so she felt isolated, so she you know she didn't wanna go back" (Group leader 1, Female)

Group leader 1 reflects on their experience of supporting a service-user to attend an art group and in doing so, highlights a point of interest regarding existing group dynamics. A Link Workers presence may prevent service-user integration into a group. Service-users do benefit from being supported to community groups (Wildman et al., 2019b), however once there, Link Workers may need to help the service-user settle into the group and interact with other group members by taking a step back and observing. If this does not occur, then others within the group may perceive that support is already being provided and therefore fail to interact with the service-user, hindering social identification.

In extreme instances, subgroups may become discriminatory towards prospective members whom they perceive to be outgroup members (Adler & Adler, 1995). For example, subgroups within senior centres have been found to become territorial and exclusionary towards new members (Salari et al., 2006). This behaviour can reflect attempts to maintain a positive distinct social identity through degradation of outgroup members (Abrams et al., 2021). As a result, service-users are likely to disengage with the group:

> "…another time before, when I joined another group when I was quite young as a teenager, there were people who were making judgements, people who are making opinions, people who were very discriminative people who were err speaking to you inappropriately. So, I think that's err what put me off from joining that group as well" (service-user 3, Male)

Service-user 3 disengaged with a group whose existing members marginalised prospective members. Aside from impeding integration into and continued engagement with a group, these negative dynamics within groups can impede one's ability to trust the group. Trust is important

in groups as it supports cohesion, enables collective action, and is built through shared group membership and group interactions (Ferguson & Peterson, 2015; Reicher, 1996; Tanis & Postmes, 2005). If one does not trust a group, they are unlikely to develop a sense of belonging with the group (Tarrant et al., 2020), which further limits access to the psychological resources provided by groups (Greenaway et al., 2016). Therefore, existing group dynamics have the potential to hinder opportunities for social identification and can limit access to the potential benefits of group membership. This finding deepens understanding of aim two by outlining when group dynamics may not be supportive during a social prescription. As such, the dynamics within a group need to be monitored carefully to ensure service-users are actively welcomed and integrated into a group by existing group members.

Summary

This study aimed to explore the social prescribing referral process to community groups and participant views and recognition of group processes that facilitate social identification via interviews with Link Workers, community group leaders, and service-users. All participants demonstrated inherent understanding of group processes occurring during a social prescription explored through three themes: 'Identification dynamics during the referral process,' 'Identification facilitators during the referral process,' and 'Identification barriers during the referral process.'

Theme one found that Link Workers focused on ensuring a service-user's readiness to attend groups, reflecting the empowering nature of social prescribing (NALW, 2019a), and supporting a service-user's perceived readiness to engage with groups they may want to socially identify with (Turner & Haslam, 2001). Matching service-users with suitable community groups was considered essential for addressing their needs and fostering group identification (Hogg & Rinella, 2018). The greater the fit, the more likely a service-user was to integrate into a group

and develop a sense of belonging (Haslam, 2004). Lastly, all participants recognised the psychological benefits and health benefits associated with social prescriptions to community groups that elicit social identification (i.e., social support, improved self-esteem, improved confidence, Greenaway et al., 2016).

The second theme highlighted the importance of developing collaborative and trusting intergroup relationships. Intergroup collaboration was crucial for supporting social prescriptions (NHS England & NHS Improvement, 2019), with communication channels and site visits supporting a mutual understanding between Link Workers and group leaders on who would fit a group (Postmes et al., 2005). Time for service-users to observe groups and develop a psychological connection was also necessary to support social identification processes (Bullack et al., 2018; Oakes et al., 1991; Tarrant et al., 2020). Providing a positive first impression during the community group connection stage through supporting a welcoming, friendly, and supportive group atmosphere (Borek et al., 2019a), was facilitative of group engagement. The use of a buddy system could welcome service-users into a group and teach them the group norms (Borek et al., 2019a). Lastly, all participants indicated that groups should be consistent with their locations and timings, and in encouraging group member interactions. Disruptions to consistency may cause service-users to disengage with a group therefore group consistency should be considered when seeking to facilitate group identification.

The third theme outlined preconceptions about groups and their impact on the referral process. Preconceived notions based on past experiences could influence Link Workers' recommendations and service-users' consideration of suitable groups, potentially hindering social identification (Levine & Moreland, 2004). Finally, existing group dynamics, particularly subgroups reluctant to engage with new members, could undermine opportunities for group identification and the referral process by impeding trust (Tarrant et al., 2020).

Overall, the findings emphasised the importance for: a) considering whether a service-user is ready to engage, b) considering the shared similarities and prior experiences of service-users to improve fit, c) ensuring that a group satisfies a service-user's needs, d) ensuring there are feedback mechanisms in place to support multi-stakeholder collaboration, e) offering time to provide a social prescription, f) providing a positive first impression, g) offering a consistent group setting, h) addressing preconceptions of groups, and I) discouraging the formation of subgroups. These insights contribute to the understanding of group processes and their role in facilitating effective social prescribing interventions.

Strengths and limitations

The study was conducted between September 2020 and March 2021 where the COVID-19 pandemic posed challenges for recruiting participants as the social prescribing and voluntary sector faced disruptions (Bertotti & Temirov, 2020; Stevenson et al., 2020b). Community group social prescriptions were replaced with support for basic needs (Fixsen et al., 2021), and many community groups ceased operations or shifted to remote sessions (Bertotti & Temirov, 2020). These changes may have influenced participant decisions to take part in the study, due to limited current experience of either supporting a community group social prescription (Link Workers), running a community group (group leaders), or having been connected to a community group (service-users). This is noted in the small service-user sample in this study, with service-users being a notoriously difficult population to recruit due to their vulnerability (Ellard-Gray et al., 2015), which was not aided by the constrictions of the pandemic. In response, service-user inclusion criteria were broadened to anyone who had been referred to a community group by a health professional rather than those referred through a social prescription. However, this increased the risk of recruiting participants who may not represent the Link Worker referral pathway of social prescribing or represent the variety of service-user experiences associated with social prescriptions. For example, this study did not capture the

voices of service-users who had declined a social prescription, who had received an online social prescription, who were placed on a waiting list, and who were unable to attend or join community groups, although this is common to most social prescribing studies. This lack of inclusivity may undermine the strength of service-user claims within this study and the applicability of finding from service-users.

Despite these limitations, this study did generate insightful and applicable information to shape the creation of a draft Community Prescribing Toolkit as discussed in the next subsection. These insights were enabled by another strength of this research, the epistemological stance of the study. The contextualist stance allowed the researcher to interpret both deductive and inductive findings within the broader social context of social prescribing and the SIAH (Braun & Clarke, 2021b). Without this stance, the deductive findings from this research may have proved too restrictive when applying the SIAH to social prescribing. The ability to incorporate inductive findings, such as assessing a service-user's willingness to engage with groups and ensuring there is consistency in how and when groups operate, is crucial for ensuring the toolkit remains theoretically appropriate to social prescribing. However, whilst inductive coding intended to generate data orientated themes, it is possible that theory influenced latent analysis of the inductive coding. This is because no research can be purely inductive or purely deductive (Braun & Clarke, 2012; Byrne, 2022). The next section details the creation of the Community Prescribing Toolkit based on the insights generated during this study and the wider SIAH literature.

Creating the draft Community Prescribing Toolkit

In response to the second aim of this study, the themes generated during Study One were utilised alongside the wider social identity literature to create a series of recommendations for facilitating social identification during a social prescription. These recommendations formed

the first version of the proposed toolkit that was created between March-April 2021. Two sets of recommendations are directed towards Link Workers and group leaders respectively, both parties being key to supporting social identification during social prescribing. Four documents were systematically created and formed into the initial Community Prescribing Toolkit. These documents included: 'Section one: Background and overview,' 'Section two: Guidance for Link Workers,' 'Section three: Community Prescribing Tool overview,' and 'Section four: Guidance for community groups.

To create these documents, the social prescribing referral process to community groups was mapped onto Tarrant et al.'s (2020) SIMBC model, detailed in Chapter Three. The nature of the Link Worker assessment processes and the community group connection processes inspired the decision to utilise Link Workers and group leaders as facilitators of social identification within Tarrant et al.'s model. The toolkit follows the chronology of a social prescription, from connection to a Link Worker to referral to a community group, incorporating recommendations guided by the SIAH.

Section one: Background and overview

- A two-page document providing a brief overview of the toolkit and the application of the SIAH to social prescribing.
- Subthemes 1.1, 1.2 and 1.3 supported the creation of this section by introducing readers to the importance of connecting service-users to groups that are accessible and that fit their needs to avoid disengagement. Readers are also informed that connecting service-users to groups that they can develop a sense of belonging with is likely to increase their health and wellbeing due to the psychological resources that groups provide. Subtheme 2.2 further supported the creation of this section by emphasising the time necessary to provide a social prescription that facilitates social identification.

- Theoretical insights that supported the creation of this section included highlighting the concerns around disengagement during social prescribing (Wildman et al., 2019b), and how the SIAH is a suitable theoretical framework that can address disengagement and optimise service-user health and wellbeing through facilitating group identification (Kellezi et al., 2019b; Wakefield et al., 2022). Readers are informed that a sense of belonging is associated with group identification but that this takes time to develop (Doosje et al., 2002). Chapter one in Jetten et al. (2012) and Chapter two in Haslam et al. (2018) supported the brief description of the SIAH for readers, whilst Hornsey (2008) informed the description of categorisation for readers. Leach et al. (2008) is then utilised to introduce readers to centrality and how important group memberships have greater health and wellbeing benefits. Greenaway et al. (2016) further supports the readers introduction to the psychological resources that groups provide. Finally, Hogg & Reid (2006), Oakes et al. (1991) and Tarrant et al. (2020) all support the readers understanding of connecting service-users to groups that are cognitively accessible.

Section two: Guidance for Link Workers

- A four-page document providing guidance to Link Workers on how they can facilitate social identification during a social prescription to a community group. The SIAH is applied at the community mapping stage precluding a service-user's referral into social prescribing (NHS England & NHS Improvement, 2019), the Link Worker assessment stage, and the connection to a community group stage (Runacres, 2022) of the referral process.
- Subthemes 1.1, 1.2, 2.1, 2.2, 2.4, and 3.1 supported the creation of this document. Readers were informed about the importance of building collaborative working relationships between stakeholders (subtheme 2.1). Recommendations included visiting groups to gain a greater understanding of who they could support, and

providing opportunities for feedback from group leaders and service-users to understand if social prescriptions were successful. The time necessary to build collaborative relationships and support social identification during a social prescription (subtheme 2.2) was also re-emphasised. Link Workers were further made aware of how negative prior experiences can lead to preconceptions that limit engagement in a group referral (subtheme 3.1). Link Workers were recommended to ensure a service-user is ready to attend a group (subtheme 1.1). Likewise, the section recommended exploring how a service-user fits a group and vice versa (subtheme 1.2), to increase the likelihood of maintained engagement and group identification. Finally, this section recommended Link Workers to confirm the likelihood of a group providing a welcoming experience (subtheme 2.4) for their service-users to improve first impressions and facilitate maintained group engagement.

- Theoretical insights for this section cohesively provided insight into how Link Workers can build and apply knowledge of group processes during a social prescription. Link Workers were informed of the importance of building positive intergroup relationships based on trust (Halabi et al., 2021), direct personal contact (Allport, 1954; Dovidio et al., 2011), and open communication (Schruijer & Vansina, 2008), to support a successful connection to a community group. Readers were also reminded of the time it takes to foster social identification (Abrams & Hogg, 2006). The SIAH hypotheses in Haslam et al. (2018) were also utilised in this section to emphasise how groups improve health and wellbeing through meaningful group life. Link Workers were recommended to consider a service-users prototypicality to the potential groups they were considering suggesting (Hoffmann et al., 2020), to improve the likelihood of the service-user feeling a sense of belonging to the group and receiving the benefits of group membership (Hogg & Rinella, 2018). Prior experiences can also shape the

accessibility of groups suggested by Link Workers (Hogg & Williams, 2000); therefore, group suggestions require careful consideration on their accessibility for service-users. Link Workers were also recommended to consider how similar a service-user is to other group members (if practical within their working remit) and whether the groups behaviour matches the stereotypical expectations of the group so that the group was more likely to fit the service-user (Turner et al., 1987).

- Other recommendations included fostering trusting relationships with service-users, so they perceive the support offered to be genuine (Calderón-Larrañaga et al., 2021), with trust being facilitated through similarity, physical proximity, successful collaboration towards a shared goal, and autonomy (Brown & Pehrson, 2019; Hogg & Abrams, 1993, Tarrant et al., 2020; Turner et al., 1984). Autonomy is encouraged in social prescribing and reflects a basic psychological need that group membership satisfies (Deci & Ryan, 2000; Greenaway et al., 2015; Koudenberg et al., 2017). This section also educates Link Workers on the importance of continuity and centrality (Leach et al., 2008). Self-continuity refers to a continuous sense of self across one's past, present, and future and is a motive for group identification (Sedikides et al., 2018; Smeekes & Verkuyten, 2015). Having high identity centrality may buffer the negative effectives of group-based stressors (Crane et al., 2018), therefore facilitating important group memberships may best support improved health and wellbeing.
- When connecting a service-user to a group, Tarrant et al.'s (2020) identity realisation stage of the SIMBC model supported recommendations for Link Workers. The community group should be helping service-users understand why that group matters to them so that they remain engaged in the group. Link Workers were recommended to follow up with a service-user to assess how well a social prescription had gone. Service-

user's that have a positive feeling about their group are more likely to socially identify with the group (Leach et al., 2008).

Section three: Community Prescribing Tool overview

- A six-page document provides key information and questions that Link Workers can utilise to generate identity-based information to match to a community group. A Community Prescribing Tool spanning three pages supports the monitoring of this information, acting as a summary for Link Workers to review before suggesting a potential group. Six discussion points that are informed by the SIAH are provided to Link Workers to encourage them to consider ways they can ask identity-related questions during their assessments with service-users.
- Subthemes 1.1, 1.2, 3.1, and 3.2 supported the creation of this section. Link Workers can utilise the community prescribing tool to record key responses from the assessment, the chosen groups to attend, and a plan of action to attend those groups. Thematic recommendations included considering a service-user's needs and potential commitments that could impact their ability to attend groups (subtheme 1.2), considering a service-user's readiness to attend a group (subtheme 1.1), what similarities a service-user shares with suggested groups (subtheme 1.2), a service-users prior experiences of groups (subtheme 3.1), and whether a group would support or exclude service-users due to subgroups (Subtheme 3.2).
- Theoretical insight supported the included recommendations of considering a service-user's needs (Greenaway et al., 2016) and whether a group is likely to be central to one's social identity (Leach et al., 2008). Further recommendations included considering whether a service-user is ready attend a group (Hogg & Rinella, 2018), whether prior experiences influence the accessibility of a group (Tarrant et al, 2020), whether there are shared similarities between a service-user and a suggested group

(Fancourt et al., 2020; Tarrant et al., 2020; Walsh et al., 2015), and whether service-users have existing social networks that they can re-establish or build upon (Haslam et al., 2019b).

Section four: Guidance for community groups

- A four-page document mirroring the Link Worker guidance but tailored for community groups. This section acknowledged the vital role groups play in facilitating social identification during a social prescription.
- Subthemes 2.1, 2.3, 2.4, and 3.2 supported the creation of this section. Community groups were recommended to provide clear information about their group, provide pre-group contact opportunities for service-users, and provide feedback on the suitability of new members in their group (subtheme 2.1), to provide a welcoming atmosphere and a buddy to support new member integration into the group (subtheme 2.4), to be consistent in their timings and locations if possible (subtheme 2.3), and to discourage the formation of subgroups that could prevent prospective members from joining the group (Subtheme 3.2).
- Theoretically based recommendations focused on how community groups can best work with Link Workers and support service-user integration into the group. Community groups were recommended to build a collaborative intergroup relationship with Link Workers under the shared purpose of supporting members of their community (Boudreau et al., 2016; Hogg, 2015). This included a recommendation for transparency of who the group can support and what they do. When introducing prospective members into a group, recommendations included responding positively to prospective members, encouraging them to the see similarities between them and other group members (Beauchamp et al., 2011; Leach et al., 2008; Turner et al., 1987), encouraging interaction in activities to increase trust and member familiarity (Tarrant

et al., 2020), and maintaining practical consistency to support members developing a sense of connection to the group (Code & Zapryniuk, 2010). Recommendations were also provided to support effective group leadership, including meeting a service-user before their first group session to support early assessments of fit (Postmes et al., 2005), facilitating inclusion using inclusive language and encouraging group member interactions (Tarrant et al., 2020), managing group dynamics to reduce conflict, exclusionary behaviour and subgroups (Tarrant et al., 2020), and maintaining communication with group members to support and maintain group identification (Borek et al., 2019b).

All of these recommendations are guidelines, and it is acknowledged that a Link Worker's or community group leaders' capacity to adopt any of these recommendations may be constrained by practical, financial, or workload related limitations.

Chapter summary

This chapter described the initial study conducted to inform the creation of a Community Prescribing Toolkit based on the SIAH. The study aimed to gain insight into social prescribing stakeholder perspectives on the presence and their understanding of group processes during social prescriptions to community groups. Interviews with Link Workers, group leaders and service-users generated three themes highlighting various group processes, facilitators, and barriers to social identification during the community group referral process.

The generated themes informed recommendations included in the draft Community Prescribing Toolkit. These recommendations focused on building collaborative relationships, assessing service-users' readiness for group engagement, addressing preconceptions and prior experiences, comparing service-users to group members, and evaluating the potential satisfaction of service-users' needs. Group leaders were advised to discourage subgroups,

create a welcoming and supportive atmosphere, maintain consistency, and promote interactions among group members. By following these recommendations, the likelihood of facilitating group identification during the social prescription process to a community group should be increased. The next chapter, Chapter Seven, details the collaborative refinement of the draft toolkit with the involvement of Link Workers and group leaders.

Chapter 7: Reviewing the Community Prescribing Toolkit

Chapter overview

Chapter Six outlined step one of a two-step toolkit development process, the creation of the draft Community Prescribing Toolkit. This chapter details the refinement of the draft Community Prescribing Toolkit as the second step of toolkit development. Study Two thus sought to 1) appraise the newly formed toolkit and 2) refine it collaboratively with Link Workers and community group leaders. Two qualitative studies sought Link Worker and community group leader insights on the toolkit's structure and content. A joint inductive, semantic Reflexive Thematic Analysis was conducted, to provide collective insight on the utility of the SIAH informed toolkit for social prescribing. The chapter concludes with a general discussion, clarification on how the toolkit was refined based on participant insights, and a chapter summary.

Introduction

Chapter Four outlined how the SIAH is a useful and important theoretical framework underpinning the benefits of a community group social prescription by improving belonging, social support, health-related quality of life, and reducing loneliness (Kellezi et al., 2019c; Wakefield et al., 2022). However, occasionally service-users are referred to groups that do not meet their needs resulting in disengagement (Laing et al., 2017; Pescheny et al., 2018b; Wildman et al., 2019a). The Community Prescribing Toolkit created following Study One was designed to minimise disengagement, by improving the likelihood of service-users being connected to community groups that facilitate social identification.

This chapter explores the refinement of the toolkit through stakeholder consultation as defined in Chapter Five (Thompson et al., 2021). Stakeholder engagement through consultation was

deemed necessary to ensure that the toolkit was feasible, useful, and beneficial to the Link Workers and group leaders who would be utilising it. As touched upon in Chapter Five, Stakeholder consultation was utilised over consensus and collaboration research methods such as the Delphi study. Despite being a rigorous methodology for obtaining consensus on a topic, a minimum qualification is often required for a participant to qualify as an expert in Delphi research (Fink-Hafner et al., 2019). Consequently, Delphi research often captures expert opinions on social reality, rather than a true reflection of that reality as experienced by those encountering it (Fink-Hafner et al., 2019). The requirement to have a minimum qualification to be considered an expert, limits the value of Delphi research in social prescribing, considering that the Link Workers who provide social prescriptions are not required to have specific qualifications (Moore et al., 2023). Furthermore, selecting experts based on qualifications as opposed to lived experience limits the value and voices of those who have direct of experience of receiving or providing a social prescription, which detracts from the purpose of the research documented in this thesis. Thus, whilst Delphi research undoubtedly supports collaborative refinement via consensus (Fink-Hafner et al., 2019; Thangaratinam & Redman, 2005), it achieves this in a way that neglects to capture experienced reality and thus may not support the creation of a practical toolkit that has utility within social prescribing.

The draft toolkit created with the insights from Study One formed the basis of two bespoke versions of the toolkit: one for Link Workers and one for community group leaders. For this reason, consultation with both stakeholders was necessary to support the toolkits refinement. The Link Worker version contained four sections (Figure 7.1), whilst the community group version contained three sections (Figure 7.2).

Figure 7.1

Brief overview of the Community Prescribing Toolkit sections that Link Workers reviewed

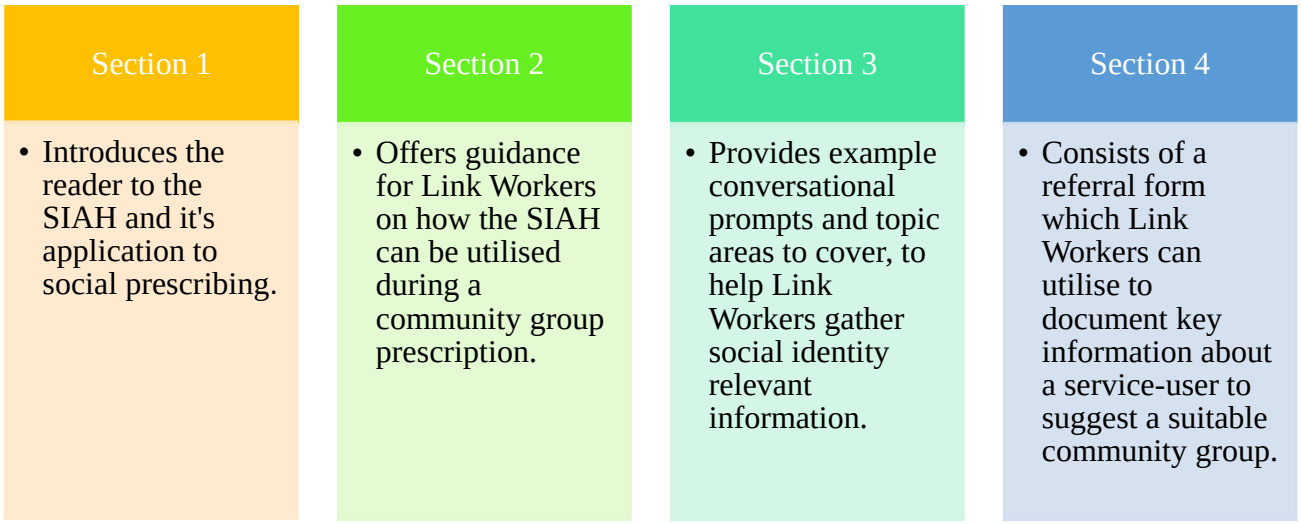
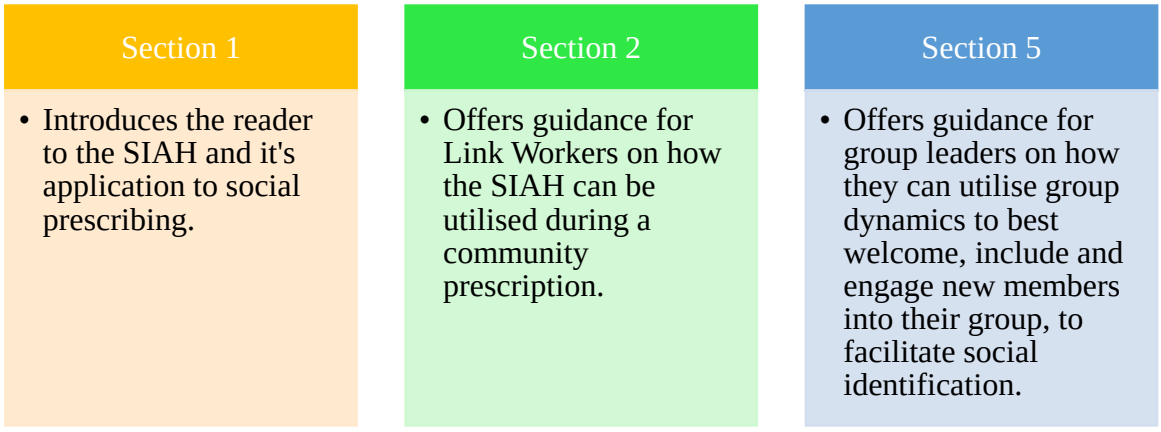


Figure 7.2

Brief overview of the Community Prescribing Toolkit sections that group leaders reviewed



The following studies document the process and outcomes of toolkit refinement for Link Workers (Study 2a), and community group leaders (Study 2b). The studies aimed to answer the research question: 'How would social prescribing stakeholders refine the Community

Prescribing Toolkit?' Only participants who had taken part in the interviews in Study One (September 2020 – March 2021) that informed toolkit creation were invited to review and refine the draft toolkit. No participants had been made aware of the results of Study One prior to them reviewing the toolkit.

Method

Study 2a

Design

This study consulted with Link Workers to determine the utility of the Community Prescribing Toolkit via online focus groups conducted in April 2021. Consultation was essential for determining the utility of the toolkit for Link Workers. The focus group design decentralised the researcher and instigated collective discussions of the toolkit which provided rich insight into participant views of the toolkit (Kamberelis & Dimitriadis, 2011; Stewart & Shamdasani, 2017).

Participants

Eight Link Workers from Study One (Chapter Six) were invited to review the Community Prescribing Toolkit in one of two Microsoft Teams focus groups, aligning with sample size recommendations in the literature (Guest et al., 2017). Two Link Workers were not invited due to retirement from the Link Worker role. Six Link Workers agreed to participate in one of the two focus groups offered to accommodate majority attendance at a session. Four Link Workers had agreed to attend focus group one, and two Link Workers agreed to attend focus group two. However, on the day of focus group one only two Link Workers were present, resulting in four participants having engaged in the two focus groups, two in each group. A third focus group was offered to the two participants who dropped out of focus group 1, however only one attended on the day resulting in a solo interview conducted in May 2021. Consequently, five Link Workers reviewed the draft toolkit. Table 7.1 details the homogenous demographics.

Table 7.1

Study 2a demographics

Participant type	Age (years)	Gender	Ethnicity	Marital status	Employment status	Experience in role
Link Worker 1	36	Female	White British	unknown	Employed	10 months
Link Worker 2	44	Female	White British	Cohabiting	Employed	9 months
Link Worker 6	45	Female	White British	Married	Employed	14 months
Link Worker 9	46	Female	White British	Cohabiting	Employed	24 months
Link Worker 10	27	Female	White British	Cohabiting	Employed	12 months

Procedure

Participants were emailed a participant information sheet, consent form and toolkit with instructions on how to review it in April 2021. Participants reviewed the draft Community Prescribing Toolkit one week before the focus group. On the day, participants were welcomed and informed of their rights and the house rules. Discussions were initiated by the researcher, using a focus group schedule (Appendix B), but remained participant led with occasional input from the researcher. A semi-structured interview occurred for the solo participant, following the same schedule as the focus group. Participants were video recorded during the focus group/interview using Microsoft Teams; the video was removed post-study and the audio retained for transcription. Afterwards, participants were debriefed.

Study 2B

Design

Community group leaders chose to review the toolkit via a qualitative online questionnaire due to lack of availability for focus group participation. The flexibility of online questionnaires

allowed group leaders to review the toolkit at their convenience (Ball, 2019; Evans & Mathur, 2005).

Participants

All seven group leaders from Study One were invited over email in April 2021 to decide if and how they would like to review the Community Prescribing Toolkit. Three group leaders accepted the invite, choosing an online questionnaire format for convenience and availability. Table 7.2 outlines the homogenous participant demographics.

Table 7.2

Study 2b demographics

Participant type	Age (years)	Gender	Ethnicity	Marital status	Employment status	Experience in role
Group leader 1	54	Female	White British	Married	Self-employed	5 years
Group leader 3	61	Female	White British	Married	Retired and volunteering	11 years
Group leader 7	72	Female	White British	Married	Retired	10 years

Procedure

Group leaders were emailed a participant information sheet, consent form, the Community Prescribing Toolkit, and instructions on how to review it. Participants who completed the questionnaire were compensated with a £10 Amazon voucher. Acceptance of the voucher did not impact their right to withdraw. Participants were recruited in May 2021, and questionnaires completed in June 2021. Following informed consent, participants were provided with the toolkit and the questionnaire to review over a 2-week period. The two-week period was provided to allow participants time to read and review the toolkit, prior to completing an online qualitative questionnaire. The questionnaire mirrored the topic schedule utilised in the focus group studies, allowing group leaders to clearly document their thoughts and opinions of the

toolkit as a whole document and per section. Reminders to complete the questionnaire were sent after one week, and a debrief and voucher were sent once completed.

Ethics

A key ethical concern for focus groups is confidentiality. Data collected through research must be confidential for it to be considered ethical, particularly when it concerns personal or sensitive information (BPS, 2021a; 2021b). Focus groups impede confidentiality as they involve multiple participants sharing their views at once (BPS, 2021a; Sim & Waterfield, 2019). To maintain ethics, participants were informed that confidentiality could not be guaranteed, and they were asked to not repeat anything stated in the focus group. Additionally, obtaining informed consent is a concern of online questionnaires (BPS, 2021b). The BPS advises the use of a distinct consent page with tick boxes for online questionnaires (BPS, 2021b), which was applied in Study 2b. Participants were unable to access the questionnaire contents without first consenting to participate.

Data analysis

An inductive Reflexive Thematic Analysis was conducted on the focus group data using the guidelines set by Braun and Clarke (2021b). Inductive thematic analysis was considered ideal for addressing the research aims, through its focus on data-driven themes (Braun & Clarke, 2021b; Castleberry & Nolan, 2018), which would capture and represent participants' understandings and opinions on the feasibility of the toolkit.

The quantity and quality of responses obtained in Study 2b was deemed inadequate to perform a thorough qualitative data analysis of any form. Participant responses were short and a technical error with one participant resulted in increasing data loss when completing the questionnaire. Therefore, Study 2b's data was analysed inductively, using semantic coding

guidelines in Reflexive Thematic Analysis (Braun & Clarke, 2021b) and outcomes interwoven into the themes generated in Study 2a.

Analytic procedure

Focus group data were analysed first, followed by the questionnaire data. Focus group data were transcribed into word documents and questionnaire data were exported into Microsoft Excel from Qualtrics and cleaned. Questionnaire responses were then transferred into a Microsoft Word document for each participant in the order they appeared on the questionnaire. The Microsoft Word documents for Study 2a and Study 2b were imported into NVivo Pro-12 to support the six steps of Reflexive Thematic Analysis (Braun & Clarke, 2021b) as outlined in Chapter Five.

The researcher first familiarised themselves with the data by repeatedly reading the transcripts, aligning with step one (Braun & Clarke, 2021b). Semantic codes were generated, reviewed, and condensed if duplicates were present after every transcript. Semantic codes were then interpreted by looking at the latent meanings within the data. Latent codes were reviewed, and duplicates removed after every transcript, aligning with step two. Latent codes were clustered around shared concepts and collated into working themes, aligning with step three. These working themes were then reviewed by reading extracts to ensure the theme label adequately represented the data in a cyclical process of refinement, aligning with step four. Theme creation was restricted by the small sample. A final review of the data within the themes and adjustments to theme and subtheme labels were made to ensure the essence of the data was fully captured following step five, before completing step six by writing up the results. Table 7.3 details the generated themes and subthemes.

Analysis

Four themes were generated, ‘A relevant and useful theoretical approach to social prescribing’, ‘Fine-tuning the utility of the toolkit for social prescribing’, ‘Adding the finishing touches to the toolkit’, and ‘The impracticality of the toolkit during COVID-19’. Refinements to the toolkit based on the insights from these four themes are presented after the analysis

Table 7.3

Coding table demonstrating the main themes and subthemes for Study Two

Main Theme	Subtheme
Theme one: A relevant and useful theoretical approach to social prescribing	1.1: The SIAH is relevant for social prescribing but not novel
	1.2: Real-world examples of the SIAH in situ are useful
Theme two: Fine-tuning the utility of the toolkit for social prescribing	2.1: Balancing language for lay and professional audiences
	2.2: The utility of measurement scales in the toolkit
	2.3: Conversational pointers not conversational scripts
Theme three: Adding content to the toolkit	
Theme four: The impracticality of the toolkit during COVID-19	

Theme one: A relevant and useful theoretical approach to social prescribing

Following reading the information included in the toolkit, participants indicated that the SIAH was a suitable theoretical framework to apply to social prescribing. Whilst some participants did not consider the theoretical processes outlined in the toolkit to be novel, the provision of real-world examples increased the relevance of the SIAH to social prescribing. Two subthemes

explore this further, 'The SIAH is relevant for social prescribing but not novel', and 'Real-world examples of the SIAH in situ are useful'.

1.1: The SIAH is relevant for social prescribing but not novel

Most participants perceived that the toolkit provided beneficial and useful insight into how the SIAH could be utilised to support a successful social prescription to a community group. Link Workers appreciated the SIAH's insight into how they could provide a social prescription that could become meaningful:

> "It just showed a really nice flow of when approaching somebody to holistically look at what would be appropriate, meaningful and useful to them, I found that really helpful" (Link Worker 6, Focus Group 2)

The guidance offered in the toolkit provided all Link Workers with deeper insight into social identity related factors that could be considered meaningful and relevant to a service-user. Knowing what could be meaningful and valuable to a service-user in relation to their broader needs, is beneficial in helping Link Workers to provide a social prescription that fosters social identification. The relevance of focusing on fostering psychological connection stood out for Link Worker 2:

> "Yeah, I mean I could see you know, it's clearly there, you kept talking about the psychological links, the connections, so I could see it kept coming up and through for me. So yeah, I could see the relevance yeah." (Link Worker 2, Focus Group 1)

The consistent theme of fostering psychological connections helped to increase the relevance of the guidance in the Toolkit for Link Workers. Grounding the document with the purpose of facilitating group identification through promoting psychological connection benefitted Link Worker's understanding of how the SIAH is embedded within social prescribing. However, one Link Worker and group leader appeared indifferent towards the content of the toolkit and

the theory due to perceptions that the guidance was already known. Link Worker 9 considers the theory to reflect organic social prescription processes:

> "I think with this document, I think that a lot of this approach, the questions the exploration, it's innate within social prescribing link workers just to- on that, we're almost intuitive, responsive. You know it happens organically, automatically, you know this approach." (Link Worker 9, Focus Group 1)

Through self-reflection, Link Worker 9 perceives that the processes described within the toolkit are already functioning within social prescribing, indicating that they are intuitively promoting psychological connection when providing social prescriptions. Consequently, Link Worker 9 maintains an ambivalent and sometimes critical attitude towards the toolkit's content throughout their focus group. This stance may be due to Link Worker 9 stating that they find groups boring and irrelevant for most service-users accessing social prescribing in their Study One interview. In response to Link Worker 9's comment above, Link Worker 2 suggested increasing the theoretical presence within the toolkit:

> "I think we got it because we do the job. But I wonder if someone didn't, who was reading it for the first time or who was new to the role, I wonder if it stood out enough for them. I'm not sure if it was- sometimes it needs to be in your face doesn't it (laughs). And it's quite subtle the way you write" (Link Worker 2, Focus Group 1)

Despite Link Worker 2 appreciating the accessibility of the toolkit (subtheme 2.1), they query whether the theory was visible enough to new social prescribers. The intention of ensuring that the explanations of the theory remained accessible to non-experts and non-academics may have resulted in an under-representation of crucial theoretical elements for Link Workers. Alternatively, the SIAH was perceived to be overly complicated and full of jargon for group leaders. One group leader did not understand sections informed by the SIAH, whilst another

was confused as to why the SIAH was included in the toolkit. Group leader 7 provided an alternative introductory paragraph to the toolkit:

> "Change to: Welcome to this Social Prescribing Toolkit designed by a student of psychology. Its aim is to support the process of referral to community groups. We want to make it easy for service users to find a group where they *feel at home* and an activity suitable to their needs. In more technical terms we are using **a social identity approach** to find a good fit." (Group leader 7)

This alternative is perceived to be a more accessible introduction to the toolkit which sees the SIAH rewritten into plain English. Consequently, the researcher gained insight into how the SIAH could avoid jargon for those unfamiliar with technical language. Despite the jargon, all group leaders found the information about connecting with groups convincing. Group leader 3 indicated that the information contained "good advice and good ideas", whilst group leader 7 reflected on the difficulty of putting the theory into practice:

> "On the ground it's often very different. If the leader is sociable and the group is sociable that's fine. All my groups are wonderful and very welcoming. We had one group who chased the tutor away in tears and then most of the rest of the class!" (Group Leader 7)

Group leader 7 emphasises the complexities of applying theory to reality, perceiving the success of which to rely on group dynamics such as effective leadership. Where group dynamics are not supportive the group may break down or not support the integration of new group members. Link Workers also noted complexities in applying the theory to practice, highlighting tensions between the SIAH and existing Link Worker training:

> "Ok I'm- I'm uncomfortable with that providing a sense of control. I would really like to see that gone and changed and flicked round because we're not, we're not providing a sense of control, that's inauthentic… we're promoting empowerment, rather than- it's just me. It's just

> me, I think that's really important wording to consider, providing a sense of control" (Link Worker 9, Focus Group 1)

Link Worker 9 highlights tensions regarding how group memberships satisfy a psychological need for control either due to unclear information in the toolkit or a possible misunderstanding of the guidance. Rather than perceiving the guidance as stating that service-users can have greater agency over the decisions in their life, Link Worker 9 perceived the sense of control guidance to clash with their understanding of social prescribing and the requirement to empower service-users, reflecting the training that Link Workers receive. Responding to Link Worker 9, Link Worker 2 demonstrated a greater understanding of the intended interpretation:

> "Yeah, totally agree Link Worker 9, I think you've hit on a good spot there because I think you're right, a lot of work is around people understanding that most of life isn't under your control and learning to live with that and find the strategies for it. So, maybe it's more about having err- being able to make your own decisions or your own choices. I suspect that's probably what you're getting at" (Link Worker 2, Focus Group 1)

Whilst understanding Link Worker 9's interpretation by stating that they work with service-users to overcome the concept that they are in control of their life, Link Worker 2 acknowledges the intended interpretation for service-users to make their own choices in life. The nuances between retaining a person-centred approach to social prescribing which facilitates empowerment, appears to undermine interpretations of the SIAH. When minimising jargon and adapting the SIAH into an accessible toolkit, consideration of tensions between current knowledge and practice, alongside incorporating new learning and practice is required. It remains important for the toolkit to be phrased appropriately for both Link Workers and group leaders. However, the strength of the relatability of the toolkit may reveal a limitation. Considering that most participants perceived the SIAH to reflect an inherent, albeit complex functioning of social prescribing, there is the possibility that the theory was overly simplified.

As a result, Link Workers were seeking greater theoretical presence in the toolkit, whilst group leaders were confused over the theoretical presence and requested the removal of all jargon. The next subtheme explores the relevance of providing examples of using the SIAH in practice.

1.2: Real-world examples of the SIAH in situ are useful

All Link Workers appreciated sections of the toolkit that illustrated the relevance of the SIAH for social prescribing through applied examples. Participants especially appreciated the utility of an example conversation regarding the proposal of potentially suitable groups to service-users:

> "I think sometimes it's helpful to have it in, because it suddenly brings it back and you think oh yeah, that is like a real conversation, and I did. I thought you- that's kind of how it would- a conversation would easily go you know. So erm and sometimes I think that is useful to- because it reminds you back into the practicality a bit of what you doing, you know brings you back round to it a bit, so I liked it personally." (Link Worker 2, Focus Group 1)

The applicability of the example conversation was appreciated, highlighting how easily the SIAH framework fits into and supports current social prescribing practice. The example conversation detailed a key stage during a social prescription, where Link Workers collaborate with service-users on which groups are suitable to attend. How the discussion is framed could influence whether a service-user feels ready to attend the group:

> "Yeah, no. I- I thought that was very erm a good reflection of a likely conversation I could have had. And I like how you're picking out all the positive things erm in a group so that somebody could erm, attach to that if that makes sense, to motivate them to want to start, yeah." (Link Worker 6, Focus Group 2)

Link Worker 6 perceived the group descriptions within the example conversation to be beneficial for increasing understanding of the importance of a group being perceived to be accessible to service-users, whilst increasing motivation to engage with a group. Highlighting

positive aspects of a group during discussions with service-users, whilst checking to see whether the service-user is interested in attending the suggested groups is important for encouraging active decisions to engage with the group:

> "It absolutely is, you're asking them open questions. Erm you're not sort of saying you know, we're gonna do this, we're going to do that… you're asking that permission and giving that person autonomy, you know that is so important throughout our support with people. People need to feel empowered throughout and they need to feel that everything that they are doing, everything that they're talking about is their choice and it's what they're wanting from this rather than us saying you know, we know what would make your life better, we know how we can help you, we know what we can do. It needs to come from that person as to what they want to do, what matters to them and I think that's [the toolkit] captured it" (Link Worker 10, interview)

Link Worker 10 outlines how the example conversation in the draft toolkit supports a person-centred empowering dynamic between the Link Worker and service-user, whilst applying the SIAH. With the service-user retaining a sense of control over their life in terms of which groups they attend, they are more likely to derive a sense of meaning or purpose and motivation for attending the group. The example conversation thus provided insight into the level of detail required during discussions of potentially suitable groups, to help service-users assess whether the group fits them. Whilst service-users still need to attend a group to determine a true sense of fit, discussions about the group could increase the perceived benefits of the group for their needs, which would increase motivation and readiness to engage with the group.

Overall, both Link Workers and group leaders appreciated the value that the SIAH framework brings to the social prescription to community group referral process. Whilst aspects of the SIAH may already be innate within social prescribing, participants acknowledge the benefits of recognising and utilising the SIAH in their practice. Going forward, the visibility of the

SIAH in the toolkit requires adjusting to adequately support Link Workers and group leaders in providing a community group social prescription that facilitates social identification. The next theme outlines elements of the toolkit that require modification to best support Link Workers and group leaders in providing a successful social prescription.

Theme two: Fine-tuning the utility of the toolkit for social prescribing

Whilst participants were appreciative of the theoretical toolkit, improvements were suggested to increase the utility of the toolkit for each social prescribing stakeholder. Three subthemes explore this in greater detail, 'Balancing language for lay and professional audiences,' 'The futility of scales in the toolkit,' and 'Conversational pointers not conversational scripts.'

2.1: Balancing language for lay and professional audiences

All participants commented on the language utilised throughout the toolkit, and suggested changes to increase its readability. Most Link Worker participants found the toolkit to be accessible and easy to understand:

> "**R:** What did you feel about the language that I used?
>
> **LW10:** Yeah, it's very, you know it's not too complex you know, it's well described, well wrote. Erm, I don't think, I don't think there was anything that I could sort of- I think it's quite easy to sort of interpret and understand, especially if you're new coming into the role." (Link Worker 10, Interview)

Link Worker 10 notes the utility of the toolkit for being accessible to newly established Link Workers. This suggests that the toolkit provides practical insight into the role and how Link Workers can best support a successful social prescription to a community group. Link Worker 2 further comments that:

> "The language isn't over complicated or complex, that… you have to read several times to get the gist off and that makes it a lot more accessible. So, you know, I really like that. I'm a bit of

> a fan of plain English you know, why make it more complicated than it needs to be you know, it's not an academic document, it's not you know." (Link Worker 2, Focus Group 1)

The appreciation for the no-nonsense approach of the draft toolkit in conveying information about the social prescription process to community groups may be due to the complexity of the Link Worker role. Having to balance multiple roles, toolkits are likely to be most appreciated if the content is easy to grasp and visibly applicable to their role. Link Worker 2 further reflects that the toolkit is not an academic document, indicating that jargon must be avoided or minimised, which contrasts slightly for the desired increase in theoretical presence outlined in theme one. These contrasting recommendations indicate a requirement to increase the visibility of the SIAH, whilst making it easy to understand. Furthermore, Link Workers were conflicted over the language used to describe those who access social prescribing. Language preferences varied depending on whether a Link Worker was charity, community, or NHS based:

> "I know that we use clients. I mean I work up under the umbrella of citizens advice and in our write-ups, clients are clients." (Link Worker 9, Focus Group 1)

Community-based Link Workers like Link Worker 9 appear to utilise client terminology, whilst Link Worker 2, who is charity-based, experiences conflict between NHS terminology and their terminology:

> "I think we get a kind of dilemma between ours because as a charity we'd use service-user, but the NHS deems us- they want us to use patient, so it's been a bit of a Mindshift. I don't like any of the terms to be honest for me, I'll use people wherever I can or person because I think you really lose that sense of this person underneath, if you use the terminology all the time" (Link Worker 2, Focus Group 1)

This highlights tensions between schemes set up within community and medical settings. Patient terminology was disliked by the participants in focus group one due to the medical connotations associated with the label:

> "I definitely agree with the patient thing. I don't think that clients- I'll just use the word clients, should be referred to as erm patients, because we are coming away from that clinical medical model, that's the point… erm patient is quite disempowering I feel." (Link Worker 9, Focus Group 1)

Patient was considered unrepresentative of the empowering nature of social prescribing. In contrast, the term service-user was considered appropriate by all participants:

> "It's just quite a nice generic term that a lot of places use I think and the whole what we call our, our people is a, in lots of services I've been in is an ongoing thing, and certainly for us we don't tend to use patient, we would talk about err- I think we use client generally but yeah, I don't have a problem with service-user." (Link Worker 1, Focus Group 2)

Link Worker 1 outlines the ongoing discourse surrounding service-user terminology, with Link Worker 6 also stating a preference for "service-user or client to be honest" (Focus group 2). Two group leaders further disliked the term service-user, with group leader 3 suggesting that "Client may be more appropriate." These preferences for group leaders contrast with Link Workers and appeared to differ depending on the group leader's professional background. Therefore, despite the various language used to describe those utilising social prescribing, the term service-user was deemed an appropriate label by Link Workers with NHS, charity, and community backgrounds and suitable for use in the Community Prescribing Toolkit. Group Leaders however preferred the term client.

Regarding group leaders, two group leaders felt that the toolkit was well structured, if complicated to read. One group leader commented on the language utilised in the toolkit:

> "I really do not like the word 'referral' at all. Social Prescribing Link Workers should not be referring service users to community groups. They should be finding out what matters to Sus [service-users], helping them to think about what sort of activities they would be interested in, helping them to find out about what's in the area, helping them to access them and if necessary,

> accompanying them the first couple of times. But they should NOT be referring them." (Group Leader 1)

Their understanding of social prescribing meant they did not agree with the term referral as the term implied that the Link workers chose the social prescriptions, rather than the service-users being empowered to choose their own community resources to attend. To increase the utility of the toolkit for each stakeholder, separate refinements may be required to fully accommodate the requirements of group leaders and Link Workers. The next subtheme explores the utility of scales in the toolkit.

2.*2: The utility of measurement scales in the toolkit*

Link Workers had mixed reviews of the community prescribing form. The form itself was created to offer a space for LWs to record an accurate and useful summary of the referral process to aid a social prescription. Thus, the form supported Link Workers to make notes on a service-user's needs and other identity-based information that could be utilised to recommend a community resource, measurement scales of anxiety, loneliness, and confidence. The scales were intended to add context to potential barriers or factors that may prevent a service-user from feeling able to engage with a recommended community group. However, discourse arose around the measurement scales in the form:

> "I think it's important to have the confidence level for the link worker really, because they'd be like "yeah, yeah, yeah I want to go" well how confident are you, "oh, three" (laughs), so that just gives you an idea if they're saying it for the conversation or in the moment you know. Erm the scales for the loneliness before, it's quite subjective isn't it sort of how they're experiencing it. And what was the other one, oh anxiety, again somebody's five could be different to your five." (Link Worker 6, Focus Group 2)

Link Worker 6 perceived the confidence scale to be beneficial in understanding whether a service-user was ready to engage with a community group. However, participants were

concerned over the subjectivity of the scales, which could vary in meaning depending on the service-user. Link Worker 10 suggested turning the scales into conversational questions:

> "So, I do like the scales but sometimes with the scales, I think it's better having a question, in terms of like the loneliness one, sort of like you know, who do you have in your life? Do you have family, do you have friends that you speak to on a regular basis." (Link Worker 10, interview).

Link Worker participants felt that information on confidence, loneliness, or anxiety may be divulged naturally and questions relating to those constructs would be best interwoven into conversations, limiting the utility of measurement scales in the draft toolkit. This was recognised by Link Worker 1 for the anxiety and confidence scales, which they hesitantly suggested could be beneficial as quantifiable scores:

> "I think anxiety and confidence they're the sort of things you would be asking about, and a score might be useful and it's something that might be used in assessments… you know it can be used as a tool to kind of guide that conversation. I think degree of loneliness I'd probably be a little bit hesitant… I think getting people to score how lonely they are, for some people might be a little bit triggering." (Link Worker 1, Focus Group 2)

However, they raised concerns over the abruptness and potential triggering nature of the loneliness scale, which may impede the rapport building process. Link Workers in this sample thus reflected tensions between current practice and the requirement for statistical evidence of social prescribing's effectiveness, through their views on the impracticality of scales and the sensitivity in which they need to be collected. Such tension may be due to the training that Link Workers receive regarding the purpose of a social prescription, which may result in some Link Workers completing scales themselves based on their perceptions of a service-user or not using them at all. Some of the Link Workers in this sample reported using measures infrequently despite being asked to utilise them due to the concerns outlined above. Removing the scales

may be more suitable for the purpose of the toolkit. The next subtheme explores the importance of offering guidance rather than a script during Link Worker assessments with service-users.

2.3*: Conversational pointers not conversational scripts*

Link Workers reflected on the included conversational topics that explored examples of the information necessary to provide a social prescription that can become meaningful to a service-user. Participants in focus group two appreciated this information:

> "Like Link Worker 6 says, if you're new to the role, you might not think to- and I'm guilty of it you know, if somebody drives, I think oh brilliant you know, it's accessible, but actually, it's only accessible if they can park within a five meter walk and there's a disabled spot and, but yeah you know I think it's nice to prompt some of these like for example other commitments people might have like having pets you know, these things that maybe you know don't think to ask for all the time. So yeah, I think that's very useful." (Link Worker 1, Focus Group 2)

Participants in this focus group felt that the example questions provided useful conversational pointers, collecting valuable information about the service-user, which they could utilise when suggesting potentially suitable and meaningful community groups. The example questions supported Link Workers to consider information they may have previously neglected during discussions with service-users. Link Worker 10 particularly appreciated the open-answer nature of the questions:

> "I like the pointers you know, some of the like suggested questions to go through with patients and people that we're working with. Erm, you know, I think that's a really sort of good tool in itself, just having them sort of motivational interviewing questions erm to really engage with the person. Because I think, that initially is quite hard to do in itself, when you work with people who may be quite demotivated and not too engaging, or they haven't been engaging previously. Erm and I think those sorts of questions are just quite good at opening things up a little bit more for a person, sort of reflect upon their own sort of thoughts and feelings as to why they are not

> wanting to integrate into things and better their health and wellbeing." (Link Worker 10, interview)

Link Worker 10 outlines the benefit of open-questions to encourage service-users to reflect and discuss their needs and wellbeing. Service-users typically lead conversations, in line with the person-centred nature of social prescribing. Consequently, Link workers are trained in motivational interviewing techniques designed to foster service-user engagement with discussions. The questions in the toolkit appeared to reflect the current style used during conversations, increasing the applicability of the SIAH to social prescribing. However, tensions arose once more between the toolkit and current social prescribing practice. Link Workers in focus group one misinterpreted the conversational tool, perceiving that the questions were a script:

> "I think that if we try and break it down into a tick box lists and what have you, then I think you lose a lot of the- you might not hear something, you might not tune in and connect to something subtle, where the client actually wants to go, but the document wouldn't allow the client to go" (Link Worker 9, Focus Group 1)

Link Worker 9 perceived the conversational tool to be an inflexible document that was unsupportive of service-user tangents rather than conversational pointers. This misunderstanding relates to the requirement for Link Workers to collaboratively work with a service-user, where the service-user leads conversations and indicates that the guidance on the toolkit on how to use the conversational tool was unclear. Therefore, Link Worker 9 remained concerned that a script would impede their ability to provide effective social prescriptions, which Link Worker 2 agreed with:

> "I agree with you, I mean I'm a bit like that you know. When I first came in the role, they tried to give us a guided conversation, which was like a list down and I screwed it up and threw it in the bin, because conversations don't happen like that do, they and they shouldn't you know.

> And totally you know, yeah client led- and if that only means they talk about one thing and the one thing that's important, the rest doesn't actually matter, because that's the golden nugget in there anyway" (Link Worker 2, Focus Group 1)

Link Worker 2 implies that service-user conversations can be meaningful and beneficial with one key conversational area if the information gathered acts as a gateway for recommendations. The action of physically rejecting a scripted conversation shows insight into how strongly Link Workers embody person-centred practice. Despite this misunderstanding, other Link Workers recognised the adaptability of the conversational guide:

> "It doesn't feel like you're telling these are the questions you have to ask, because you can work them into conversations and word them slightly different depending on the conversation and the person, you're with. So, it's quite adaptable as well which is good." (Link Worker 10, interview)

Being able to adapt the conversational pointers to a service-user was considered beneficial by Link Worker 10. Therefore, the questions within the toolkit offer guidance on topic areas which would help Link Workers connect service-users to community groups that have the potential to become meaningful through group identification. The more social identity-based information a Link Worker gathers, the greater their ability to provide a potentially meaningful referral, with the example questions acting as beneficial pointers, rather than a checklist. Emphasis on the flexibility and guidance-based nature of the conversation topics is needed to prevent further misunderstandings.

Overall, the proposed scales in the toolkit may not be practical for the purpose of the Community Prescribing toolkit, with the utility of the toolkit improved through the removal of this section. Likewise, revisions to the language utilised throughout the toolkit is required to describe the process of connecting a service-user to a community group, and those accessing social prescribing. Finally, emphasising the flexibility of the conversational topics should

increase their utility with social prescribing. These revisions need to be tailored to Link Worker and group leader preferences regarding the visibility and accessibility of the SIAH framework, as outlined in the refining the Community Prescribing Toolkit subsection following analysis. The next theme explores sections that should be added to improve the toolkit's utility.

Theme three: Adding content to the Community Prescribing Toolkit

All participants suggested adding sections to improve and refine the toolkit. Group leaders provided numerous recommendations, including the addition of a top tips section, executive overviews, consideration of practical needs, and checking the credentials of group leaders. For example, group leader 1 reflected on the practical needs that should be considered:

> "Logistics - really important for link workers to think about access - toilets, disabled loos, flat surfaces, car parking, bus stops, lifts if appropriate, where activities are based - ground floor or up steep staircases, lighting, ventilation, cafes, kitchens, steps, surfaces, ramps, rails. Who attends the groups - ethnicity, age, gender, physical ability." (Group Leader 1)

These practical issues reflect important considerations that could become potential barriers to accessing a community group, therefore hindering possibilities for social identification. If these practicalities do present a barrier for accessing a group, this could limit how accessible a group is perceived to be by a service-user, reducing the likelihood of them attending. Group leaders further reflected on the size of a group:

> "It's all about safety for the participants. Qualified tutors are expensive. I was horrified when someone told me they had 24 people in their exercise class for older people. Financially I can understand why but these people have complex medical problems. With 24 you can't watch them all. I suspect they sit all the time and do a little mobility. You can't learn to balance better if you are sitting." (Group Leader 7)

Group leader 7 indicates that the size of a group could influence how effective the group is at supporting its members and required careful consideration. Therefore, discussion on who the

group is for and who already attends may be beneficial for helping service-users decide whether they fit the group. Such discussions would indicate greater time spent on reviewing and selecting potentially suitable community groups to recommend to service-users and relies on strong relationships with community resources. Finally, group leaders also reflected on the need to consider group integration strategies for new or prospective members:

> "I think that there could be more tactics included about ways of integrating newcomers into groups; the leader or buddy acting a bit like the host of a dinner party making sure that the newcomer gets to meet different people within the group, while making sure they're not overwhelmed, or stuck with a boring or inappropriate person for too long. Also trying to understand what the newcomer would like - do they want to throw themselves into the new group or would they like to stand back a bit to see what's going on first… Should include chatting to the newcomer at the end of the session to find out their initial feelings - what went well, what didn't go so well, what could be done differently/better the next time." (Group Leader 1)

Group leader 1 outlines the importance of an ingroup member acting as a welcome point for new group members and checking in with a new group member at the start and end of the session to understand their experience of the group. This recommendation is particularly beneficial for helping service-users to integrate effectively into the group, increasing the likelihood of social identification. Through considering the needs of the service-user and communicating with them about how they are getting on, the group leader can ensure the service-user has a positive and comfortable experience with the group.

Aligning with promoting a positive and comfortable group experience that promotes engagement and group identification is the suggestion from Link Workers to increase discussion on barriers preventing engagement and how to overcome then in the draft toolkit. Barriers that prevent a service-user from engaging with a community group could impact the

perceived benefits of social prescribing. Where barriers cannot be problem-solved, then this could impact whether a community group is considered accessible and meaningful to the service-user:

> "Sort of looking at them solutions to them barriers and where the motivation is to that. Some people will put barriers up on purpose for themselves because they don't want to do things, erm so I guess again it's sort of looking at- it goes back to that sort of erm readiness to attend and interact with them groups so yeah that's really good." (Link Worker 10, interview)

Link Worker 10 considers how purposively built barriers may reflect a service-user's readiness to attend a group. Community groups, whilst beneficial to our health and wellbeing, may not suit everyone and the extent to which barriers are preventing a community group social prescription from occurring requires further discussion:

> "I think barriers is a very big part in it and maybe, I don't know, I wonder if it should (sighs) have a bit more about that, about addressing those and doing some more work around those… It [the toolkit] does look at those barriers to accessing support, but that in itself can be a huge piece of work, erm not just a thing on the list further down it. So sometimes you know, it's about spotting those a bit sooner, rather than leaving those late in the conversation." (Link Worker 2, Focus Group 1)

Link Worker 2 considers incorporating discussions about barriers sooner into conversations because they can impact continued engagement with a social prescription. Barriers could be personal, group related as indicated by the group leaders above, psychological, practical, or physical. Regardless of the type of barrier, it could impact a Link Worker's ability to provide a social prescription that could become meaningful to the service-user. A final solution recommended by Link Workers that could address barriers and increase the meaning behind a social prescription is planning achievable and scalable goals:

> "I- I would say about goals erm. Sometimes there's short term goals, sometimes there's longer term goals and sometimes you cannot achieve obviously a longer-term goal without first tippy toeing or so… You know it just facilitates a better journey and it makes the journey more tangible in working with the client… what do they want to get out of their social prescription, how do they want to address their needs, what are their short-term goals, what are their longer-term goals." (Link Worker 9, Focus Group 1)

Where a social prescription satisfies a purpose, it becomes meaningful, which is beneficial for fostering social identification. Goal planning breaks down a social prescription into manageable steps that service-users can achieve which Link Worker 2 acknowledges in their agreement with Link Worker 9:

> "Very important, I agree. I mean I kind of go one step further and I set- I set short, mid-term and longer-term goals, and perhaps the longer-term goals are something they'll take beyond my social prescription, they're something they're aspiring to into the future you know… it is helpful to sort of create that visual of where you're going to and what's gonna happen on the way, you know. Almost like a journey you know, what point are we gonna stop off and where we want to be, and when do we want to be there you know, how's it gonna happen… it can be quite a powerful thing to have something to look back on as well." (Link Worker 2, Focus Group 1)

Action plans therefore add structure to social prescriptions, which the service-user controls through setting achievable goals. By outlining short, mid, and long-term goals, the purpose behind a community group prescription is outlined, increasing the likelihood of maintained engagement due to accountability. For social prescribing, maintained control of the goals service-users set (and the groups they attend) is vital for satisfying their psychological need for control and for adding value and purpose towards a community group social prescription. Therefore, this data suggests that the toolkit should include a goal planning section which enables service-users to break down a social prescription into achievable steps that support

group engagement.

Overall, to refine the toolkit and improve its utility for both Link Workers and group leaders, further additions to the toolkit are required. Group leaders suggested that considering practical needs pertaining to the group including its size and demographics are required, alongside integration techniques to support service-user engagement with a recommended group. Link Workers further suggested incorporating a barrier section into the toolkit that considers how they can be addressed and a goal planning section. The next theme stems from Link Worker participants raising concerns within the data regarding the practicality of trialling the Community Prescribing Toolkit within a pandemic setting.

Theme four: The impracticality of the toolkit during COVID-19

Most Link Workers raised concerns about social prescribing's capacity to support a trial of the toolkit during the COVID-19 pandemic. Whilst most Link Workers perceived the toolkit to be beneficial for their role, they queried whether it would be feasible in the context of a pandemic:

> **"**Yeah, I think at the moment because of the pandemic, we've had to work in a more targeted and streamlined way and the community just shut down and we're not available. So, we've had to work differently. And need and trend has changed as well. So, people, I found there's a lot of erm welfare housing, food banks, finances, those kinds of issues that erm could be resolved in a few contacts, but they're not about enabling people to start groups and activities and make those long-term changes for their wellbeing. Its more about erm first responder sort of erm current troubling issues and that I feel is affected by the covid situation." (Link Worker 6, Focus group 2).

Link Worker 6 is reluctant to utilise the draft toolkit during a pandemic that has changed who social prescribing supports and the community resources that are being accessed. With limited social prescriptions occurring to in-person community groups and a focus on short-term health and wellbeing improvements, trialling the toolkit during the COVID-19 pandemic may not be

appropriate or a useful test of its effectiveness. Link Worker 10 shared similar concerns on the utility of trialling the toolkit within a pandemic-impacted workforce.

> "I think erm 50/50 on it really, because I think in terms of the sort of you know, understanding how we're working with a person, such as that you know, time and trust with a person, finding things that fit with them, that meaningful conversation… I think they're all things that we're using now and that are working really well now. In terms of the group stuff, it's a little bit difficult, because we're still not quite seeing any groups up and running yet and a lot of them don't look like they'll be up and running until late June/July time. Erm so in terms of getting people accessing groups is quite difficult at the moment." (Link Worker 10, interview)

Link Worker 10 indicates that trialling the toolkit would not be feasible within a setting impacted by the pandemic. This study was conducted between April and May 2021, at the start of a national roadmap to reduce pandemic restrictions, meaning that community groups were not running but may have been preparing to re-open. Community groups need to be operating for there to be a participant sample to trial the toolkit with. Whilst this study has demonstrated interest in the Community Prescribing Toolkit and highlighted several ways to increase its utility for Link Workers and group leaders, there are concerns on its suitability during the COVID-19 pandemic. As the pandemic continued to impact community groups and social prescribing, and Link Workers were questioning the practicality of trialling the toolkit, explorations into whether it was possible to trial the refined version of the Community Prescribing Toolkit are required.

Refining the Community Prescribing Toolkit

The Community Prescribing Toolkit was refined between June and July 2021, in response to the insights from Study Two and a second review of the social prescribing and SIAH literature. Stuart et al. (2021), and Borek et al. (2019a, 2019b) supported the refinement of the toolkit. To

tailor guidance to each stakeholder, the toolkit remained divided into two versions, the Community Prescribing Toolkit for Link Workers, and the Community Prescribing Toolkit for community groups. After refinement, five sections were included in the toolkit for Link Workers and four sections were included in the toolkit for community groups. The readability of the toolkit for community groups improved following the edits from Study Two. The version given to group leaders to review was calculated to have a Flesch Kincaid reading ease score of 42.05, which is defined as "challenging" (The First Word, 2022). Following refinement, the revised toolkit had a reading ease score of 61.97 and is defined as "plain English" (The First Word, 2022), aligning with requests by group leaders. The refinements for each version are jointly discussed below for brevity. Discrepancies between the toolkits are highlighted.

Executive overview and contents

- Recommendations to include an executive overview were provided by group leaders in Theme three. Executive overviews were added to both versions of the toolkit to provide an overview of the toolkit and its contents. Page numbers were added to improve the navigation of both versions of the toolkit.

Section one: Theoretical overview of the Community Prescribing Toolkit

- Labelled as 'the theory behind the toolkit' in the community group version, this section contained two pages explaining the SIAH framework applied to social prescribing. All jargon was removed for group leaders and the section was rewritten in plain English as requested in subtheme 2.1. For example, rather than focusing on providing a meaningful connection that promotes social identification, group leaders were advised to build a sense of belonging and to help new group members feel at home with their group. The plain English introduction to the toolkit in subtheme 1.1 was included in the community group version, but not the Link Worker version. Inclusive language was utilised, and

the terms ‘referred,’ and ‘service-user’ were changed to ‘connected’ and ‘client’ in the Community Group version of the toolkit as requested by group leaders in subtheme 2.1.

- For Link Workers, in-text citations supporting the theory were included to increase the visibility of the SIAH literature, as requested in subtheme 1.1. Furthermore, misinterpretations of the SIAH were addressed by defining jargon, such as the psychological need for control. A guidance box initially labelled ‘accessibility’ was also changed to ‘readiness to engage with groups’ to minimise confusion of the term with practical accessibility such as travel or access requirements.

Section two: Link Worker Guidance

- The Link Worker version contained four pages, including an additional page addressing barriers to attending groups as requested in theme three. The new barriers section outlined the types of barriers that could occur and ways of addressing those barriers at different points of the social prescription. Examples of barriers were created from Study One and Two and from Stuart et al. (2021). Additional refinements included emphasising the importance for Link Workers to check group leader qualifications as indicated in theme three. Utilising further insights from Stuart et al. (2021), Link Workers were also advised to consider the language service-users used when discussing plans for social connection, and to fully consider social identity compatibility. This included assessing whether a service-user is seeking to socialise with people or is seeking to do something for people, and what aspects of their existing identity are important and require continuation. Finally, Link Workers were also advised to consider the logistics and composition of the groups they suggest, following recommendations from group leaders in theme three and drawing upon Borek et al.’s (2019a) guidance on how shared similarities between group members can facilitate shared identity.

- The community group version contained three pages detailing the Link Worker role to increase understanding of social prescribing in the community. Aughterson et al. (2020) indicate that there remains a lack of understanding of what social prescribing is and who it can support in GPs, which can hinder engagement. Adding this section was intended to increase transparency of the Link Worker role and trust and engagement with social prescribing.

Sections three/four: Community prescribing tool and prescription form (Link Worker toolkit)

- Section three consisted of a four-page community prescribing tool containing discussion points relating to identifying goals, discussing outcome expectations, and prompting accountability as recommended by Borek et al. (2019b). Changes to this section impacted changes to Section four.
- Section four contained the community prescription form consisting of three pages that provided space for Link Workers to document the social identity facilitating information gathered when using the community prescribing tool. As requested in subtheme 2.2 the scales measuring loneliness, confidence, and anxiety were removed and included in the discussion points provided in section three. The removal of these evaluation points was deemed compatible with the purpose of the toolkit which was to facilitate social identification to improve health and wellbeing, rather than measure health and wellbeing improvements directly. For example, the degree of loneliness scale was transferred into questions pertaining to the service-user's wider social network. Example questions added to this discussion point includes 'Would you say you have friends or family living close by?' and 'Are you comfortable being by yourself?'. The latter question was deemed necessary to account for service-users who enjoy solitude without feeling lonely (Nguyen et al., 2018).

- In replace of the scales in section four, a brief table to provide basic information about the service-user was added to aid the storing and tracking of a service-user's basic information (e.g., name, date of birth etc.). Finally, following recommendations by Link Workers in theme three, a goal planning section was added to the community prescription form. Link Workers were provided space to write short, mid, and long-term goals for service-users to plan achievable milestones during their social prescription.

Section three: Community group guidance (community group toolkit)

- This section contained four pages that offered community groups guidance on how to facilitate social identification with signposted community groups. Top tips sections were added to this document following recommendations in theme three. The top tips introduced integration tactics as requested in subtheme 2.1 and highlighted guidance informed by the SIAH that could facilitate a sense of group belonging. Integration techniques were informed by Borek et al. (2019b), Tarrant et al. (2020), and Stuart et al. (2021), to support group leaders to welcome new members into their 'household'. An example integration tactic included helping new members to see similarities between them and other group members through shared tasks and conversation. Interacting in this way could address social anxieties and facilitate trust (Borek et al., 2019a; 2019b; Tarrant et al., 2020).
- Groups were also advised to involve group members in the running and planning of sessions, aligning with recommendations provided by Stuart et al. (2021) and Tarrant et al. (2020). Effective leadership was also re-emphasised following recommendations in subtheme 1.1 and by Borek et al. (2019a; 2019b) and Tarrant et al. (2020). Skills such as maintaining group cohesion, managing conflicts, promoting a positive group atmosphere and being approachable were included in this section as guidance.

Section four/five: Concluding remarks

- Both versions of the toolkit contained a one-page concluding remarks section. For Link Workers, this was section five, and for group leaders it was section four. In this section, a summary of the key messages presented in the toolkit was provided. The Link Worker version contained a reference list to allow Link Workers to follow up on the in-text citations provided.

Discussion

This study aimed to collaboratively review the draft Community Prescribing Toolkit and collate feedback from Link Workers and group leaders on its utility, which applied insights from the SIAH to Link Worker support and group integration processes during social prescribing. Focus groups with Link Workers and an online qualitative questionnaire with community group leaders supported the research aim by providing participants with opportunities to suggest alterations to the toolkit that would increase its utility for their role in supporting a service-user to access community resources that they could identify with. Group leaders discussed barriers to a successful social prescription, whilst Link Workers requested a section that addressed barriers to attending a social prescription. Barriers may influence a service-users continued engagement with a social prescription (Husk et al., 2019; Laing et al., 2017; Pescheny et al., 2018b; Wildman et al., 2019a), therefore the sooner they are identified, the sooner they can be assessed and potentially mitigated. Additionally, group leaders suggested including integration tactics and considerations of group size and demographics in the toolkit. Chapter Four notes that a group members' response to a service-user, and active engagement with a group could influence social identity development. For example, social identity research outlines that active engagement with a group increases one's capacity to assess their similarity to other group members (Sani et al., 2015a; Turner et al., 1987), including

whether they demographically fit existing group members. Considerations of these group dynamics could be applied to service-users in a social prescribing setting. Furthermore, the size and demographics of a group can impact social identity development, with smaller groups facilitating social identification more effectively (Badea et al., 2010; Brewer et al., 1993; Abrams & Hogg, 2006). Therefore, reflecting on these factors and providing strategies for integration was considered beneficial for the Toolkit as outlined in its refinement.

Regarding the SIAH framework, participants recognised and appreciated the toolkits' emphasis on promoting a sense of belonging via social prescriptions to community groups as requested in Study One. However, some participants felt that the knowledge provided by the theory was already known, while group leaders questioned its relevance to social prescribing and preferred a plain English version of the toolkit. Minimising jargon is important to ensure that the toolkit can be understood and applied by diverse stakeholders involved in social prescribing. In organisational communications, jargon can impede processing ability and training effectiveness due to a lack of understanding or meaning (Marshall, 1964; Patoko & Yazdanifard, 2014). Thus, care should be taken to make the application of the SIAH visible and understandable while minimising jargon, misinterpretations and potential tensions between the theory and the person-centred nature of social prescribing (NALW, 2019a; NHS England, 2019a, 2022b). One such tension that arose involved the psychological need for control in Focus Group One (Greenaway et al., 2016). Participants may have been referring to a service-user having personal autonomy (another psychological need) over their life (Koudenberg et al., 2017; Kyprianides & Easterbrook, 2020) rather than the psychological need for control when interpreting the guidance within the toolkit. Autonomy in social identity terms refers to having choice over one's actions that are congruent with one's sense of self (Deci & Ryan, 2000; Koudenberg et al., 2017). Personal autonomy is thought to improve health and wellbeing by increasing perceptions that one has the capacity to change their behaviour and can sustain

behaviour change (Koudenberg et al., 2017), with group identification satisfying autonomy as a psychological need in vulnerable populations (Kyprianides & Easterbrook, 2020) and music groups (Draper & Dingle 2021).

Furthermore, while the toolkit was perceived to be beneficial, Link Workers expressed concerns about the feasibility of trialling it due to uncertainties relating to the reopening of communities during the pandemic. At the end of Study 2a (April 2021) preparations were being made to re-open communities through the relaxation of national pandemic guidelines (HM Government, 2021). Whilst social prescriptions to community groups were not occurring during this study, they may have begun within the near future. However, if community groups were not fully operational, trialling the toolkit would be impractical as there would be no target sample to test it on. Thus, future research is required to explore the practicality of trialling the toolkit during a social prescribing setting impacted by the COVID-19 pandemic.

Strengths

The focus groups utilised in Study 2A encouraged Link Workers to discuss the toolkit in greater detail and allowed for novel considerations between participants, reflecting a strength of focus groups (Kamberelis & Dimitriadis, 2011; Morgan, 1996). This type of discussion ensures that the data collected portrays the participants genuine thoughts and opinions. Participants in the focus groups provided greater constructive criticism than what was provided in the solo interview, suggesting that participants were more comfortable to speak truthfully in the group setting – another benefit of focus groups (Kamberelis & Dimitriadis, 2011; Morgan, 1966; Stewart & Shamdasani, 2017).

Utilising stakeholder involvement in reviewing the toolkit is a further strength of this study. There are growing demands in health research for patient, public, and stakeholder engagement throughout the research process, to enhance the depth and applicability of research findings

(Morgan et al., 2016; Greenhalgh et al., 2019). Patient and public involvement refers to working with the public to plan, design, and conduct research (Russel et al., 2019; Staley, 2013), which this study adopted elements of to provide those who would be utilising the toolkit a voice in the content and development of the toolkit. Thus, this study engaged in stakeholder consultation (Thompson et al., 2021) involving symbolic participation (Goodman & Thompson, 2017), as outlined in Chapter Five. For both studies, the researcher consulted the stakeholders for their opinions and thoughts of the toolkit, to ensure that the toolkit would be a functional and useful resource. However, full stakeholder involvement was limited due to Link Workers lack of voice in planning the study. Alternatively, Study 2b supported greater stakeholder involvement, with community group leaders selecting their preferred methodology for reviewing the toolkit.

Limitations

High rates of participant attrition proved problematic in this study. As noted in Chapter Four, the coronavirus pandemic changed the working and social lives of many, including Link Workers and community group leaders (Bertotti & Temirov, 2020; Stevenson et al., 2020b). Many professions adapted to working from home in an online manner (Bertotti & Temirov, 2020; Stevenson et al., 2020b), however most community groups were forced to shut down during national and local lockdowns to minimise the spread of COVID-19 (Bertotti & Temirov, 2020; Stevenson et al., 2020b). This meant that both Link Workers and community groups were operating in constrained circumstances and, in the case of some community groups, may not have been operating at all. Link Worker participants had changing and increasing workloads as the nation shifted in and out of national lockdowns (Fixsen et al., 2021; Stevenson et al., 2020b), whilst community groups leader's workload increased with preparations to re-open following the governments roadmap to recovery (HM Government, 2021). Pandemic restrictions were relaxed from the 8$^{th\ of}$ March 2021, with some community groups allowed to

re-open from the 29th of March if they were outdoors. By the 17th of May all community groups were allowed to reopen. Since recruitment and data collection for Study 2b occurred between May and June 2021, the lack of engagement by group leaders could be attributable to limited availability.

Regrettably, the poor response rate for both studies, particularly the poor quality and quantity of responses for Study 2b, impacted the quality of the data analysis. Braun and Clarke (2021a) recommend that to generate quality data to be analysed using Reflexive Thematic Analysis, the researcher should be responsive to participants' developing accounts and have deep engagement and reflexive interpretation of the generated data, which was not possible in Study 2b. Whilst the online questionnaire was requested by participants for the ease and convenience they provide (Ball, 2019; Evans & Mathur, 2005), the questionnaire lacked the exploratory value of focus groups or interviews (Adams, 2015; Ball, 2019; Morgan, 1996), resulting in the researcher being unable to inquire further into participant responses. The lack of response for Study 2b could have been negated through forced responses to the questionnaire. However, the technical issues faced by one participant, alongside the frequent single-word responses indicate that additional viable responses may not have occurred. Likewise, the utilisation of a forced response can be viewed as a violation of a participant's rights to not answer specific questions (Baker, 2012; Nayak & Narayan, 2019). The lack of a researcher presence may have also contributed to the poor quality and quantity of responses, which is a common limitation of online questionnaires (Ball, 2019; Nayak & Narayan, 2019). The same applies for the online focus groups conducted in Study 2a, with online focus groups reflecting higher attrition rates due to reduced commitment influence (Stewart & Shamdasani, 2017). Therefore, whilst Link Workers initially agreed to take part in Study 2a, the commitment to do so may have been reduced due to the online nature of the study.

Chapter summary: Future directions

This chapter explored Link Worker and group leader perspectives of the draft Community Prescribing Toolkit. Two studies were conducted involving focus groups and an online questionnaire. An inductive Reflexive Thematic Analysis was conducted, generating four themes. Participants suggested tailoring the language and visibility of the SIAH to different stakeholders in social prescribing and making specific additions and removals to refine the toolkit. The study also highlighted implications for the future of the toolkit, with Link Workers expressing concerns about the practicality of trialling it. A lack of suitable referrals into and out of social prescribing (Bertotti & Temirov, 2020) indicate that it may not be practical to trial the toolkit until the impacts of the pandemic were overcome. Consequently, the next chapter, Chapter Eight, explores the practicality of conducting a feasibility trial of the toolkit during a social prescribing setting impacted by the COVID-19 pandemic.

Chapter 8: COVID-19 and social prescribing: Exploring the practicality of trialling the Community Prescribing Toolkit in the UK

Chapter overview

The next study was planned to be a feasibility trial of the Community Prescribing Toolkit. However, following Link Worker concerns on whether a feasibility trial would be practical in Chapter Seven, an alternative study was planned. Thus, this chapter presents a qualitative and quantitative questionnaire conducted between August – October 2021, to explore whether it would be practical to trial the toolkit in a social prescribing setting recovering from the coronavirus pandemic. The chapter introduces the rationale for the questionnaire, before describing the methods and questions used. The results are then presented. Link Workers provided insight into the impact of the pandemic on social prescribing referrals, community group capacity to support social prescriptions, utility of toolkits, and their understanding on the perceived importance of group processes supporting social prescribing. The findings are then discussed in relation to the study plans and subsidiary aims, before summarising the chapter and signposting the final study described in Chapter Nine.

Introduction

This study took place during the COVID-19 pandemic recovery period when social prescribing and communities were transitioning back to face-to-face contact (HM Government, 2021). Understanding the current climate of social prescribing during the pandemic recovery period, including whether community groups were being accessed by social prescribing service-users, is important for assessing whether social prescribing could support a feasibility trial of the toolkit. A six-month feasibility trial exploring demand, acceptability, and implementation (Bowen et al., 2009) was planned, involving a trial and control condition. A social prescribing service would need capacity to support Link Workers to engage in either condition of the trial.

Link Workers would need capacity to attend training in the study and the toolkit (for the trial condition), commit to recruiting service-users throughout the trial, and community group availability would be required to support a target population for the trial.

Considering the impacts of the coronavirus pandemic and the uncertainty of trialling the Community Prescribing Toolkit, this study aimed to explore the research question: "Can social prescribing and communities practically support a feasibility trial of the Community Prescribing Toolkit, whilst recovering from the ongoing impacts of the COVID-19 pandemic?" The primary aim was to explore the possibility of conducting a feasibility trial of the Community Prescribing Toolkit. This involved exploring if there were any perceived changes to social prescribing as a result of the pandemic. Comparing why a service-user accessed social prescribing and the community resources they were connected to both before the pandemic and during the pandemic recovery period is important for understanding whether social prescribing has the capacity to support a feasibility trial of the toolkit. A secondary aim of this study was to explore whether Link Workers were connecting people to community groups during the pandemic recovery period.

The questionnaire also provided an opportunity to gauge the perceived usefulness of the developed toolkit alongside other alternative toolkits during the pandemic recovery period. Given the changes to social prescriptions during COVID-19, three alternative SIA-informed toolkits which could be adapted from the Community Prescribing Toolkit, and that may be more useful during the pandemic recovery period were suggested. These alternative toolkits are detailed below and supported a second subsidiary aim to explore Link Worker perceptions on the usefulness of four psychoeducational toolkits informed by the SIAH framework during the pandemic recovery period.

Alternative one: An online community group toolkit

The first option presented to participants was a toolkit to support connections to online community groups which was suggested in response to the shift towards online sources of support during the COVID-19 pandemic (Fixsen et al., 2021). Qualitative research conducted during the pandemic suggests that service-users were being connected to online support due to social distancing measures (Ladds, 2021). Studies indicate that social identification supports engagement, perceived social support, and psychological well-being in online groups (Brandt & Carmichael, 2020; Zhu & Stephens, 2019). These findings align with the SIAH framework, as they suggest that facilitating social identification in online groups can improve health and well-being. Therefore, an online group toolkit could be a viable alternative if deemed useful by Link Workers.

Alternative two: A toolkit to support referrals to practical or support services

During the COVID-19 pandemic, many community groups temporarily closed (Ogden, 2020), and their reopening was delayed. In the absence of community groups, Link Workers increased connections to other essential, non-group resources such as housing, financial support, and counselling (Anfilogoff, 2020a; Fixsen et al., 2021). However, research suggests that a service-users' ability to engage with practical resources is hindered when their cultural, physical, and accessibility needs are not considered (Pescheny et al., 2018b; Smith, 2021). Considering the compatibility between practical resources, a service-user's social identity, and their needs could help overcome these barriers. Therefore, the Community Prescribing Toolkit could be adapted to support connections to practical resources, if such a toolkit is deemed useful by Link Workers.

Alternative three: A toolkit to support remote rapport building between Link Workers and service-users

During the COVID-19 pandemic, building rapport between Link Workers and service-users became challenging due to limited face-to-face contact and a lack of social cues (Fixsen et al., 2021; Morris et al., 2022). This hindered the trust-building process, which typically requires multiple sessions (NHS England, 2019c; Polley et al., 2017b; Stevenson et al., 2020b). The prolonged time required to establish trust can be problematic as the Link Worker-service-user relationship is crucial for maintained engagement with social prescribing (Halder et al., 2019). To address this issue, a SIAH toolkit that promotes remote trusting interpersonal relationships could be developed to support rapport building. The Link Worker guidance document from the Community Prescribing Toolkit could be adapted to focus solely on supporting the facilitation of trusting interpersonal relationships with service-users, if deemed useful by Link Workers.

These alternatives, if perceived to be useful by Link Workers, could provide useful extensions of the developed Community Prescribing Toolkit by increasing its capacity to support social prescriptions to various community resources. Should one of these alternatives be perceived to be useful in comparison to the Community Prescribing Toolkit, the direction of this PhD research could shift towards developing and trialling a secondary supportive toolkit that may better support social prescriptions following the pandemic. For each alternative the utilisation of the SIAH is necessary to either increase the likelihood of a service-user identifying with an online group, foster a remote therapeutic alliance between a service-user and Link Worker that maintains engagement with social prescribing, or consider identity and need compatibility when accessing practical and support services. The next section outlines the final opportunity provided by the questionnaire.

Exploring Link Workers understanding of group processes

This study provided a final opportunity to further explore and compare Link Worker's understanding and utilisation of group processes during social prescribing and the pandemic recovery period. Comparing Link Workers perceptions of group processes when they were face-to-face before the pandemic and online during the pandemic recovery period is useful for understanding whether group processes are perceived to be important in social prescribing regardless of format. Furthermore, understanding Link Worker's knowledge of group processes and their perceived importance to social prescribing is important when considering the training materials (Eldridge et al., 2016) for a feasibility trial of the Community prescribing Toolkit. Chapter Four detailed how social identification is associated with social prescribing outcomes of reduced loneliness, isolation, and improved wellbeing and health (Kellezi et al., 2019c; Wakefield et al., 2022), and that social integration, belonging, inclusion, and need satisfaction underpin the health benefits of group identification (Borek et al., 2019b; Greenaway et al., 2016; Wakefield et al., 2022). For example, group identification satisfies a psychological need to be socially included by providing people with a sense of belonging (Brewer, 1991; Wakefield et al., 2019). Social integration fosters belonging (Thoits, 1983) through participation in various social relationships, including active engagement in social activities, and a sense of communality with one's social role (Holt-Lunstad et al., 2015). Therefore, social integration, inclusion, belonging, and need satisfaction are included in this study, to support a final subsidiary aim to explore Link Workers understanding on the perceived importance of group dynamics during a social prescription.

Method

An online quantitative and qualitative questionnaire study with UK social prescribing Link Workers was conducted. This method was chosen due to its capacity to overcome geographical

boundaries in a time and cost-effective manner during the pandemic (Ball, 2019). Open-ended questions were utilised to provide greater depth and context (Fuchs & Diamantropolous, 2009; Zuell et al., 2015) on the current climate of social prescribing.

Participants

Participants were required to be a social prescribing Link Worker or be involved in similar roles, i.e., community connector and were recruited through purposeful sampling. Two hundred and twenty-one organisations, including all clinical commissioning groups in the UK, were invited to distribute a research flyer containing information about the study and a link to the questionnaire. Three organisations declined to participate because they did not recruit Link Workers and one declined due to not supporting student research. Three organisations had incorrect emails, eleven forwarded the information on, eight provided alternative contacts, and the remainder did not respond. Additionally, snowball sampling was conducted on Twitter, targeting Link Workers through tailored posts and research flyers containing a link to the questionnaire. The Twitter posts received 6,875 views and 21 clicks on the questionnaire link.

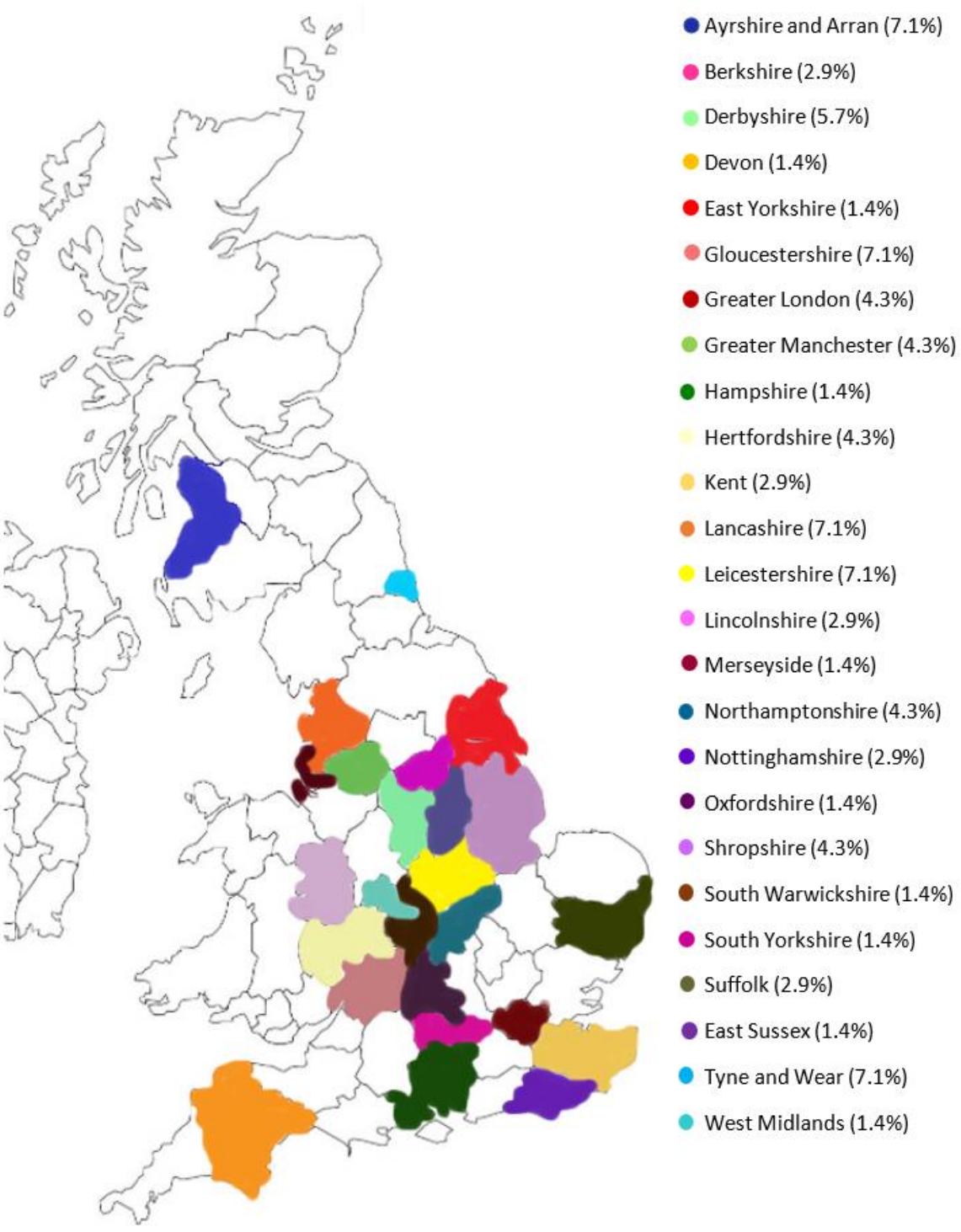
A total of 124 responses were received with 54 participants excluded due to not starting the questionnaire (12), only completing the consent section (28), or only completing the demographics section (14). The final sample included 70 Link Workers, with 58 completing all sections and 61 providing responses to open-ended questions.

Most participants were female (N = 61, male = 8, prefer not to say = 1) located in England (N = 64, Scotland = 6), with an average age of 46 years (SD = 12.91, range = 22-78). On average, they had been in the Link Worker role for 18 months (SD = 15.14, range = 1 – 78 months [6.5 years]), with prior experience in a similar role averaging 20 months (SD = 37.28, range = 6 – 180 months [15 years]). The participants were spread across various counties as noted in Figure

8.1, with higher participation rates observed in counties such as Ayrshire and Arran, Gloucestershire, Lancashire, Leicestershire, and Tyne and Wear.

Figure 8.1

Percentage of participant's location at the county level



Measures

The questionnaire is provided in Appendix C.

Demographics

Demographic questions included age, gender, country and county of work, length spent in the role, and prior experience of the role.

Reasons for referral to social prescribing

Two questions explored the changes in reasons for referral into social prescribing pre-pandemic and during the pandemic recovery period (described as the current working environment to participants), to understand the type of support being sought. An example question is: "Please indicate how often service-users were referred into your service before the pandemic, for the following reasons."

The responses provided were selected from the social prescribing literature (Featherstone et al., 2021; NHS England, 2019c) and include: debt, housing support, domestic violence, social isolation, loneliness, mental ill-health, anxiety, depression, bereavement, chronic ill-health, weight management, and other.

Type of community resources being linked to

Two questions explored the types of community resources that service-users were being linked to before the pandemic and during the pandemic recovery period, for example: "Please indicate how often a service-user would be referred to one of the following community resources now, during the current working environment". The community resources provided were selected from the social prescribing literature (Barnes, 2020; Polley et al., 2017b), and included the Citizens Advice Bureau, housing support, financial advisor, counselling, other therapy (i.e., addiction support), health coach, volunteering, gym, local community groups, online community groups, exercise classes, and other. Participants responded on a six-point Likert

scale (never - very frequently). Higher scores reflected greater frequency in social prescriptions to each community resource. The responses provided were selected from the social prescribing literature (Featherstone et al., 2021; NHS England, 2019c) and include: debt, housing support, domestic violence, social isolation, loneliness, mental ill-health, anxiety, depression, bereavement, chronic ill-health, weight management, and other.

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Ability to connect to community groups

Six statements explored whether participants were connecting service-users to face-to-face or online community groups during the pandemic, e.g., "I am able to refer service-users to community groups". Participants responded on a five-point Likert scale (strongly disagree – strongly agree). Higher scores indicated greater agreement in ability to connect service-users to community groups during that period.

Perceived community group capacity within the next six-months

To explore Link Worker perceptions on whether community group capacity would return to pre-pandemic levels within the near future, participants were asked "How likely do you think it is that referrals to face-to-face community groups will return to normal capacity within the next six-months". Participants responded on a five-point Likert scale (very unlikely – very likely). Higher scores indicated greater perceptions that community group capacity would return to normal within the next six-months post-questionnaire completion.

Useful support for the Link Worker role

The questionnaire assessed the perceived usefulness of four psychoeducational toolkits informed by the SIAH, by asking participants to rate the usefulness of the Community Prescribing Toolkit and each of the three alternative toolkits described in the introduction. These options were presented as four statements, i.e., "a psychologically informed toolkit designed to support the referral process to online community groups." Participants rated the usefulness of each toolkit using a five-point Likert scale (not at all useful – extremely useful). Higher scores indicated greater perceptions of usefulness during the pandemic recovery period.

Group dynamics and social prescribing

Four questions assessed Link Worker's perceptions of the importance of providing a good match that supports group processes during social prescribing. The questions were split across three sections 1) perceived ability to support need satisfaction, belonging, and integration during social prescribing, 2) perceived importance of group processes during social prescribing, and 3) perceived capacity for face-to-face or online groups to support integration, inclusion, and belonging.

Perceived ability to support need satisfaction, belonging and integration during social prescribing. Three statements explored a Link Workers perceived ability to provide a

community group match that supports need satisfaction, belonging, and integration. An example statement includes “I am usually able to connect people to community groups that fit their needs”, referring to a service-user’s general needs. Participants responded on a 5-point Likert scale (strongly disagree – strongly agree). Higher scores indicate higher agreement in Link Worker’s abilities to provide a community group match that meets service-users’ needs.

Perceived importance of group processes during social prescribing. One question explored Link Worker perceptions on the importance of fit, “How important is it to provide a good match, where the service-user enjoys and fits in with the group?”. Participants responded on a five-point Likert scale (not at all important – extremely important). Higher scores indicated greater perceived importance of providing a good match.

A second question asked participants to respond to three statements assessing the perceived importance of community groups supporting need satisfaction, belonging, and inclusion: “Connecting people to community groups that include them in the groups session or activities is important”. Participants responded on a five-point Likert scale (strongly disagree – strongly agree). Higher scores indicated greater perceived importance for community groups supporting group processes during a social prescription.

Perceived capacity for face-to-face or online groups to support integration, inclusion, and belonging. Six statements assessed participants views of online versus face-to-face group’s capacity to support group dynamics; three expressed preferences for online groups and three for face-to-face groups, I.e., “Face-to-face groups are easier to integrate into than online groups”. Participants responded on a five-point Likert scale (Strongly disagree - Strongly agree). Higher scores indicated higher agreement that face-to-face groups or online groups were better at supporting group dynamics.

Qualitative questions

Seven open-ended questions allowed participants to expand on their answers. Participants could utilise a textbox to expand on their views of the current referral process, the availability of community groups for social prescribing during the pandemic recovery period, the likelihood of groups returning to normal capacity within the next six-months, the ratings of usefulness they gave the toolkits, alternative support they would require, their perceptions on the importance of group belonging, and the utility of online groups.

Procedure

Participants were presented with a participant information page, followed by a consent page. Those who did not consent were redirected to the end of the questionnaire, whilst those who did consent, proceeded to the questions. A debrief page with supportive resources was provided at the end.

Ethics

Confidentiality and anonymity (BPS, 2021a) were ethical concerns within this study as participants may identify themselves in the anonymous survey if their demographic information is reported alongside their location. To mitigate this risk, participants were asked to provide generalised locations at the county level (I.e., Nottinghamshire, Leicestershire) to avoid being associated with a particular town or city. The localisation of social prescribing (Ladds, 2021) means there are likely to be multiple schemes within a county, minimising the risk of identification.

Quantitative data analysis

Raw data was cleaned in Microsoft Excel. Twelve of the 70 participants did not answer all questions but were retained as the missing data satisfied Little's (1998) test for missing completely at random, producing a non-significant result (P = .692) which indicates that the

data can be analysed normally due to a low chance of bias (Howell, 2007; Scheffer, 2002). Any missing data was appropriately handed using casewise deletion (Howell, 2007; Scheffer, 2002). Cleaned data was imported into SPSS to conduct descriptive analysis and paired sample t-tests. Paired samples t-tests were conducted to compare the mean differences (Park, 2009) for the referral reasons into social prescribing, the types of community resources being linked to, and the face-to-face versus online groups capacity to support the group processes of integration, inclusion, and belonging items. Paired sample t-tests were appropriate for this study because participants answered all questions (Field, 2013; Nardi, 2018) and the tests could provide insight into any significant changes in Link Worker's perceptions of reasons for referral into social prescribing, the types of community resources being linked to, and whether face-to-face or online groups are perceived to better support the aforementioned group processes. To minimise type one error, post-hoc analysis using Bonferroni correction were used which involved dividing the standardised p-value (0.05) by the number of statistical tests being conducted to obtain a maximum significance value (Lee & Lee, 2018). P-values higher than the maximum significance value were not considered significant.

Qualitative data analysis

A qualitative content analysis was conducted to produce a condensed, broad (reflective of the breadth of the data), and authentic (true to what was said) description of Link Worker experiences of social prescribing during the pandemic recovery period (Bengtsson, 2016; Elo & Kyngäs, 2007; Erlingsson & Brysiewicz, 2017). This approach suited the generation of new insights (Bengtsson, 2016; Krippendorff, 2018). An inductive, manifest analysis (semantic description of participant responses) was conducted, despite the presence of theory within the study framing (Bengtsson, 2016), due to the novelty of the research area (Elo & Kyngäs, 2007; Kyngäs, 2004). Theoretical interpretations of the data are therefore provided in the discussion.

However, it is acknowledged that no inductive analysis is without theoretical influence from the researcher's prior knowledge (Erlingsson & Brysiewicz, 2017; Krane et al., 2002).

Qualitative procedure

In this study, rigour was enhanced through various measures to improve credibility, such as acknowledging the researcher's preunderstanding of the topic, employing a logical study design, and creating a coding table to document the iterative analytic process (Bengtsson, 2016; Elo et al., 2014; Erlingsson & Brysiewicz, 2017). The four-stage analysis process outlined by Bengtsson (2016) was conducted in NVivo Pro-12. The data was familiarised through repeated reading and broken into smaller meaning units that captured the content of a sentence known as decontextualisation. Recontextualisation then occurred, which involved comparing the meaning units against the research aim to ensure comprehensive representation of the data and excluding any irrelevant text. The meaning units were then condensed into codes without losing their content during categorisation. Codes were grouped into subcategories based on similarity, and through an iterative process of fit and refinement, these subcategories were further consolidated into broader categories (Bengtsson, 2016). This iterative process continued until no data fell between two categories. The same process was applied to all qualitative questions, and the findings were compiled into a formal report that maintained the essence of the original text. Table 8.1 provides an example of the coding process, demonstrating the progression from data extract to category labelling.

Reports of the findings created during the compilation stage remained close to the original text. The use of '[]' within quotes represents the researchers' inputs for clarity. Table 8.2 outlines the four generated categories and subcategories and their frequency in the data. The relevance of the findings to the wider literature and whether they were logical and reasonable are considered in the discussion.

Table 8.1

An example of the coding process applied to participants' qualitative comments

Meaning unit	Condensed meaning unit	Code	Sub-category	Category
"There are more mental health and weight referrals coming in now" (Link Worker 24, female, 64 years, Shropshire, 1 year 6 months in role)	High need for mental health support	Reduced mental health	Increased complexity of service-user's needs	The current social prescribing referral process during COVID-19
"Debt and housing issues on the rise and bereavement of lost ones coming to terms, coping strategies. Referrals are on the high, each referral differs for support/guidance" (Link Worker 33, Female, 52 years, Lancashire, 1 year in role)	High need for debt housing support	Need financial support	Increased complexity of service-user's needs	The current social prescribing referral process during COVID-19

Results

Normal distribution analysis

Most of the quantitative data fell within the normality parameters of +/- 2 for skewness and +/- 7 for Kurtosis (Byrne, 2010; Hair et al., 2010). Four questions were negatively skewed with a long tail towards the left side of the distribution (Banyard & Grayson, 2017) indicating higher score responses for those questions. The skewed data for the social isolation response in the reason for referral to social prescribing question was not considered problematic in this study because of increases in isolation across the UK during the pandemic (Office for National Statistics, 2021), aligning with prior research treating negatively skewed data normally when

it is expected, e.g., IQ levels (Devlin et al., 1997; Plotnik & Kouyoumdjian, 2013). The remaining three questions relating to the perceived importance of matching someone to a group they can belong to, that fits their needs, and that includes them in group activities were negatively skewed by -2.10, -2.42, and -3.22 respectively, indicating that there were consistent higher ratings of importance for these questions.

Table 8.2

Summary of the main findings across the data, including frequency of responses

Category	Sub-categories	Frequency of reference by participants
1: Social prescribing referrals have changed during the COVID-19 pandemic	1.1: Increased complexity of service-user's needs	11
	1.2: High demand for social prescribing	30
	1.3: Remote social prescriptions are impractical	24
2: Divided access to community groups during the COVID-19 pandemic	2.1: Community groups are re-opening	19
	2.2: Community group capacity differs during the pandemic recovery period	51
3: Uncertainty over the future of community groups	3.1: Group capacity unlikely to return to normal due to COVID-19	17
	3.2: The new 'normal' of group interactions	38
4: Group belonging is vital for social prescribing success		54

Reasons for referral to social prescribing

Table 8.3 presents the results of twelve paired samples t-tests, conducted with 70 participants to compare the mean difference between reasons for referral into social prescribing before the pandemic, and during the pandemic recovery period.

Table 8.3

The results of twelve paired samples t-tests comparing the differences between Link Workers' perceptions on the reasons for referral into social prescribing before the pandemic, and during the pandemic recovery period

	Before Pandemic		During Pandemic					
Referral Reason	**M**	**SD**	**M**	**SD**	**df**	**t**	**P**	**d**
Debt	4.07	1.41	4.89	.89	69	-5.88	.001	1.16
Housing support	4.31	1.36	5.21	.83	69	-5.57	.001	1.35
Domestic violence	3.29	1.14	3.91	.97	69	-5.28	.001	.10
Social isolation	4.73	1.53	5.66	.63	69	-4.94	.001	1.57
Loneliness	4.63	1.52	5.54	.63	69	-5.34	.001	1.43
Mental ill-health	4.79	1.47	5.61	.62	69	-4.67	.001	1.48
Anxiety	4.71	1.53	5.61	.60	69	-5.44	.001	1.39
Depression	4.64	1.49	5.59	.65	69	-5.47	.001	1.44
Bereavement	4.01	1.30	4.60	.86	69	-4.13	.001	1.19
Chronic ill-health	4.16	1.36	4.66	.90	69	-3.08	.003	1.36
Weight management	3.84	1.36	4.53	1.02	69	-3.78	.001	1.52
Other	4.21	1.72	4.90	1.37	28	-2.49	.019	1.49

Following Bonferroni corrections, results indicated a maximum significance value of .004. Eleven paired samples t-tests were significant, suggesting that Link Workers perceived that the frequency of people being referred into social prescribing for the reasons presented to participants was significantly higher during the pandemic recovery period, than before the pandemic. This suggests that Link Workers think that more people were accessing social prescribing during the pandemic recovery period. There was no significant mean difference between the frequency that the 'other' referral reason was selected by Link Workers for the before the pandemic period and during the pandemic recovery period. The results from the

content analysis of the open-ended responses regarding the referral process into social prescribing are reported in category one.

Category one: Social prescribing referrals have changed during the COVID-19 pandemic

Forty-seven of 61 (77%) participants commented on the referral process into social prescribing during the pandemic recovery period across three subcategories: 'Increased complexity of service-user's needs', 'High demand for social prescribing', and 'Remote social prescriptions are impractical'.

1.1: Increased complexity of service-user's needs

Twenty-three percent of the 47 participants described the pandemics impact on service-user needs. These included an increased range and need for practical, emotional, physical, and mental support, as indicated by Link Worker 23:

> "Specific referrals to welfare reform have remained high along with mental health supports. Those referrals focussing on more social aspects of need have been more challenging due to pandemic restrictions." (Link Worker 23, Female, 46 years, Ayrshire and Arran, 3 years in role)

The social distancing restrictions that were imposed as a measure to keep people safe, may have increased the need for mental health support as people became socially isolated from each other, whilst increasing the challenges around supporting such needs. Eleven percent of participants reported increases in referrals for depression, anxiety, and general coping during the pandemic recovery period:

> "Currently a lot of clients struggling with fear of the pandemic. Trying to motivate and build their confidence is very challenging. Debt and housing issues on the rise and bereavement of lost ones coming to terms, coping strategies. Referrals are on the high, each referral differs for support/guidance." (Link Worker 33, Female, 52 years, Lancashire, 1 year in role)

Service-user reluctance to mix socially due to fear of catching coronavirus increased the complexity of referrals for Link Workers. If one felt the mental and emotional impacts of the coronavirus pandemic on top of the practical impacts, this could further increase the complexity of a referral. Subcategory 1.2 explores how COVID-19 impacted the referral process to social prescribing.

1.2: High demand for social prescribing

Sixty-four percent of participants provided insight into referral processes into their service during the pandemic recovery period. High demand for some Link Workers seemed "unmanageable" (Link Worker 21, Male, 53 years, Gloucestershire, 4 months in role). This may have been due to some services broadening their entry pathways. Twenty-eight percent of participants reported several ways they accepted referrals into their service:

> "Referrals into our service have opened up to external agencies using a referral form into our shared clinical mailbox. This has increased access to those that do not engage with our service initially through Primary Care." (Link Worker 26, Female, 46 years, Ayrshire and Arran, 3 years in role)

For Link Worker 26, broadening referral pathways increased access to a large service-user population who were unable to access social prescribing previously. However, broadening access to the service could increase demand at a time where providing support was challenging. For 6% of participants, the pressure to support their service-users may have resulted in inappropriate connections to community resources:

> "Very frequently in [location], partnership organisations are feeding back that Social Prescribing Link Workers are completing inappropriate referrals due to the Housing, Social Care and Mental Health Crisis's in [location]" (Link Worker 61, Male, 30 years, Greater London, 2 years in role)

The increased complexity of needs and demand for social prescribing suggests that Link

Workers were challenged with providing a good fit during the pandemic recovery period. Prioritising which issues to address in complex referrals may explain the poor fit, however the limited community resources available to Link Workers during the pandemic recovery period could be another reason, as explored in subcategory 1.3.

1.3: Remote social prescriptions are impractical

Fifty-one percent of participants commented on the referral processes to community activities and services during the pandemic recovery period. Eleven percent of participants explicitly stated that social prescriptions to community resources occurred remotely via "email, referral form or by telephone" (Link Worker 39, Female, 48 years, Ayrshire and Arran, 2 years in role). For 6% of participants who commented, remote referrals were difficult:

> "Many organisations retain arm's length referral processes and elongate the whole process...with some taking weeks to contact clients and other failing to contact at all. a REAL HIT AND MISS situation with Social Prescribers chasing continually to get services in for clients. Massive waste of time and very frustrating when services are withdrawn or fail to be offered due to conflicting eligibility criteria and changes in charities strategies." (Link Worker 13, Female, 61 years, Derbyshire, 9 months in role)

Link Worker 13 was frustrated by inaccurate information on group eligibility criteria, alongside lengthy referral processes to access a resource. This meant it was challenging to make social prescriptions during the pandemic recovery period to certain community resources. Furthermore, those that remained available were not suitable for every service-user:

> "The only one that is running now is the health walks, but most clients are not well enough to go on these" (Link Worker 10, Female, 67 years, Hertfordshire, 6 months in role)

Ill-health could hinder a service-user's capacity to engage with community resources. Furthermore, one Link Worker acknowledged that there were "still few resources for the folk who aren't online or are tech-phobic" (Link Worker 8, Female, 65 years, Hertfordshire, 1 year

9 months in role), indicating that digitally excluded service-users were challenging to support. The minimal availability of community resources meant that waiting lists grew as services became overwhelmed as explained by Link Worker 31:

> "The demand for services to be referred in to exceeds service's capacity. Due to lengthy waits for NHS MH [mental health] support we are holding patients at high risk as they are not able to get support quick enough." (Link Worker 31, Female, 41 years, Shropshire, 10 months in role)

Retaining service-users with complex mental health needs, increased the complexity of referrals and the support required from Link Workers when they could not be signposted to appropriate support. Together, these accounts provide a snapshot into social prescribing capacity to support service-users during the pandemic recovery period. The increased demand for social prescribing and the increased complexity of referrals provided insight into why Link Worker participants reported increased frequency of referrals into their service during the pandemic recovery period. However, Link Workers further reported that there were reduced community resources available to support the increased demand for social prescribing. The low community resource supply resulted in lengthening waiting lists hindering entry into social prescribing and community resources. The next two subsections explore the availability of community resources further.

Types of community resources being accessed

Table 8.4 depicts the results of twelve paired samples t-tests conducted to compare the mean perceived difference between the community resources being accessed before the pandemic and during the pandemic recovery period. Eight participants were excluded for non-response and data from 62 participants were analysed. Following Bonferroni corrections, results indicated a maximum significance value of .004. Link Workers perceived that they could significantly link people to housing support, financial aid, counselling, other therapy, health

coach, and online community groups more frequently during the pandemic recovery period, than before the pandemic.

Table 8.4

The results of twelve paired samples t-tests comparing Link Worker perceptions on the community resources being accessed before the pandemic, and during the pandemic recovery period

	Before pandemic		During pandemic					
Community resource	**M**	**SD**	**M**	**SD**	**df**	**t**	**P**	**d**
Citizens Advice Bureau	4.18	1.39	4.61	1.32	61	-2.37	.021	1.44
Housing support	4.39	1.30	5.19	.77	61	-4.78	.001	1.33
Financial aid	3.69	1.40	4.44	1.39	61	-5.17	.001	1.13
Counselling	4.40	1.41	5.35	.83	61	-5.89	.001	1.27
Other therapy	3.95	1.25	4.74	1.02	61	-5.64	.001	1.10
Health coach	3.15	1.49	3.92	1.60	61	-4.79	.001	1.27
Volunteering	3.98	1.32	4.29	1.07	61	-1.67	.100	1.44
Gym	3.76	1.31	4.15	1.19	61	-2.59	.012	1.18
Local community groups	4.79	1.48	4.95	1.17	61	-.68	.501	1.86
Online community groups	3.56	1.52	4.98	1.04	61	-8.00	.001	1.40
Exercise classes	4.21	1.41	4.53	1.06	61	-1.53	.131	1.66
Other	3.55	1.84	4.15	2.03	19	-1.64	.117	1.64

There were no significant mean differences between the frequency of linking people to the Citizen's Advice Bureau, volunteering, local community groups, exercise classes, gym, and other community resources. This suggests that Link Workers felt they were making just as many referrals to community groups and the other community resources before the pandemic as they were during the pandemic. Category two below, explores perceptions of community group availability further.

Category two: Divided access to community groups during the COVID-19 pandemic

Fifty-one of 61 (84%) participants chose to comment on the availability of community groups in their area through two subcategories: 'Community groups are re-opening' and 'Community group capacity differs during the pandemic recovery period'.

2.1: Community groups are re-opening

As pandemic restrictions were lifted, people could socialise in small outdoor socially distanced groups. For 61% of the 51% that commented, community groups were re-opening, as detailed by Link Worker 59:

> "Availability and accessibility of community groups was extremely low when we started our job last October (mid-pandemic), due to changes in restrictions and national/regional lockdowns. During the lockdown, there was a major shift from face-to-face community groups to online sessions... However, since the restrictions have lifted there has been greater availability of groups and services we can refer/signpost individuals to, both face-to-face and online." (Link Worker 59, Female, 22 years, Leicestershire, 1 year in role)

Compared to October 2020, group availability had increased due to reduced COVID-19 restrictions. Both face-to-face and online groups were available. However, some participants reported insufficient group availability for their service-users. Thirty-three percent of participants commented on the challenges of supporting digitally excluded service-users to access online or remote groups. Accessibility challenges to face-to-face groups when combined with digital exclusion, limited the support available to some service-users:

> "Things are starting to open up, but in some areas, there is very limited service and often no transport. Very few spaces and still a lot of online which a lot of people don't want or feel can't access well." (Link Worker 37, Female, 53 years, Leicestershire, 1 year in role)

Link Worker 37 struggled to support their digitally excluded service-users due to limited face-to-face community resources in their area. In summary, whilst face-to-face community groups

were re-opening for most Link Workers in this questionnaire, availability remained limited. Online sessions were offered in replace of face-to-face, however these isolated those unable or unwilling to access digital support. Subcategory 2.2 outlines the changes in community group capacity during the pandemic recovery period.

2.2: Community group capacity differs during the pandemic recovery period

Eighteen percent of participants reported that community groups were not running in their area during the pandemic recovery period. Link Workers reported difficulties in connecting service-users to the expected community support:

> "Can't count the number of times I have enthused to a client about a service I was under the impression was available and had restarted...to find when I tried to refer ...it was full/ failed to respond/ or had shut." (Link Worker 13, Female, 61 years, Derbyshire, 9 months in role)

Link Worker 13 was frustrated by a lack of communication from community groups on their capacity and functioning. Other difficulties stemmed from the protections that many groups maintained from the pandemic:

> "It varies greatly from person to person but some S/U's [service-user's] do not have access to internet or feel comfortable engaging in online groups. Then, face-to-face engagement is even more difficult as usual groups that used to run are either fewer capacity than normal, or made harder to book on to (for example, needing tickets for track and trace info, when maybe before you would have just popped in)" (Link Worker 9, Female, 30 years, Nottinghamshire, 3 months in role)

Groups operating at reduced capacity cannot include all group members in the same session and may require multiple sessions to provide support to their members. Similarly, booking systems limit a group's accessibility, particularly for digitally excluded individuals. Forty-three

percent of participants reported that community group availability was lower than it was before the pandemic. One Link Worker considers a lack of volunteers as the reason behind low group availability:

> "There are many organisations willing to run groups but lack of volunteers and coaching to facilitate groups" (Link Worker 6, Female, 54 years, Derbyshire, 2 years in role)

A lack of support in facilitating the re-starting of groups meant that those who wished to re-open during the pandemic recovery did not have the resources to do so safely. Furthermore, Face-to-face community groups that were operating were described as "oversubscribed" (Link Worker 31, Female, 41 years, Shropshire, 10 months in role) by 6% of participants, and 4% indicated that groups were "only taking current and previous members" (Link Worker 46, Female, 62 years, Greater Manchester, 1 year in role). In summary, whilst community groups in some areas were unavailable, most Link Workers indicated that their community groups were reopening. However, groups that were running were overwhelmed, difficult to access, or had limited capacity.

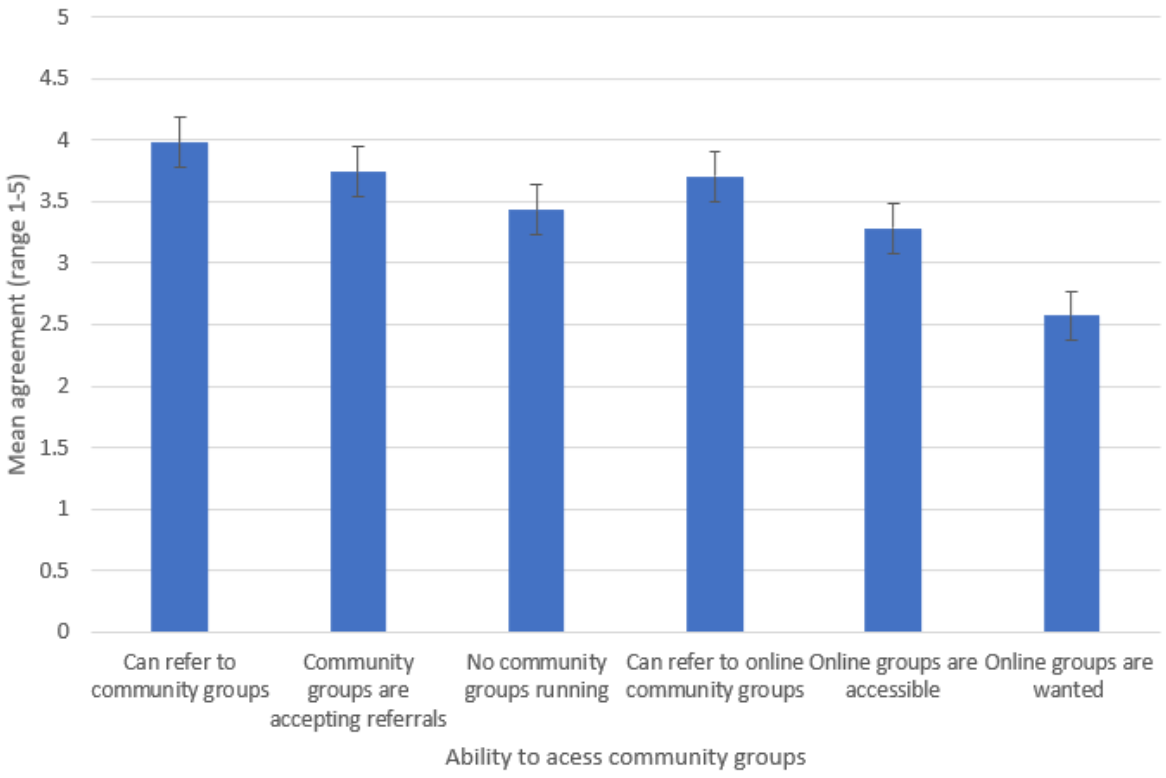
Together these qualitative findings provide insight into the non-significant change in social prescriptions to community groups. Given the restrictions on group activities as evidenced in subcategory 2.1, one may have expected referrals to community groups to be lower during the pandemic recovery period. However, as evidenced above, most community groups were beginning to re-open, but were operating at reduced capacity and were overwhelmed. The next three subsections further explore Link Workers abilities to connect service-users to community groups.

Ability to connect to community groups

Figure 8.2 outlines Link Worker's average agreement on six statements relating to their perceived ability to connect people to face-to-face and online community groups during the pandemic recovery period. Most Link Workers in this sample agreed that they were able to connect people to both online and face-to-face groups.

Figure 8.2

Link Worker perceptions on accessing community groups during the pandemic recovery period



Note. **Participants responded on a 5-point Likert scale rated from strongly disagree (1) to strongly agree (5).**

Additionally, there was lower average Link Worker agreement with the statement that online groups were wanted by service-users, suggesting that on average, online groups were perceived to be a less desired resource. Figure 8.2 further indicates that on average, participants could not agree with the statement "no community groups were running during the pandemic"

considering that the average rating (M = 3.43, SD = 1.26) aligns with the neither agree nor disagree rating.

Community group capacity within the next six-months

Most Link Workers perceived that community group capacity was somewhat likely to return to normal within the next six-months (mode = 4). However, the median response to this question was 3 and the mean was 2.89 (SD = 1.36), which falls between somewhat unlikely and neither likely nor unlikely. This suggests that whilst some Link Workers believed community group capacity in their locality would likely return to normal within the next six-months, other Link Workers were not confident. Category three explores community group capacity further.

Category three: Uncertainty over the future of community groups

Forty-four of 61 (72%) participants chose to add more detail on whether face-to-face community group capacity would return to normal within the next six-months, as explored in two subcategories: 'Group capacity unlikely to return to normal due to COVID-19' and 'The new 'normal' of group interactions.

3.1: Group capacity unlikely to return to normal due to COVID-19

Eighty-six percent of the 44 participants could not predict whether community groups would return to normal capacity within the next six-months. The variation in lockdowns and pandemic restrictions from March 2020 until the questionnaire (August – October 2021) hindered Link Worker's abilities to judge the near future capacity of community groups in their area. Consequently, 14% of participants expanded upon remaining sceptical of the return of community groups:

> "Many local groups like "knit and natter" groups aren't reforming as the people who ran them previously aren't around now. Community centres aren't open to groups yet. Funding has dried

> up. New uses for funding have emerged. Lots of activities that transferred to online are staying online" (Link Worker 8, Female, 65 years, Hertfordshire, 1 year 9 months)

Physical and practical consequences of the pandemic meant it would be difficult for community groups to return to normal capacity within the next six-months. The unpredictability of COVID-19 meant some community groups were reluctant to restart:

> "With the increasing numbers of Covid and the pressure to protect people and the winter season I am finding lots of groups are either deciding not to return or to run a limited service or are too worried about the implications of starting." (Link Worker 37, Female, 53 years, Leicestershire, 1 year in role)

Views of a lack of motivation to return to face-to-face socialisation and capacity to support the re-opening of community groups meant that Link Workers felt a return to normal capacity was unlikely. Consequently, many Link Workers were not hopeful for community group capacity to return to normal within the six-months following the questionnaire. However, some Link Workers felt a new form of normal could develop as explored in subcategory 3.2.

3.2: The new 'normal' of group interactions

Thirty-six percent of participants whose groups were re-opening face-to-face perceived that they could return to normal capacity. Although one Link Worker indicated that a return to 'normal' capacity could be different to what it was before the pandemic:

> "I think there will be a large number of people waiting to go back to face-to-face groups, due to difficulties accessing online sessions, so there may be a slight increase in intake in the next 6 months. However, many people we support are reluctant to return to face-to-face groups due to complete changes in their habits/routines/comfort with in-person sessions as a consequence of the pandemic. This may mean that groups are unable to return to 'normal' capacity (as they had before covid), but rather take on a new normal in terms of numbers attending groups." (Link Worker 59, Female, 22 years, Leicestershire, 1 year in role)

The routine changes caused by the pandemic may lead to a 'new normal' level of functioning in community groups. One Link Worker considered that a new normal of smaller capacity groups may occur to protect the vulnerability of people attending the groups:

> "They are taking people in some groups, some groups are not going to restart until next year so will likely do what groups open are doing currently and taking restricted numbers to test things out, I suspect everyone's anxieties will remain and also as it's often the most vulnerable attending the groups. I suspect the groups sizes will remain restricted." (Link Worker 41, Female, 49 years, Devon, 2 years in role)

Whilst some groups were accepting new people, other groups were reluctant to restart until the following year, with 5% of participants indicating that the new 'normal' may involve a "blended approach" (Link Worker 60, Female, 46 years, Kent, 3 years 2 months in role). In summary, Link Workers considered it unlikely for face-to-face community group capacity to return to pre-pandemic levels over the next six-months (the time when the toolkit would be trialled). The fluctuations in lockdowns and pandemic restrictions during the preceding year and a slow return to before pandemic levels of operation in community groups fuelled this perception. However, community groups may start a new form of normal, involving smaller face-to-face groups and blended offers of face-to-face and online interactions. The next subsection explores the utility of the newly created toolkits and three potential alternatives in light of their possible usefulness during the pandemic recovery period.

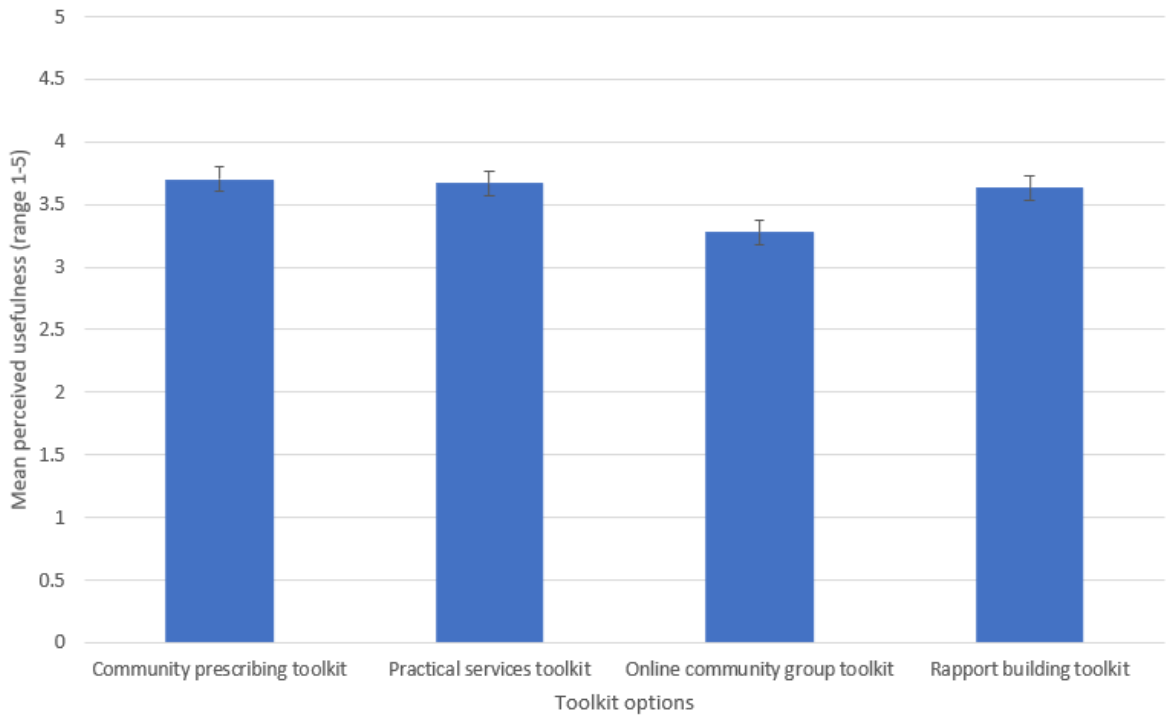
Useful support for the Link Worker role

Exploring Figure 8.3 shows participants' average perceptions of usefulness of the suggested four toolkits. On average, Link Workers perceived the Community Prescribing Toolkit to be the most useful toolkit (M = 3.70, SD = 1.31), followed by a toolkit to connect service-users to practical/support services (M = 3.57, SD = 1.35), an interpersonally-focused remote rapport building toolkit (M = 3.28, SD = 1.47), and a toolkit to support connecting service-users to

online community groups (M = 3.63, SD = 1.31). However, median values (median = 4) indicate that Link Workers perceived all toolkits to be very useful, except the online community group toolkit, suggesting multiple support needs. The next four subsections explore participant's abilities to support group processes during social prescribing.

Figure 8.3

The average perceived usefulness of four psychologically informed toolkits



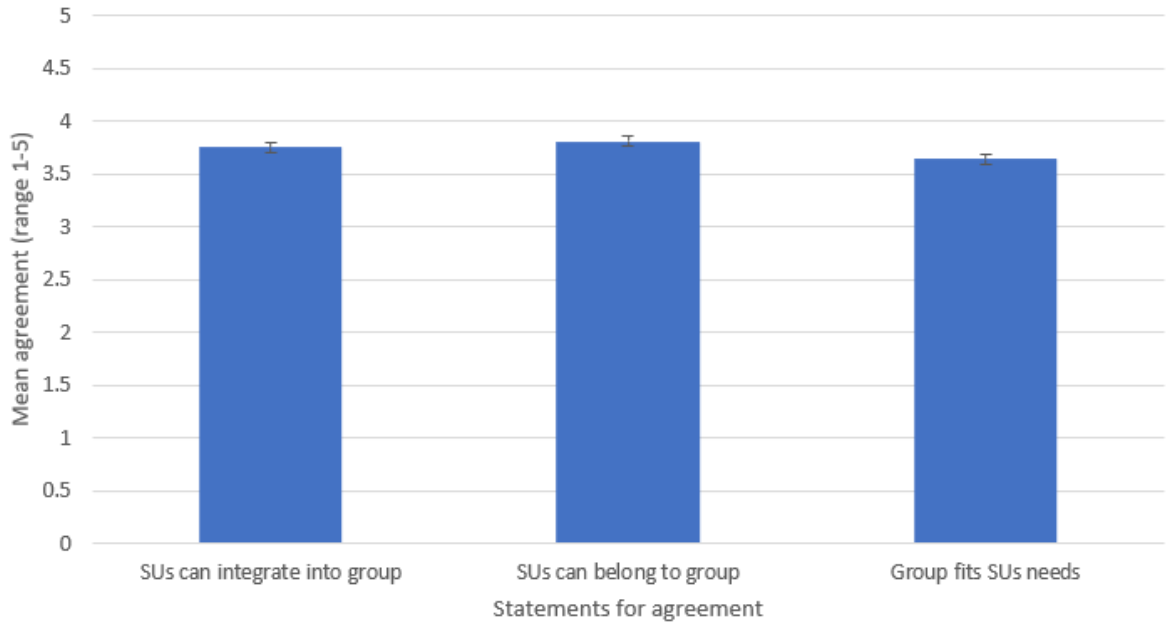
Note: Participants responded on a 5-point Likert Scale ranging from (1) not at all useful, to (5) extremely useful.

Perceived ability to support need satisfaction, belonging, and integration during social prescribing

Figure 8.4 shows that participants perceived themselves capable of supporting the group processes leading to integration, belonging, and need satisfaction during social prescribing. Link Workers more strongly agreed that they could support belonging, followed by integration, with need satisfaction having the lowest average agreement rating.

Figure 8.4

Link Workers average agreement on their perceived ability to support group processes during social prescribing



Note. **Participants responded on a 5-point Likert Scale ranging from (1) strongly disagree, to (5) strongly agree.**

Perceived importance of belonging, need satisfaction, and inclusion during social prescribing

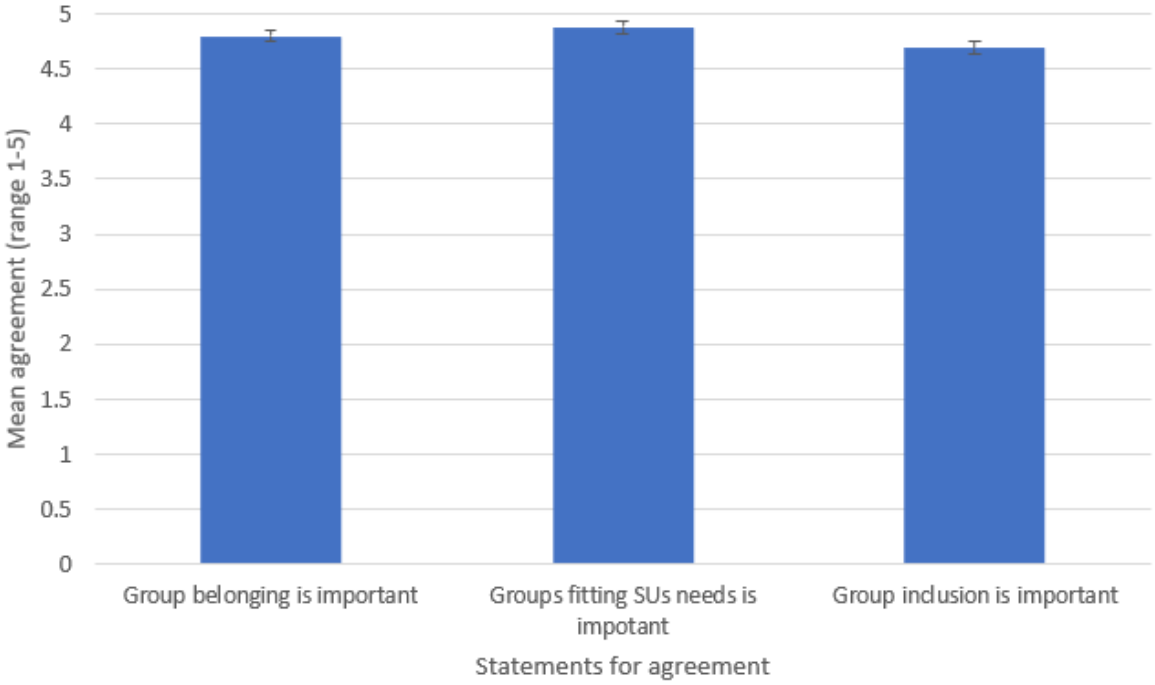
Most Link Workers in this study considered the provision of a good match between a service-user and a community group, where the service-user experiences a sense of fit with the group, to be very important (Mode = 5, M = 4.66, SD = .48). Link Workers in this sample, on average, also agreed that belonging, need satisfaction, and inclusion were important features of group experiences in social prescribing (Figure 8.5). Need satisfaction was considered the most important, followed by belonging and inclusion.

Comparing Figures 8.4 and 8.5, Link Workers in this sample perceived themselves to be less able to support group processes, despite recognising their importance. This is particularly

relevant for need satisfaction, which had a higher importance rating than other group experiences in Figure 8.5 yet had the lowest agreement rating in Figure 8.4. Category four explores the perceived importance of group processes for social prescribing further.

Figure 8.5

Link Workers average agreement on the perceived importance of group processes



***Note*. Participants responded on a 5-point Likert Scale ranging from (1) not at all useful, to (5) extremely useful**.

Category four: Group belonging is vital for social prescribing's success

Fifty-four of 61 (88%) participants provided comments on their perceptions of group belonging within social prescribing. Some participants perceived that developing a sense of group belonging was vital for service-user progression and helped to build community capacity. For example, 22% of participants recognised belonging was a human need:

> "It is a basic, core, human need and can elevate a person's overall well-being." (Link Worker 15, prefer not to say, 53 years, East Sussex, 1 year 2 months in role)

When the need to belong is met, Link Worker 15 recognised that it could improve a person's wellbeing. Twenty-two percent of participants recognised how belonging could maintain group attendance that empowered service-users:

> "A sense of belonging is often what patients are seeking. They feel undervalued and disassociated from their neighbourhood for a number of reasons. Those able to connect with groups that offer friendship, inclusion and a sense of purpose and belonging always thrive better and their attendance is more sustained, often resulting in life changing experiences." (Link Worker 43, Female, 51 years, Gloucestershire, 1 year 7 months in role)

Service-users that develop a sense of belonging are likely to feel included and as though they have a purpose, which in turn results in health and wellbeing improvements. For 13% of those who commented, building a sense of belonging was a fundamental purpose of social prescribing:

> "This is the whole ethos of social prescribing - to promote a sense of belonging, raise self-esteem and increase wellbeing. If someone does not feel a sense of belonging this can be damaging." (Link Worker 44, Female, 53 years, Southwest, 6 months in role)

Link Worker 44 understands social prescribing to be an initiative that raises self-esteem and increases wellbeing by promoting belonging. They recognise belonging as a psychological need that requires satisfying, otherwise it may be damaging to a service-user. Service-users are likely to disengage from a social prescription if it is not a good fit, which is likely to increase isolation, as captured by Link Worker 8:

> "It dispels isolation - shoehorning them into an inappropriate group only increases isolation. Acceptance by like-minded individuals promotes self-confidence, self-esteem, well-being, community resilience and eventually health." (Link Worker 8, Female, 65 years, Hertfordshire, 1 year 9 months in role)

Link Worker 8 acknowledges how belonging dispels loneliness, but only when that group is appropriate and is selected by the service-user. Indeed, "working alongside their peers and similar difficulties makes it less daunting" (Link Worker 21, Male, 53 years, Gloucestershire, 4 months in role), meaning belonging provides access to social support which should motivate maintained engagement with a social prescription. Therefore, group belonging has emotional, social, and psychological value to service-users that keep them motivated to progress in their social prescription.

Overall Link Workers recognised the importance of group belonging for social prescribing, considering it to be fundamental for social prescribing. These findings provide insight into why Link Workers consider the provisions of a good match to be very important, alongside supporting belonging, need satisfaction, and inclusion when providing social prescriptions to community groups. The next subsection explores whether face-to-face or online groups are perceived to be supportive of group dynamics.

Perceived capacity for face-to-face or online groups to support group processes

Three paired samples t-tests (Table 8.5) explored the mean differences between perceptions of a face-to-face versus online group's capacity to support the social identity processes of integration, inclusion, and belonging.

Table 8.5

The results of three paired sample t-tests comparing face-to-face or online groups capacity to support three group processes of integration, inclusion, and belonging

Social identification process	F2F M	F2F SD	Online M	Online SD	df	t	P	d
Integration	3.83	.84	2.62	.86	57	6.57	.001	1.40
Inclusion	3.97	.96	2.43	.96	57	7.01	.001	1.67
Belonging	4.24	.73	2.21	.81	57	11.94	.001	1.30

Following Bonferroni corrections, results indicated a maximum significance value of .017. On average, Link Workers perceived that face-to-face groups were significantly better at supporting the three processes of integration, inclusion, and belonging than online community groups.

Discussion

This study first aimed to explore whether social prescribing could support a feasibility trial of the Community Prescribing Toolkit during the pandemic recovery period. A subsidiary aim explored whether Link Workers could connect service-users to community groups during the pandemic recovery period and whether the whole process could support feasibility testing (requiring groups to be efficiently working too). Two further subsidiary aims explored Link Worker preferences for psychologically informed toolkits, and the perceived importance of group processes during social prescriptions.

Regarding the first objective, Link Workers and Community groups would need capacity to support a feasibility trial of the toolkit to ensure a participant sample and commitment to a trial. Quantitative analysis revealed no significant difference in ratings of Link Workers connecting to community groups during the pandemic recovery period compared to before the pandemic. This suggests that the demand for community groups remained consistent. However, qualitative insights indicated a high demand for face-to-face community groups but limited supply due to the limited number, capacity, and format of operational groups. Slow return to normal capacity for community resources and fear of COVID-19 also affected the availability of face-to-face offerings (Bakolis et al., 2021; Morris et al., 2022; Westlake et al., 2022). Waiting lists for social prescribing and social prescriptions to community resources were also reported in this study and the wider literature (Gould, 2021; Westlake et al., 2022), further complicating the feasibility of trialling the Community Prescribing Toolkit. Consequently,

these findings indicate that it would not be practical to trial the toolkit due to a limited availability of community groups for service-users to be connected to, reducing the participant sample to trial to the toolkit with. Likewise, with Link Workers experiencing high workload with complex cases, the likelihood of them being able to commit to, engage in, and support a feasibility study was low.

Quantitative analysis did reveal significant increases in ratings of referrals to statutory services and counselling, indicating that service-users may have sought other forms of support. For instance, the significant increase in ratings for therapeutic and financial support in this study coincided with continued service closures and the ongoing mental and financial impacts of the pandemic (Fixsen et al., 2021; Mahase, 2020; Westlake et al., 2022). One Devonshire evaluation found that social prescribing Link Workers were holding at-risk service-users with severe mental health issues during the pandemic, due to high demand and low availability of statutory and community-based mental health services (Westlake et al., 2022). When supply cannot meet demand, existing systems may become strained which could increase the complexity of service-user's needs, as recognised in this study. Furthermore, Link Workers remained uncertain about groups returning to normal capacity within the six-months post-questionnaire. Together these ongoing concerns may be responsible for the lack of significant ratings in differences in community group social prescriptions and further outline the impracticalities of trialling the Community Prescribing Toolkit.

Concerning the second objective, participants on average considered the Community Prescribing Toolkit to be the most useful option during the pandemic recovery period, while the online group toolkit was considered the least useful. However, all the toolkits received moderately to very useful ratings, suggesting that other toolkits supporting social prescribing could also be beneficial during the pandemic recovery period. Such insight is useful when considering future studies in this research programme whilst also highlighting the ongoing need

for appropriate training and support to effectively conduct the Link Worker role (NALW, 2019a, 2019b).

For the third objective, face-to-face groups were perceived to be better at supporting integration, inclusion, and belonging compared to online groups. Draper and Dingle (2021) support this finding in their research showing that group identification and need satisfaction was significantly higher for face-to-face music groups compared to their virtual counterparts. Link Workers recognised the importance of group dynamics, including need satisfaction and fit, in social prescribing. The qualitative analysis highlighted the importance of group processes in successful social prescriptions, indicating that Link Workers would appreciate measures enhancing their understanding of these processes. These findings align with existing research emphasising the importance of community connections and group processes in social prescribing such as Kellei et al. (2019c). However, this study extends Kellezi et al. (2019c) by increasing insight into the emotional, social, and psychological value that community connection has in motivating service-services to engage with their social prescriptions through group belonging. This study further indicates that a SIAH based toolkit could benefit Link Workers by supporting them to provide social prescriptions that support the group processes perceived to be important in social prescribing, facilitating social identification. These insights suggest that continued exploration into how Link Workers can facilitate social identification during social prescribing, including overcoming potential barriers to social identification, would be beneficial to social prescribing and this research programme.

Strengths and Limitations

This study provides further evidence supporting the use of the SIAH as a theoretical framework for promoting successful social prescribing that is understood and valued by Link Workers. The descriptive, statistical, and qualitative findings in this study have contributed to a better understanding of the recovery of social prescribing and communities after the pandemic. These

insights can help inform decisions about the practicality of conducting a feasibility trial during the pandemic recovery period.

However, the utilisation of bespoke measures impedes this study by introducing interpretational challenges (Fuchs & Diamantropolous, 2009) that may not have been present with validated measures. Furthermore, whilst this study aimed to capture niche, context specific information, the inability to follow-up qualitative responses, due to the online nature of the questionnaire (Ball, 2019), limited the researcher's ability to interpret and understand the context of responses.

The low response rate from Link Workers also weakens the strength of the findings. With only 70 participants, 58 of which completed all quantitative questions, the sample size was small. The limited recruitment of Link Workers may be attributed to the high demand for social prescribing and other pressures on their work during the pandemic (Bertotti & Temirov, 2020), which may have restricted their capacity to engage in research relevant to their role. Moreover, many participants had only been in their roles for a brief period, and their experience and knowledge of community group capacity before the pandemic may have been limited. The stress and burnout experienced by Link Workers during the pandemic (Westlake et al., 2022) could have further demotivated their participation in research activities. For example, in Devon, Link Workers reported increasing levels of stress and burnout as the complexity of their caseloads and role boundaries increased during the COVID-19 pandemic (Westlake et al., 2022).

Chapter summary: Decisions for trialling the community prescribing toolkit

This chapter aimed to assess the feasibility of conducting a trial of the Community Prescribing Toolkit in a pandemic-affected context. Participants recognised the importance of group processes in social prescribing. However, the questionnaire revealed an unstable environment

for social prescribing and community support, making it impractical to proceed with the trial. Discussions with a social prescribing service willing to support a feasibility trial confirmed these findings. The emergence of the Omicron variant further exacerbated concerns (Karunanthi, 2022), as it led to the reintroduction of some pandemic measures and the potential for future lockdowns (Vaughan, 2021). As a result, both the researcher and the social prescribing service decided to postpone the trial until the service and community were in a better stage of recovery from the ongoing impacts of COVID-19.

To continue the research programme within the thesis, a shift in focus was made to deepen understanding on the predictors of engagement and disengagement during social prescriptions to community groups. Such understanding could provide further insight into how and when Link Workers and community groups can facilitate social identification. Chapter Nine details the rationale behind this shift and its alignment with the broader research aims, alongside the study conducted to explore this new focus.

Chapter 9: Exploring why service-users disengage with recommended community groups

Chapter overview

After determining that it would be impractical to trial the toolkit during the pandemic recovery period in Chapter Eight, this chapter describes the altered fourth study supporting the research program in this thesis. Semi-structured interviews were conducted with service-users who had disengaged with or declined to attend a recommended community group. Understanding why service-users disengage is important for developing the Community Prescribing Toolkit which aims to reduce disengagement by facilitating social identification. A rationale for the study is first provided, followed by the aims. The methods utilised in the study are described, followed by the conducted phenomenological Reflexive Thematic Analysis. The findings are then detailed before outlining the refinements to the Community Prescribing Toolkit based on the findings. The study is then discussed, highlighting its strengths and weaknesses prior to summarising the chapter.

Introduction

Disengagement is a common issue in social prescribing (Bickerdike et al., 2017; Husk et al., 2020; Porter et al., 2022; Tierney et al., 2022) with reasons for disengagement varying across different services as noted in Chapter Two. Approximately 6% of service-users stopped attending a Welsh social prescribing service between February 2019 – October 2021 for reasons including unmet expectations, no longer desiring the service, poor health, inappropriate referrals, and inability to contact the service-user (Mind Cymru, 2021). Further reasons for disengagement include a lack of knowledge of social prescribing, transport limitations, and social anxiety (Bertotti et al., 2018; Brandling & House, 2009; Wildman et al., 2019a).

Sandhu et al. (2022a) conducted a qualitative content analysis on data from an American social needs screening and referral intervention, from people who reported barriers to accessing clinical support. They found that approachability (a lack of information about resources), acceptability (the suitability of resources for a service-user's needs), availability (the ability to access and attend a resource), accommodation (the capacity for a resource to support a service-user in accessing it), affordability (cost) and, the appropriateness of a resource in terms of current need or interest, were barriers preventing service-users from addressing their social needs. These barriers are likely to be a snapshot of the true range experienced by service-users, with some of these barriers being present within UK social prescribing schemes, such as availability (i.e., transport barriers, poor health), appropriateness (i.e., continued need to access social prescribing), and approachability (i.e., lack of knowledge).

However, there may be other barriers preventing service-user engagement that are yet to be explored, particularly when considering the suitability of recommended community groups. Social prescriptions to community groups are more likely to foster health and wellbeing benefits when they facilitate social identification (Kellezi et al., 2019c; Wakefield et al., 2022), as noted in Chapter Four. When service-users disengage with a community group social prescription, they are less likely to improve their health and wellbeing because they do not access the available support (Husk et al., 2020).

Additional barriers preventing isolated service-users from engaging with groups may include negative group experiences, a lack of social experiences, and existing health problems (Stuart et al., 2021). These experiences may reduce a service-users capacity to consider groups to be a good fit for them. In Stuart et al. (2021), unwelcoming groups exacerbated the barriers of negative group experiences and lack of social experiences. Consequently, the stress and conflict experienced through negative social encounters are likely to undermine one's health and wellbeing (Bolger et al., 1989; Cohen, 2004; Stevenson et al., 2014) and produce a social

curse rather than cure (Kellezi & Reicher, 2012). Social curses occur when there are limited opportunities for positive social identification which could be due to stigma, a loss of agency in one's life, social isolation, and a lack of social support impacting one's ability to cope with stressors, as noted in Kellezi et al.'s (2019b) qualitative study exploring immigration detention centres as social curses or cures. Should a service-user perceive themselves as unable to engage with a social prescription, they will be unable to develop a sense of belonging with a group and may not experience the health and wellbeing benefits of a community group social prescription, resulting in a social curse.

Despite existing evidence on barriers to engagement, further insight into the specific barriers related to group-based social prescriptions is needed. Understanding the experiences of service-users who disengage or decline to engage with recommended groups, can inform the development of strategies to minimise disengagement and the potential development of a social curse. Therefore, this study aimed to 1) deepen understandings on why service-users may decline or disengage with recommended group activities and 2) further explore the potential facilitators that may encourage service-user engagement with community groups. Consequently, this study explored the research question: 'How can the experiences of service-users who disengage or decline to engage with recommended community groups, inform understanding of the barriers and facilitators of engagement with social prescribing?" The findings from this study can inform recommendations that can be included in the Community Prescribing Toolkit to further increase the likelihood of it reducing disengagement by facilitating a social cure.

Method

Design

Semi-structured in-depth interviews were conducted between March 2022 and February 2023 and explored service-user experiences of disengagement with recommended community groups. Semi-structured interviews provided the depth and flexibility necessary to fully explore the unique qualities of a participant's experience through follow up questions (Adams, 2015; Dejonckheere & Vaughn, 2019). The SIAH was utilised as a framework to contextualise and interpret participant responses.

Ethics

There was a potential risk of discussing sensitive or emotionally charged topics, such as bereavement, loneliness, social isolation, or mental health. To minimise potential harm to participants, they were informed about the potential to discuss sensitive topics in the information sheet, and their right to withdraw from the study was emphasised (BPS, 2021a). The researcher also remained attentive to signs of distress during the interview.

Participants

Initially, service-users were required to have declined to engage or disengaged with a community group social prescription as part of a service evaluation. Recruitment criteria was broadened in May 2022 due to low response to the study, to include those who had attended some sessions before disengaging and those who had self-referred and disengaged. Low response and the end of the evaluation saw a widening of recruitment in August 2022. People in local communities who were 18 years or older, UK-based, had the capacity to attend an interview online or over the telephone, and who had declined to engage or disengaged with a recommended community group were targeted. Participants were recruited using gatekeepers, purposeful and opportunistic sampling. Appendix D provides further details of these recruitment pathways.

Remote recruitment was necessary to comply with ethics permissions and was thought to increase the chances of obtaining the intended target sample of 15 participants, following guidance from Malterud et al. (2016). Smaller sample sizes are appropriate for hard-to-reach populations because they may be reluctant to engage in research due to increased stigma and reluctance to associate with authorities (Raifman et al., 2022). Five participants were recruited, and their demographics are detailed in Table 9.1.

Table 9.1

Participant demographics

Participant	Aged	Gender	Ethnicity
Clover	45	Female	White British
Theo	68	Male	White British
Rose	94	Female	White British
Jasper	30	Male	Black Caribbean
Lily	60	Female	White British

Two participants were recruited via the social prescribing service evaluation, and three from local communities. All participants in this sample had disengaged with recommended groups in their past and declined to attend a socially prescribed or recommended group. No participants had disengaged with a socially prescribed group in this sample, whilst one had disengaged with a group recommended by their therapist.

Procedure

Participants who expressed interest in the study were emailed a participant information sheet and consent form upon contacting the researcher. Interviews were scheduled once informed consent was obtained. For participants recruited through the community, screening questions

were conducted over the telephone to ensure that they met the study requirements. Interviews were guided by an interview schedule (Appendix E), were audio recorded, and lasted on average for 40 minutes. The interviews explored the participant's community, how they were referred to their group, their experience of being recommended to a group, why they disengaged or declined to attend those groups, and what factors may have supported them to attend those groups. Afterwards, participants were debriefed and compensated with a £10 shopping voucher.

Reflexive Thematic Analysis

Similar to Mitchell (2020), an experiential approach to Reflexive Thematic Analysis utilising a phenomenological lens was conducted following six-steps to Reflexive Thematic Analysis by Braun and Clarke (2021b). This approach aimed to capture the unique qualities of participants' lived experiences (Finlay, 2011; Ho et al., 2017; Ozuem et al., 2022), giving voice to the under-researched and isolated population of disengaged service-users (Braun & Clarke, 2013; Ho et al., 2017; Mitchell, 2020). The analysis was inductive and latent, utilising the SIAH to aid interpretation of participant responses (Braun & Clarke, 2021b).

Analytical procedure

Participant interviews were transcribed into Word documents and imported into NVivo Pro-12, to aid analysis. Each transcript was familiarised, through repeated reading and coded before moving to the next transcript, to support a phenomenological approach that captures the uniqueness of participant experiences (Ho et al., 2017; Mitchell, 2020). During familiarisation (step one of Reflexive Thematic Analysis), initial impressions, ideas, and thoughts were noted using the annotations function in NVivo. Transcripts were then analysed inductively, coding sections of data at the semantic level first that were relevant to the research question. Latent coding was then conducted to explore the meaning within the data, aligning with step two. Step

three involved searching for patterns of meaning across the dataset by clustering similar conceptual latent codes together to generate initial themes/subthemes. These initial themes/subthemes were then reviewed and revised through an iterative process of reorganisation, expansion, or removal, aligning with step four. During this iterative process, initial themes were shared with the wider research team and refined into finalised themes that captured the shared patterns of participant experiences, aligning with step five. Step six was then conducted by formally writing up the results. Table 9.2 outlines the two themes generated during the analysis.

Table 9.2

Thematic table detailing the experiential themes generated during a phenomenological reflexive thematic analysis

Experiential superordinate theme	Experiential subordinate theme
1: Incompatible social experiences create vicious cycles of disengagement	1.1: Existing identities are incompatible with recommended groups
	1.2: Social disappointment increases distrust of future group experiences
	1.3: Self-fulfilling prophecies impede opportunities for psychological connection
2: Engaging with peers by choice	2.1: Building shared psychological connections facilitates engagement
	2.2: Autonomy in building social relationships

Analysis

Theme one: Incompatible social experiences create vicious cycles of disengagement

Participants indicated that they were socially disconnected from their community and had mostly experienced poor quality social relationships. When combined with incompatible recommendations to groups which did not suit their existing identities and needs, participants

became distrustful of future social experiences. For some participants, chronic experiences of isolation resulted in self-fulfilling prophecies that impeded their capacity to engage with others. Three subthemes explore this further, 'Existing identities are incompatible with recommended groups,' 'Social disappointment increases distrust of future group experiences,' and 'Self-fulfilling prophecies impede opportunities for psychological connection.'

1.1: Existing identities are incompatible with recommended groups

All participants outlined how a professional (i.e., Link Worker, therapist etc.) had recommended them to groups that were incompatible with their existing identity. In this sample, group incompatibility was due to a lack of shared characteristics with other group members, a lack of fit between one's capabilities in attending group activities, and a mismatch with the type of group recommended. Lily's occupational therapists (OTs) had offered and failed to refer her to social prescribing. Instead, they provided Lily with a list of four groups that were incompatible with her sense of self and needs. Consequently, she perceived the group recommendations to be stigmatising due to the OTs not listening to her needs:

> "Those OTs just assumed, but because I- and I feel like this, I don't know if it's right or not, but this is what I feel so therefore it's valid, but I feel like they thought oh she's over 60 on her own all day and right we'll try and fit what over 60's do. It was a bit ageist to be honest with you." (Lily, Female, 60 years, White British)

Lily feels that her OTs provided discriminatory group recommendations based on her age. Considering herself to be "young at heart" Lily was provided inappropriate recommendations that were perceived to be incompatible with her sense of self. Jasper was also recommended to a group by their therapist that was incompatible with his sense of self:

> "I feel the main factor there was the factor that erm should I say, these people in the group weren't like the same ethnicity in the group as me and I erm saw a lot of erm older people, like people older than me in the group. So, I felt like, you'd never be able to bond with people that

> are should I say 20-30 years older than you in the group. So, I felt that maybe I was recommended to the wrong group and that's the reason I disengaged." (Jasper, Male, 30 years, Black Caribbean)

The lack of shared important and valued group identities (ethnicity, age) between Jasper and the existing group members made it difficult for him to bond with and integrate into the group. Consequently, he disengaged with the group after the first session. Shared similarities can support assessments of fit (Oakes et al., 1991) and the development of a psychological connection with the group (Hogg & Reid, 2006). Group recommendations that do not consider shared similarities appear to increase their incompatibility and the likelihood of disengagement.

In this sample, incompatible recommendations to groups seemed to occur because the service-user was not listened to by those recommending the group. Theo was provided with an incompatible group recommendation by his Link Worker after explaining his aversions to group settings:

> "I've not heard anything from her apart from when I were recommended to her. Apart from when she rang me up and asked me if I wanted to go to a coffee morning where everybody meets at the, this whatever school it is. And they all sit round having a coffee, and I said, "did anybody listen to what people are saying". I said, "I told you I don't like groups and I don't like crowds. I've got to know people very well before I get into a crowd." She says, "well your welcome to come for a coffee", and I says, "well I won't come". I said it don't matter how many times you ask. I won't just walk into a room with a crowd of people. I won't even walk in a coffee shop where it's crowded. You know, people they sit there listening to you, but they can't hear what you're saying" (Theo, Male, 68 years, White British)

Theo expresses his frustration at having to repeat his preferences for social contact following an inconsiderate recommendation that did not align with his sense of self. The prospect of being in a crowded room resulted in an immediate rejection of the recommended group because a

group setting was not perceived to be accessible to Theo. Consequently, Theo felt that his needs were not valued by the Link Worker, and he did not engage with the recommended group. Feeling unheard by a Link Worker, or others recommending community groups can be demotivating (Levine et al., 2004) and increase the likelihood of disengagement. In contrast, when a service-user felt that their needs were heard and supported, they remembered their experience fondly, even if they had yet to act upon a recommendation:

> "My highlight is when I approached the services, I felt welcomed. And listened, helpful advice and further information. They were the key factors for me. I was- if I wasn't clear enough, I was made clearer, so I've got the understanding and I've got the information at hand to follow up." (Clover, Female, 45 years, White British)

Clover was the only service-user in this study to have a 'pleasant' social prescribing experience, and who was looking forward to joining groups that she had yet to engage with due to bereavement. The informative and helpful nature of the social prescribing service that Clover experienced, made her feel valued, heard, and appreciated. Where a service-user feels valued and heard by those recommending groups, they are more likely to have a positive experience that motivates future group engagement. Unfortunately, none of the service-users in this study appear to have been guided to access a compatible group that was considerate of their needs and their existing social identity. The next subtheme explores the impact of being recommended to incompatible groups.

1.2: Social disappointment increases distrust of future group experiences

Most participants were disappointed with the groups they were recommended due to misplaced expectations. Sometimes elevated expectations were created by the person recommending the group and when expectations were not met, participants lost faith that they could be supported. For example, Theo's Link Worker stated that he was "the ideal type of person that they were

looking to help," which may have triggered expectations that he would be supported by the service:

> "They help people like myself who were struggling to make way in life, and who were alone and erm, struggling with everyday things to plod on you know. Erm. Just said it was something that would probably be beneficial to me because it was from local area… and that erm they'd be able to help you find things to do (laughs). And erm. Like I say, they only suggested a walker which never transpired, so I can't say it was a good service, because they never provided a service. They had a phone call and that were it." (Theo, Male, 68 years, White British)

Theo perceives social prescribing to be "of no use" to him due to the disappointment in not being supported to an appropriate social activity. Theo's aversion to groups appears to be due to disappointing and sometimes abusive prior relationships that depleted his faith in other people. For example, Theo describes himself as having an "an abusive upbringing… a bullied life" having experienced a long-term emotionally abusive relationship, his best friend committing suicide, and his own children disowning him. As a result, he has struggled to develop social relationships throughout his life:

> "I've never bothered with a partner or made friends since he hung himself. Erm so, I don't know maybe it's a… defence mechanism I've set up. I should say I don't trust anybody. If I get too close to people, they seem to, I don't know they just seem to disappear from life, and it hurts so." (Theo, Male, 68 years, White British)

Following emotional turmoil at the loss of multiple relationships, Theo is wary of socialising and avoids social interactions to protect himself from further psychological and emotional distress. Like other lonely individuals, Theo experiences elevated levels of social anxiety in social settings which undermines his ability to develop successful social relationships (Knowles et al., 2015). Consequently, Theo adopts a pessimistic avoidant coping style that he described as a "defence mechanism" to avoid being hurt by future social interactions (Cacioppo

& Hawkley, 2005; Hawkley et al., 2005). However, his avoidance of social situations fosters a vicious cycle of distrust that predisposes Theo to unsuccessful and negative social encounters which increase his loneliness:

> "I says, "if I find myself in a group, I'll go in a corner and look for a way out. I'm like a little cornered rat. I'll get myself into a corner away from the group, so that I can sneak out, never to be seen again". I said, I don't know. I've spent so many years alone, driving lorries up and down country and over Europe. I've spent so many hours alone, it's like people- when I get into a group of people, I seem to get uptight, scared." (Theo, Male, 68 years, White British)

Years of isolation, including solitary working, and inadequate social relationships have further increased Theo's social anxiety and distrust of group settings. His social anxiety and expectations of other's intentions increases his fear of socialising (Knowles et al., 2015) and motivates his actions to "sneak out" of group settings. For other service-users, distrust in groups and supportive services developed due to high expectations from other's experiences of social prescribing. Lily was excited to be referred to social prescribing after hearing about it from a friend:

> "You see as far as I'm aware- my friend, she's had it. She had erm a specific person who was an expert on social prescribing come to her house and you know, offer to talk to her about what she wanted. And she offered to take her to groups you know on the first day and stuff like that. And I had none of that, none of that at all. And at a time where I'm mentally and physically not well, I haven't got the energy to do it anymore. And I feel like erm with the OTs they've lost confidence in me and therefore I've lost confidence in the- the social prescribing scheme." (Lily, Female, 60 years, White British)

Her disappointment in not experiencing social prescribing after having high expectations following her friends experience of it, was emotionally and physically draining. Lily states how

she does not have the "energy" to search for and join groups themselves. Following the disappointment, Lily lost trust in her OT and became demotivated to engage in social settings:

> "I just wish they never really mentioned it to me to be honest. Because it frustrated me. It's made me even more anxious. It got my expectations up… I thought at last here's this new resource that can actually make a difference to people but the way in which they explained it to me, I could have found out more myself on the internet." (Lily, Female, 60 years, White British)

After developing false of hope of being supported, Lily became disheartened by the experience and perceived themselves to be "back to square one." When one encounters such negative experiences of a service or support it can influence perceptions of accessibility, which influence the likelihood of one engaging with such support in the future as noted in Cruwys et al. (2014b). Exploring social isolation schemas in homeless people, Cruwys et al. (2014b) found that negative social experiences of a service reduced the likelihood of people accessing new groups which increased isolation over time. For Lily, her false social prescribing experience alongside previous incompatible group experiences have discouraged her from seeking future support:

> "People weren't supportive at all. I remember going out because I was feeling really quite panicky, and I was sat on a chair trying to do my deep breathing, and throughout this class, there was about twelve, there was nobody that came to say are you ok. Not even the facilitator. So that again has put me off and groups like that have also contributed to me not wanting to access it" (Lily, Female, 60 years, White British)

Lily felt unsupported by group members during a course she was attending which increased her negative perceptions of group situations. She became demotivated to seek further group support because the group neglected her psychological and emotional needs and did not make her feel valued (Levine & Moreland, 2004). Groups that are insensitive to a service-user's needs may increase feelings that they do not fit the group, particularly when a group's dynamics

change. Rose disengaged with her local church group when the leadership changed and altered the feel of the group:

> "Erm, I joined one at the church, and then we got a change of vicar and for personal reasons I didn't go to that. And that was all about four or five years ago now. The vicar were a good friend, but he moved into North Yorkshire and left two women vicars. Which I thought was a bit excessive, two women, so that was certainly my first thoughts about it." (Rose, Female, 94 years, White British)

Rose displays disappointment with the replacement vicars who she perceived to be "excessive" due to her culturally situated expectations of gender and religious roles. The loss of a close friend, alongside the shift in group dynamics to one that was not sensitive to Rose's traditional expectations of church management, resulted in her disengaging with her group. Consequently, groups that are incompatible with one's sense of self and expectations may lead to conflict and disengagement (Haslam et al., 2019b). Prior social experiences that are disappointing may discourage future group attendance, particularly when that group does not support a service-user's needs. For some service-users with histories of disappointing social relationships, a vicious cycle of social avoidance may develop that enhances their social isolation by discouraging engagement with groups (Cacioppo & Hawkley, 2005; Hawkley et al., 2005). The next subtheme explores how labelling oneself may create self-fulfilling prophecies that maintain the vicious cycle of social avoidance.

1.3: Self-fulfilling prophecies impede opportunities for psychological connection

Where participants adopted pessimistic-avoidant coping strategies, they created self-fulfilling prophecies which consolidated their perceptions of isolation (Cruwys et al., 2014b). Prior research notes how socially isolated individuals are more vigilant to negative social cues, which can facilitate self-fulfilling prophecies where people avoid socialising due to cynicism that others will reject them because they do not fit in (Jones, 2022; Schuurman et al., 2022; Swift

& Chasteen, 2021). Some participants had reconciled themselves to living a lonely life, either due to self-ageism (negative perceptions of one's own age), labelling oneself as lonely (Bodner, 2009), or by cynically judging the worth of socialising with others. For example, Rose, who had been brought up as an only child, indicated that you "have to be prepared to be lonely" as you age, due to the stereotype that "people don't like to be with old people" and the inevitable loss of family and friends (Gardiner et al., 2018). Applying this stereotype, Rose perceives herself as unable to socially engage with others due to ageing:

> "They thought I was lonely that's the thing. But I think when you've had a family and then you're left on your own, you do become lonely, because in old age you can't go and join a crowd or go to a pub and get to know people. And I wouldn't have done that anyway. I'm not too bad on my own. I do get down sometimes, but on the whole, I managed to cope fairly well." (Rose, Female, 94 years, White British)

Rose may have created a self-fulfilling prophecy as she aged (Swift & Chasteen, 2021; Schuurman et al., 2022) by drawing on age-based stereotypes that older people do not go out and socialise, which enhanced her loneliness (Bodner, 2009). However, Rose dismisses the isolating nature of her self-ageism through her perception that she copes with being alone because it is her "character to be a loner." For Rose, perceptions that it is their character to be alone could act as a coping mechanism to deal with the emotional and psychological distress associated with loneliness. Conforming to her self-ageist views, Rose's capacity to engage and psychologically connect with others was further defined by her age-related declining health:

> "It would depend on my health. It would depend on- I don't walk very well now and I gave up driving a long time ago. Er so it would depend on circumstances really. A lot of things come with old age that you don't expect. Erm, you think you're going to go on forever and then suddenly things drop off one by one." (Rose, Female, 94 years, White British)

Rose had a melancholic sense of inevitability towards her declining health because it was related to the uncontrollable aspect of life, ageing. Due to ageing, Rose had given up driving as a means for accessing resources, that when combined with her declining physical health and mobility, meant that Rose was unable to attend groups without support in getting there. The effects of ageing were cumulative and disabling for Rose, as she perceived the prospect of psychological connection to be incompatible with her ageing health and mobility (Bodner, 2009). Longitudinal research with nine older adults interviewed throughout COVID-19 further outlines how declining physical health due to ageing undermined participants' perceived capabilities to engage with groups, particularly when others were ageist towards them during COVID-19 (Harkin et al., 2023). The medically vulnerable participants in Harkin et al. (2023) display similar ageist perceptions towards themselves that Rose reported in this study, due to being categorised as vulnerable by others and forced into limited social contact during the pandemic. The social isolation policies served to reinforce participants' experiences of age-related loneliness as their social worlds reduced. Alternatively, Theo had experienced a chronic lack of quality interpersonal relationships throughout his life that shaped his social isolation:

> "Erm I've got no friends. Err no family, my family of my son and daughter. My daughters into drugs and my son steals from me and he won't talk to me now because I've told him I want the money back. So, he won't talk to me because I've asked for what he stole of me, and he won't give it me. So, he'd prefer not to talk to me and not let me see my grandchildren. So, I'm stuck in house all seven days a week" (Theo, Male, 68 years, White British)

His experiences are described as betrayal as Theo lost access to important group memberships (his family) and his sense of purpose for leaving the house. Limited opportunities for social interactions combined with his self-description as "cynical" shaped how Theo categorised others:

> "I just couldn't do anything that's in a group or- not unless I got to know everybody possibly individually beforehand, over a period of time. And then I could make my mind up over the people I like and the people I don't like. And then I can say, well I don't want to go there because he's there or she's there (laughs). You know, I've got this ability to pick people out of a crowd. I don't know whether it's a blessing or it ain't, but I can always tell what, what do you call it, the people that you don't really want to be a- you know a personality. I can pick up on people's personalities whether they are really truthful people, or whether they're not. Genuine people or not genuine people. I don't like disingenuous people." (Theo, Male, 68 years, White British)

Theo's deep-rooted distrust of others manifests itself when he judges the social worth of others based on their perceived level of honesty. By deciding someone is dishonest, Theo creates a scapegoat for avoiding social interactions that may reject him. His prior social experiences have led him to become cynical of other's intentions (Jones, 2022), which reinforces the vicious cycle of social avoidance detailed in subtheme 1.2. Theo provides an example of this cycle in action when he declined to volunteer at a wood workshop because he perceived the facilitator to be a dishonest bully:

> "When I came out, I thought oh dear, if that's how he talks to these poor students and he loses it like that just because they're making a noise, banging wood, we'd be at loggerheads very quickly. I wouldn't have been able to put up with him for very long. You don't talk- it don't matter who you are, you don't talk to students like that. There were no need for it… if I went up there and started working with him, I think I'd have the job off him within ten minutes. I think I'd get him the sack (laughs). Because I just couldn't have worked with somebody that's- he was to me, he came across as one of these little Hitlers. He didn't know a lot, but he were a good bully." (Theo, Male, 68 years, White British)

Perceiving themselves as incapable of working with a bully, Theo further isolates himself away from a volunteering opportunity that could have been beneficial to their health and wellbeing.

Theo had stated that they "would have loved to have helped them people making them items out of wood, because wood's my favourite", indicating that the wood workshop may have been a valuable social experience for Theo. However, his cynical interpretations of the facilitator's actions increased Theo's distrust of the facilitator and he declined to help. The next theme explores two perceived facilitators of group engagement.

Theme two: Engaging with peers by choice

This theme explores service-user perceptions that a thorough understanding of a group's content, the presence of shared similarities between group members and themselves and choosing which social relationships to build would support group engagement. Two subthemes explore this further, 'Building shared psychological connections facilitates engagement', and 'Autonomy in building social relationships'.

2.1: Building shared psychological connections facilitates engagement

Participants indicated that getting to know the group prior to attending and the presence of visible shared characteristics may have supported them to engage with their recommended groups. Knowledge about a group can help the service-user form early impressions, set expectations, and support the assessment of fit (Hogg & Rinella, 2018; Postmes et al., 2006). Lily provided a detailed outline of the group information she needed to know:

> "For them to give me a ring and tell me things like what exactly they do. What the cost is. Erm how flexible the course is. Maybe on a day where I can't get there, just to reassure me that it's ok not to turn up if I'm not well. Not to feel like you're letting people down. I would like detailed information on what the group entailed, the cost of it. And how many members go and what the age range was, the demographic. Erm just generally the ground rules of the content, the group content. So, I don't have to go through all of the effort to turn up, get there, as I have done years ago, get there and think oh my god this group is not good for me" (Lily, Female, 60 years, White British)

For Lily, being able to appraise every detail of a group was important for her deciding whether to attend a recommended group. Lily's distrust of being recommended to groups (subtheme 1.2) motivates her to assess the suitability of groups herself to avoid wasting time attending groups that are not a good fit. Her requirement for a group that is understanding of her absence could increase Lily's perception of being valued by the group, which can support experiences of belonging and encourage maintained engagement (Stewart et al., 2009). However, knowledge of group demographics may also lead some participants to make cynical judgements before attending a group:

> "And she said well, "I can recommend ya to a Nordic walker, she does a class every week where you walk with two sticks", and she says they like dash across the park with two sticks. And I said, "they walk quite fast don't they", and she goes yeah. So I goes, "well I can't do that duck, I've got bad legs, I can't walk like that". She goes well, "if you go up and see her, she might be able to do it a bit slower". And I said, "then I'll feel guilty if she's got other people who want to walk fast, so I'm at the back, and she's having to walk slowly with me". (Theo, Male, 68 years, White British)

Theo was cynical of the groups suggested by his Link Worker and their potential adaptability for his needs. His perception of being unable to engage in fast-paced activities due to an injury received in the army increased his reluctance to consider attending any group that is not suited for restricted mobility. He feels guilt over a preconception that he would slow other group members down which further solidifies his cynical perceptions of the recommended group. Consequently, knowledge of a group may influence a service-user's first impressions of that group by increasing or decreasing the groups perceived accessibility. Highlighting visible similarities between the service-user and other group members was described by participants as one way of increasing the perceived accessibility of groups. Social identity literature outlines that shared similarities between group members help to foster social identification (Hogg &

Rinella, 2018) and increase the likelihood of social support being provided to group members (Wakefield et al., 2011). In Lily's case, she had previously developed a psychological connection to a group she shared experiences with:

> "Erm the group facilitator, he's had mental health problems himself, so he truly understands. And of course, as I say we're all likeminded people, we all sort of support each other. And because we've all got similar health problems. We all sort of know what not to do to help someone in that situation." (Lily, Female, 60 years, White British)

The presence of shared experiences of mental health within the group she regularly attended before her health declined was described as "a big family". Being amongst peers meant that Lily could develop a sense of belonging due to the mutual understanding and reciprocal support between group members (Hogg & Rinella, 2018; Jetten et al., 2014). For Jasper, who joined an online group after disengaging with a group recommended to him by his therapist, being in a peer-based group was freeing:

> "I've met someone from, should I say, from my own country. So I feel like erm, I feel that I be free, I'm very free and I can share whatever I want to share, because people in that group are actually people like from my age grade, and erm should I say, your ethnicity, erm like you, I feel like I erm I feel very free with them and I can share whatever I want to share." (Jasper, Male, 30 years, Black Caribbean)

Jasper did not feel judged by others in the online group, instead Jasper identified with the group members, stating that they saw each other as "siblings" due to sharing similar ethnic backgrounds and ages. His similarity to other members in the online group helped to foster psychological connections between members through shared experiences and mutual understanding. The next subtheme explores the facilitative nature of choosing which social activities one engages in.

2.2: Autonomy in building social relationships

Most participants indicated that they wanted autonomy in selecting the type of social activities they engaged in. Autonomy is a psychological need which social inclusion facilitates through improved self-efficacy (Koudenberg et al., 2017). For Theo, building social relationships over time may have increased his confidence to engage with groups:

> "I've got to build up a friendship with somebody, who can then possibly introduce me to somebody else. And then you've got two friends, and then two friends could introduce you to two more friends. And just learn to get on with these people and find that they're not using me and they're just ringing up for a chat." (Theo, Male, 68 years, White British)

Theo's distrust of others (subtheme 1.2) meant that he required time to slowly develop a trusted social network that was based on meaningful connections. His intentions to build a new social network suggests that Theo was hoping to build his social identity through scaffolding one-to-one relationships as recommended in the SIMIC model (Haslam et al., 2019b). For others, autonomy over which groups they attended was desired:

> "Not just being recommended one group, maybe different groups are being recommended and I get to choose the one I want to." (Jasper, Male, 30 years, Black Caribbean)

Jasper desired personal control over choosing the group they attended, rather than being ascribed one by his therapist. The incompatibility of the therapist's recommended group with Jasper's identity caused disengagement (Bantry-White et al., 2018), as noted in subtheme 2.2. In Jaspers eyes, autonomy in choosing a group may have prevented him from being connected to a group that was incompatible with his needs and identity. Where choice of suitable groups was limited, some participants voiced a willingness to assert their autonomy through volunteering:

> "I have volunteered my services; I don't know if anyone got an email to be a Zumba teacher free of charge. Erm because I'm a qualified one, so I don't know, I've been told I've been referred and I'm waiting for someone to ring me back. So, I can offer the services." (Clover, Female, 45 years, White British)

Clover demonstrated a preference for contributing to a group, rather than being offered a group to help them. Her prior experience of running a domestic violence support group may have predisposed her to supporting others rather than becoming a recipient of support herself. Volunteering enables service-users to support others and give back to their communities (Turk et al., 2022) and is compatible with service-users who are skill-based. Clover's preference for providing support suggests that volunteering could be a more promising solution to promoting autonomous social interactions. However, consideration is required on whether a volunteering activity offers group-based or one-to-one support, to accommodate those service-users who are not amenable to group settings.

Additions to the Community Prescribing Toolkit

Based on the findings in this study, the following refinements were made to the community Prescribing Toolkit:

- A brief timeline of the referral process in the Link Worker toolkit was created. This highlighted key stages where Link Workers should consider group processes, such as prior social experiences, readiness to engage, perceived accessibility and fit, and the type of social contact desired, to increase the chances of facilitating social identification. The start of the journey involves considering whether a community group social prescription is possible/beneficial to a service-user.
- Edited the Link Worker guidance document to a) outline the importance of recognising inadequate social experiences and the potential impact that can have towards group

engagement, and b) outline the importance of service-users feeling actively heard during conversations.

- Edited the barrier section in the Link Worker toolkit to a) highlight the importance of supporting assessment of fit by focusing on shared similarities and peer-based groups. This included considering volunteering opportunities over community groups for those who would benefit from providing support rather than receiving it. And b) consider how to support group compatibility when providing service-users with a choice of community resources to attend.
- Edited the community prescribing tool document to include broader questions regarding social experiences, including important characteristics to be matched to a group. Example questions include "what are your past social experiences?", "What are you seeking from a community group", and "what are your thoughts on volunteering?".
- Edited the Community Group version of the toolkit to re-emphasise the importance of being welcoming to prospective members, showing they value new members to overcome potential negative expectations set by prior experiences.

Discussion

This study aimed to explore why service-users declined or disengaged from recommended group activities and identify potential facilitators of engagement. Two themes generated insight into the lived experiences of service-users who had declined to attend recommended groups and the factors they considered to be supportive of engagement. Participants reported having inadequate social relationships, influenced by traumatic events such as bereavement, solitary working patterns, and poor health. These social experiences undermined their beliefs in the value of and their capacity to form social relationships.

Qualitative research has shown that personal barriers, including past traumas and a lack of social experiences can make service-users uncomfortable in group settings (Stuart et al., 2021), aligning with the experiences reported in this study. Further research notes how lonely people tend to perceive social events negatively and adopt pessimistic-avoidant coping strategies which predispose them to unsuccessful and negative social encounters that enhance their loneliness (Cacioppo & Hawkley, 2005; Hawkley et al., 2005). The findings in this study extend this research by outlining how lonely and isolated participants experienced a social curse (Kellezi & Reicher, 2012) where their prior social experiences undermined their capacity to socially identify with groups and experience health and wellbeing improvements. Theo demonstrates such behaviour in his endeavours to avoid group settings to protect himself from emotional harm which increases his isolation. Where participants adopted pessimistic-avoidant coping strategies, they created self-fulfilling prophecies that consolidated their perceptions of isolation (Cruwys et al., 2014b). This study extends existing research by outlining how these self-fulfilling prophecies developed from service-users stereotyping themselves (i.e., older adult), and others (i.e., dishonest) based on their experiences, to the extent that some service-users had resided themselves to living a lonely life (Bodner, 2009). Service-users with such complex social histories are likely to be challenging to support in social prescribing, particularly if a Link Worker does not attempt to consider the compatibility of a service-user's existing social identity when recommending community groups. In some cases, as with Theo and participants in Stuart et al. (2021), being connected to community groups may not be a suitable solution that improves health and wellbeing. If groups are perceived to be incompatible with a service-user's sense of self, their needs and priorities around managing their health and wellbeing, and their interests then being connected to a group could decrease wellbeing rather than improve it.

Participants in this sample further outlined how prior experiences of groups and supportive services were disappointing which fostered disengagement. A qualitative study exploring social isolation schemas in homeless people outlined how negative social experiences with a support service may reduce the likelihood of people socially engaging with new groups, increasing isolation over time (Cruwys et al., 2014b). In this study, negative group experiences caused by poor perceived fit due to a lack of shared similarities appeared to increase service-user perceptions that they were not valued and welcomed by the group and that the group was unsuitable for their needs. Social psychological research has outlined how negative experiences of a service can influence the likelihood of one accessing such support in the future (Stuart et al., 2021), whilst feeling valued by a group and put at ease about attending can support maintained group engagement (Borek et al., 2019a; Levine et al., 2004). When considering the potential groups available for service-users, Link Workers may need to consider the psychological and emotional impact of prior group and social experiences to explore a service-user's receptiveness to group situations.

One perceived solution to recommending groups that would be compatible with a service-user's existing social identity was shared similarities between the service-user and the recommended group. The social identity literature outlines the importance of shared similarities for facilitating assessments of fit (Oakes et al., 1991) and for fostering a psychological connection with the group (Hogg & Reid, 2006; Hogg & Rinella, 2018). Service-users in this study reported experiencing group identification when a group had either shared physical similarities or shared experiences of mental health. Recommendations that do not consider a service-user's similarity to other group members may increase the risk of disengagement due to perceived incompatibility with one's sense of self, as noted when Jasper disengaged with a group that differed in ethnicity and age. Link Workers may need to consider

how well a service-user matches the group's demographics to support engagement, if such considerations are practical within their working capacity.

A second solution to improving engagement was increasing the perceived accessibility of a group and perceptions of fit with the group through knowledge of a groups content. Postmes et al. (2005) note how knowledge of a group can help form impressions, set expectations, and support the assessment of fit. Groups which demonstrate understanding of a service-user's needs are likely to foster feelings of value, supporting experiences of belonging and maintained engagement (Stewart et al., 2009). Link Workers should obtain detailed information about a group to share with a service-user, according to the participants in this study. However, care may be required when divulging information about a group, to prevent cynical and distrusting perceptions influencing the perceived accessibility of a group.

Finally, participants also commented on the empowering nature of autonomy for choosing which social activities or groups to engage with. Autonomy in social identity terms refers to having choice over one's actions that are congruent with one's sense of self (Deci & Ryan, 2000). Autonomy is a psychological need which social inclusion facilitates through improved self-efficacy, as shown in longitudinal field studies (Koudenberg et al., 2017). Theo particularly valued autonomy in building social relationships which could be utilised for identity gain (Haslam et al., 2019b), whilst Jasper valued autonomy over selecting a group to attend. Where recommendations cannot meet a service-user's needs, some participants in this study indicated a willingness to volunteer. Volunteering involves giving support without expecting payment, for the good of others (Turk et al., 2022). The provided support can be group based or one-to-one. Volunteering in social prescribing can be an enabling experience that improves service-users health and wellbeing (Turk et al., 2022), because it satisfies psychological needs for belonging, meaning and purpose when a shared identity is formed between volunteers or the volunteer organisation, and offers social support which contributes

to personal fulfilment (Gray & Stevenson, 2020). Consequently, volunteering may be a more suitable social experience for those more inclined to provide support rather than receive it because it can still provide access to the psychological benefits of group identification. However, Link Workers may need to consider the nature of the volunteering activity to ensure it suits a service-user's social preferences.

Overall, the experiences of service-users in this study have highlighted the complexity of prior social and group experiences for fostering motivation, willingness, and openness to new social situations. Disappointing social experiences that are incompatible with one's needs and social identity are likely to increase social avoidance and negative stereotyping that creates self-fulfilling prophecies which enhance isolation and loneliness. Engagement with groups may be increased by connecting service-users to peer-based groups with visible shared similarities, providing clear information about a group, and offering autonomy in the types of social contact a service-user engages in. The remainder of this discussion focuses on reflexivity, strengths, and limitations of Study Four.

Reflexivity

I found discussing the participant's experiences challenging in this study. After dedicating three years towards creating a toolkit to minimise social prescribing service-user disengagement, it was difficult listening to participant experiences of when things have gone wrong. This difficultly partly stems from my strong empathic capability and my academic pursuit to gain knowledge of psychological wellbeing and mental health. A contextualist approach may have confounded this further as I explored their experiences in consideration of the broader social and cultural contexts that may have influenced it. As a result, I found myself lapsing into the role of a counsellor, listening to people's problems, rather than retaining the role of a researcher sensitively probing for further details. This meant that I may not have fully probed a participant's experience of group disengagement. At times, I was unsure how to respond to

participants, particularly with Theo who seemed to have an endless supply of negative social experiences to share. These difficulties may be due to me being a White, English, female student in their late twenties who has not previously accessed support services themselves, making me an outsider to the participants in this sample. Nonetheless, I was able to build rapport with each service-user to explore their experiences in some detail.

Limitations

Recruitment for this study was challenging due to the use of social media, difficulty reaching the target population, and an influx of non-genuine participants. Regarding social media, the utilisation of a personal Facebook account on a personal laptop for recruitment may have biased the search results for community groups. Specifically, the algorithms and cookies on the laptop may have tailored the search towards the researcher's location and prior search terms, limiting the feedback of other potentially suitable groups that could be contacted (Bozdag, 2013). Reaching the desired target sample was also challenging due to there being no known places where social prescribing service-users gather to share their experiences. Many participants may have been socially isolated and may not have seen the research adverts displayed online and in local community venues. Lastly, encountering participants who pretend to fit the criteria of studies with incentives appears to be an increasing challenge, particularly with online research as explained in Owens' (2022) case study. Owens recommended knowing your field, utilising targeted ads, and screening questions that require pre-existing knowledge or experience of the topic to overcome fraudulent participants. Screening questions were utilised in this study to shape understanding on how a participant fit the study criteria before interviewing them. Some fraudulent participants did overcome the screening questions but were discovered at the start of the interview by repeating the screening questions and cross-referencing answers. Answers that did not match, such as location of the participant and if they had disengaged or declined, resulted in the termination of the interview without payment. Participants who refused to take

part in the screening questions over the phone were also unable to be interviewed, as this was one method of increasing the likelihood that the participant was UK based. Future research into this area should consider creating working partnerships with existing social prescribing schemes to aid recruitment of participants. Recruiting through a social prescribing scheme limits the risk of recruiting fraudulent participants via social media.

Chapter summary

This chapter introduced the final study in a series of studies conducted to support the development of a Community Prescribing Toolkit that was theoretically informed by the SIAH. Interviews with five service-users explored the barriers and facilitators influencing engagement with recommended community groups. Prior and current social experiences that are disappointing increase distrust of future social experiences and create cycles of social avoidance. Shared similarities between group members, autonomy over the social experience, and detailed information of a groups structure may support engagement. Edits to the Community Prescribing Toolkit were made based on Study Four findings to further reduce the likelihood of disengagement by connecting service-users to groups that are more compatible with their existing social identities. The final chapter of this thesis, Chapter Ten, reflects and discusses the research conducted during this PhD Programme and future opportunities.

Chapter 10: Overall discussion

Chapter overview

Chapter Nine presented the final study in a programme of research exploring the development of a Community Prescribing Toolkit. This chapter synthesises the research and learning achieved throughout the PhD programme supporting this thesis. The aims of the research are presented first before outlining how the research findings collectively answered the aims. The overall contribution to knowledge generated during this research is discussed before detailing the implications of the research including its utility, strengths, and limitations. Future research opportunities are then presented before concluding the thesis. The relevance of the SIAH for social prescribing and for addressing the research aims is detailed throughout the chapter, alongside what the research documented in this thesis contributes to the literature.

Aims of this thesis

As noted in Chapters One and Five, this thesis intended to gather evidence to support the creation of a SIAH-informed toolkit, before trialling its effectiveness. Thus, this thesis first aimed:

1) To gain link worker, service-user, and community group leader perspectives on the community group referral process to inform toolkit development.
2) To gain Link Worker, service-user, and community group Leader perspectives on the presence of possible group processes that facilitate identification during social prescriptions to community groups.
3) To collaboratively develop the Community Prescribing Toolkit for social prescribing stakeholder use.

Following the development of the toolkit, the research plan was reevaluated in light of the ongoing impacts of the coronavirus pandemic on social prescribing and communities (Brown et al., 2021; Mahase, 2020; Mak, 2021). Initial aims to explore the feasibility of the toolkit and conduct a randomised controlled trial were altered due to social prescribing have limited capacity to support the trials. Instead, to further develop the toolkit, the research aimed:

4) To explore the possibility of conducting a feasibility trial of the Community Prescribing Toolkit.
5) To deepen understandings on why service-users may decline or disengage with recommended group activities.
6) To explore the potential facilitators that may encourage service-user engagement with community groups.

Addressing these aims is theoretically useful in the context of social prescribing because its atheoretical history limits understanding of how and why social prescribing is successful and when it is not (Bragg & Leck, 2017; Stevenson et al., 2020a). Likewise, addressing these aims is practically useful for supporting Link Workers to minimise the problem of disengagement with social prescriptions, due to a misfit between the service-user and the socially prescribed community group (Porter et al., 2022; Tierney et al., 2022; Wildman et al., 2019a). These issues within social prescribing are concerning because service-users are being connected to groups that do not meet their needs, which increases the likelihood of disengagement. Where service-users disengage, they have limited access to the potential benefits of social prescribing such as improved loneliness and social isolation (Ellender & Bonner, 2021; Dayson & Leather, 2020; Jones et al., 2021; Reinhardt et al., 2021; Wildman & Wildman, 2021), improved health (Bertotti et al., 2020b; Elston et al., 2019; Wildman & Wildman, 2021), and improved wellbeing (Dayson & Leather, 2020; Elston et al., 2019; Gallagher, 2020; Wildman et al., 2019b). Furthermore, service-users that disengage are less likely to feel a part of their

community which creates further concern given the health and wellbeing impacts associated with group memberships and belonging to one's community (Bowe et al., 2020; Haslam et al., 2018; Kellezi et al., 2019c; Steffens et al., 2016; Wakefield et al., 2022).

The prior lack of a theoretical framework supporting evidence-based practice of social prescribing is one of the factors influencing whether a service-user accesses groups that support their needs. Group-level interactions can support a service-user's needs but only when there is a sense of social identification (Jetten et al., 2014; Wakefield et al., 2019). Previous research has found that group identification results in improved health and wellbeing in different settings, including social prescribing (Kellezi et al., 2019c; Wakefield et al., 2022), communities (Bowe et al., 2020), group-based interventions (Haslam et al., 2016; Bentley et al., 2021), and clinical populations such as those recovering from substance abuse (Dingle et al., 2021; Ingram et al., 2020).

Without social identification, the potential benefits of groups may be lost. One theoretical and practical solution to supporting social prescriptions to facilitate social identification thus involved the creation of a SIAH and SIA-informed toolkit for Link Workers to utilise during social prescriptions to community groups, as outlined in Chapter Four. A toolkit was considered the most useful solution due to its flexibility and utility in various settings (Hempel et al., 2019; Theole et al., 2020), which supports the variability in social prescribing schemes (Ladds, 2021). The purpose of the toolkit was to improve Link Workers' capacity to connect service-users to a community group that they could socially identify with, to optimise the health and wellbeing benefits they received from their social prescription. The next two sections explore how the four studies conducted during the research programme supported the aims of this thesis.

How do the conducted studies meet these aims?

Three research phases supported the exploratory sequential mixed method approach utilised during the research programme. Capturing qualitative data first was necessary to provide rich insight into the processes that occur during a community group social prescription. Such insight helped to answer the overarching research question 'How can the SIAH improve the social prescribing referral process to community groups?', by informing the creation of a toolkit that appropriately captured and applied the SIA and the SIAH as a theoretical framework to the social prescription to community groups process. Utilising a theory with evidence-based practice on how to facilitate and maintain social identification and promote health improving group interactions, should reduce the likelihood of disengagement and help to answer the research question. The research phases and their support in answering the research aims are discussed below.

Research phase one

Phase one started in September 2020 and ended in June 2021, and involved the exploratory and sequential creation and refinement of the Community Prescribing Toolkit during Study One and Two. Together, both study's outline the unique roles that Link Workers and Group leaders play in supporting a social prescription and highlight the complexity of how both stakeholders need to work together to facilitate social identification during social prescribing. Study One utilised in-depth semi-structured interviews to explore the referral process to community groups (aim one) and whether group processes that facilitate social identification were present during that process (aim two). Social prescribing Link Workers, community group leaders, and service-users were interviewed for their unique experience of the community group social prescription process and for the role they play in supporting a community group social prescription. The interviews provided insight into the group dynamics that either facilitated or hindered successful social prescriptions. For example, group processes of perceived readiness

to engage with groups (Tarrant et al., 2020), prior experiences shaping the perceived accessibility of a group (Hogg & Williams, 2000; Oakes et al., 1991), fit (Haslam, 2004; Turner et al., 1997), shared similarities (Hogg & Rinella, 2018), positive group atmosphere (Borek et al., 2019a; Levine et al., 2004), subgroups (Adler & Adler, 1995; Cohen, 1977; Abrams & Hogg, 2006), and belonging (Greenaway et al., 2016; Kyprianides et al., 2019) were found to be inherent during the social prescription pathway to community groups. These early findings from Study One outlined the relevance of the SIAH as a theoretical framework for social prescribing, providing insight into when, where, and how group processes could be utilised to facilitate group identification and minimise disengagement. It is these group processes that were incorporated into a Community Prescribing Toolkit to support Link Workers in providing social prescriptions that facilitate social identification. The SIAH literature, including the SIMBC (Tarrant et al., 2020) and the SIMIC (Haslam et al., 2016) were also utilised to support the creation of the toolkit. The structure of the toolkit was influenced by two key stages of a social prescription, the Link Worker assessment, and the connection to a community group stage.

Study Two was conducted to refine the toolkit and ensure that Link Workers and group Leaders found its content useful and relevant to their role (aim three). Focus groups with Link Workers and an online questionnaire with group leaders were utilised to support the refinement of the toolkit. Analysis indicated that Link Workers and group leaders had differing requirements when supporting a social prescription that facilitates social identification. Link Workers wanted the SIAH to be more prominent in the toolkit to support their understanding of how to utilise group processes during a social prescription. Group leaders wanted to reduce the prominence of the SIAH to increase the lay-person friendliness of the toolkit and because the information provided was not considered novel. Whilst both stakeholders perceived that the toolkit would be beneficial, Link Workers recommended adding in an ‘addressing barriers’ section, whilst

group leaders wanted greater consideration of integration tactics, the demographics of a group, and the consistency of timings and location of the group. Furthermore, Link Workers were concerned that it would not be practical to trial the toolkit during a working environment impacted by the COVID-19 pandemic. The Community Prescribing Toolkit was refined in line with the stakeholder suggestions. The practical considerations from group leaders regarding how a group operates and the role they play in facilitating social identification during a social prescription broadened the search criteria for literature supporting the facilitation of social identification during group-based interventions. Thus, the work from Borek et al. (2019a; 2019b) was reviewed and applied to the research to reflect the needs of the group leader/facilitator when facilitating group identification.

Research phase two

Phase two lasted between August 2021 – October 2021 and explored the practicality of trialling the toolkit during a social prescribing setting recovering from the coronavirus pandemic (aim four), following the concerns from Link Workers in Study Two. Consequently, Study Three utilised a quantitative and qualitative online questionnaire with Link Workers to understand whether they were able to provide community group social prescriptions during a period of recovery from the coronavirus pandemic. Link Workers were targeted for this study for their expert insight into the types of social prescriptions that were occurring during the pandemic recovery period. Quantitative insights indicated that whilst Link Workers perceived that there was a significant increase in people accessing social prescribing during the pandemic recovery period, compared to before the pandemic, there was not necessarily a significant increase in ratings of social prescriptions to community resources. Whilst there were perceived significant differences in perceptions of social prescriptions to practical resources such as counselling and financial support, there was no perceived significant difference in social prescriptions to community groups, indicating that Link Workers felt there was no change in the number of

people being connected to groups. Furthermore, Link Workers perceived face-to-face groups to be significantly better at supporting social identification than online groups, suggesting that a return to face-to-face capacity during the pandemic should be a priority for communities to best support their members.

Qualitative insights indicated that there was an altered need for and utilisation of social prescribing during the COVID-19 pandemic. There were limited social prescriptions to community groups occurring due to low resources, despite a high demand for such support and recognition of the benefits of group belonging. Likewise, Link Workers perceived remote support to be less useful for meeting the needs of social prescribing service-users. Community groups that could open were inconsistent in the support provided, had limited capacity to support their members, and were overwhelmed with referrals. Due to these constraints, Link Workers perceived that community group capacity was unlikely to return to the pre-pandemic levels within the six-months post-questionnaire that were necessary to practically plan and conduct a feasibility trial of the toolkit. Subsequently, it was deemed impractical to conduct a feasibility trial of the toolkit in a setting where social prescribing and communities were still recovering from the COVID-19 pandemic. In response, an alternative fourth study was conducted to further deepen understandings of the barriers preventing service-user engagement with recommended groups.

Research phase three

A second round of qualitative exploration occurred in phase three between March 2022 – February 2023 due to the inability to quantitatively trial the toolkit in line with the planned mixed methods research. Instead, focus shifted towards deepening understanding of why some service-users disengage or do not attend recommended community groups. Such additional understanding was sought to develop and strengthen the toolkits potential capacity to minimise service-user disengagement. Thus, Study Four explored the barriers (aim five) and facilitators

(aim six) of service-user engagement with recommended community groups and in doing so, gave a voice to a vulnerable and under researched population within in social prescribing. Interviews were conducted with service-users who had disengaged with or declined to engage with a recommended community group. Analysis indicated that service-users in this study declined to attend a recommended group when it was incompatible with their sense of self (Haslam et al., 2016; Hogg & Reid, 2006). Consistent with previous literature exploring pessimistic-avoidant coping strategies in lonely individuals, service-users who reported previously traumatic or disappointing social experiences perceived groups to be inaccessible, forming pessimistic expectations that fostered social avoidance and enhanced loneliness and isolation (Cruwys et al., 2014b; Jones, 2022; Swift & Chasteen, 2021; Schuurman et al., 2022). Likewise, aligning with the literature on group processes, the presence of shared similarities (Hogg & Rinella, 2018), detailed information of a group (Postmes et al., 2005), and autonomy in the type of social interactions engaged with (Koudenberg et al., 2017), were perceived to be facilitators of group engagement. These findings emphasise the need for Link Workers to consider the impact and influence that prior social experiences may have on a service-user when providing group recommendations. Considering a service-users past social experiences and aligning future opportunities to their existing sense of self may support the service-user to overcome potentially negative preconceptions of groups that could prevent engagement with a group if its suitability is not evident. The Community Prescribing Toolkit was revised to consider the influence that prior negative social experiences have on the perceived compatibility of recommended groups with one's existing social identity.

Supporting a Social Identity Approach to Health to social prescribing

Based on this series of studies and previous literature, the SIAH is a suitable theoretical framework for social prescribing. Social prescribing has been found to significantly improve health and wellbeing (Bertotti et al., 2020b; Jones et al., 2012; O'Hara et al., 2021; Wildman

& Wildman, 2021), through reducing loneliness and social isolation (Jones et al., 2021; Wakefield et al., 2022; Wildman & Wildman, 2021) and improving mental and physical health (Bertotti et al., 2020b; O'Hara et al., 2021; Jones et al., 2021; Moffat et al., 2017; Wildman & Wildman, 2021; Wildman et al., 2019b). Longitudinal research suggests that these benefits are sustainable when a community group social prescription facilitates social identification (Kellezi et al., 2019c; Wakefield et al., 2022).

However, social prescribing is currently an atheoretical health initiative that is diverse in its offerings and tailored to local populations (Bragg & Leck, 2017; Halder et al., 2018; Stevenson et al., 2020a). Furthermore, there are reports of inappropriate social prescriptions to community groups and other community resources (Bickerdike et al., 2017; Polley et al., 2017a; Sandhu et al., 2022a; 2022b). Service-users may be connected to groups that do not fit their needs (Husk et al., 2020; Porter et al., 2022; Sandhu et al., 2022a; Tierney et al., 2022; Wildman et al., 2019a). When a group does not fit their needs, a service-user may be less likely to socially identify and engage with their referred activity/group, which hinders access to the health and wellbeing benefits of social prescribing.

The SIAH has the capacity to address the existing limitations of disengagement and a lack of theory by providing a theoretical framework that can maintain engagement with social prescriptions to community groups by facilitating social identification (Halder et al., 2018; Kellezi et al., 2019c; Wakefield et al., 2022). Service-users that identify with a group are more likely to remain engaged because they feel a sense of belonging to the group, which reduces feelings of loneliness and isolation (Bowe et al., 2020; Greenaway et al., 2016; Jetten et al., 2012 Tarrant et al., 2020; Wakefield et al., 2019). The SIAH can facilitate group identification and minimise disengagement during social prescribing, by focusing on the type of group that would best fit a service-user and their needs.

Existing group-based interventions drawing on the SIAH, such as Groups4Health, have demonstrated the positive impact of group memberships that facilitate social identification (Haslam et al., 2016; Cruwys et al., 2021). In both clinical (Cruwys et al., 2021; Haslam et al., 2019a) and non-clinical populations (Haslam et al., 2016), Groups4Health has been found to significantly improve health and wellbeing and was found to be as effective as cognitive behaviour therapy for supporting depression during a three-month trial (Cruwys et al., 2021). Groups4Health also demonstrates longitudinal improvements in loneliness, having a large effect size at 12 month follow up (Cruwys et al., 2021). However, such an approach may be best integrated into existing medical frameworks to form a biopsychosocial approach to healthcare that comprehensively supports health and wellbeing (Haslam et al., 2018) and avoids the SIAH from being perceived as a universal remedy for those who may need medical intervention. The next subsections outline how the research reported in Chapters Six to Nine advances existing knowledge of a SIAH to social prescribing.

Past social experiences overshadow shared similarities in group settings

The research documented in this thesis further advances prior knowledge on social prescribing and the SIAH by emphasising the importance of connecting service-users to a group they can socially identify with. Prior SIAH literature shows how group identification mediates the health and wellbeing benefits of a social prescription (Wakefield et al, 2022). Social identification is likely to be facilitated when groups hold personal importance, meet an individual's needs, are accessible, provide a warm welcome and opportunities to interact with other group members, and when there are shared similarities between group members (Borek et al., 2019a; 2019b; Greenaway et al., 2016; Hogg & Rinella, 2018; Jetten et al., 2017; Kyprianides et al., 2019; Tarrant et al., 2022).

Participants in Study One and Four outlined the importance of providing a right match between a service-user and a community group and of ensuring that there are shared interests/similarities

between the service-user and the group. Shared similarities can refer to visible characteristics such as demographics (Hogg & Rinella, 2018) or shared experiences such as mental health or illness (Jetten et al., 2014). The service-users in Study Four advanced this literature by providing insight into the sensitivity required when considering shared similarities between a group and service-user, particularly when a service-user had prior traumatic social experiences. Service-users that had prior traumatic social experiences outlined ongoing difficulties in maintaining positive social relationships and distrust of future opportunities for social relationships despite the presence of shared interests. These service-user experiences reflect the social isolation schema described in Cruwys et al. (2014b) where people become pessimistic and avoidant of social experiences following traumatic or neglectful social experiences early in life. Unlike Cruwys et al., who found that positive social experiences that facilitated group identification significantly reduced the social isolation schema, participants in Study Four were unable to move beyond their pessimistic and avoidant behaviours. Whilst service-users were connected to incompatible groups that would have decreased their capacity to reduce their social isolation schemas via social identification, some service-users used their pessimistic expectations as a scapegoat for engaging with social settings. This meant that some participants found faults with any social opportunities, even when there appeared to be shared interests between the service-user and the social activity. Such strong avoidance towards group settings may reflect a service-user's lack of readiness to engage with groups (Tarrant et al., 2020).

Pessimistic preconceptions of social categories may also prevent service-users from perceiving a group to fit their sense of self. Service-user five's preconception of art in Study One had prevented them from engaging with art groups in the past as they perceived them to be unavailable to those on low-incomes. However, it was an art group that transformed their life and improved their health and wellbeing through social identification. Additionally, Link

Workers in Study One noted how their own preconceptions of beneficial groups could create inappropriate referrals to groups that did not fit the service-user's needs. If a service-user is connected to a group that is incompatible with their needs or sense of self, it may reinforce feelings of loneliness/isolation and increase a service-user's likelihood to avoid future social situations (Cruwys et al., 2014b). Thus, the collection of experiences documented in this thesis suggest the importance of working to disprove a service-users' pessimistic preconceptions and increase their receptiveness to the idea that social experiences can be a positive and possible experience they can engage with. Such insight advances the SIAH and social prescribing literature by outlining the strength to which prior social experiences can influence the perceived accessibility of and a service-users readiness to engage with community groups during a social prescription.

Incompatible recommendations disrupt existing group dynamics and increase disengagement

Groups were considered incompatible when they did not meet a service-user's needs or fit their sense of self. Where recommended groups did not match a service-users demographics, emotional, and/or physical needs, they were more likely to disengage with or not attend the recommended group as noted in Study Four. Furthermore, service-users who were connected to groups that could not support their needs and that did not fit the groups criteria, were more likely to disrupt the existing group dynamics (Levine & Moreland, 1994). Group leaders in Study One emphasised the need for service-users who are recommended into their group to not disrupt the existing dynamics, with participants in Study Two suggesting that community groups may not be suitable for everyone.

Groups and their members can facilitate engagement and social identification by providing a welcoming atmosphere that is polite, respectful, open, and friendly (Borek et al., 2019a). Link Workers in Study One acknowledged the importance of groups in providing a warm welcome

to service-users and for service-users to be psychologically ready to attend a group. Service-users in study one and group leaders in Study Two perceived that effective group leadership influences the extent that a group is welcoming. Group leaders in Study One and Two outlined the tactics they utilised to provide a warm welcome which included personable introductions, checking if the new member required refreshments, providing activities that suited the member's interests, directly connecting them with other group members, or using a buddy system to pair existing members with new members. Prior literature suggests that such tactics are beneficial for helping service-users to feel included in the group and provide opportunities for new members to interact with existing members (Borek et al., 2019a; Levine et al., 2004). Where a group has shared interests, is welcoming, and supports service-user integration into a group, it is more likely to provide a positive social experience to a service-user that could challenge any pessimistic expectations based on prior social experiences, as noted in Cruwys et al. (2014b). However, Link Workers in Study One also noted how their presence in a group may prevent other group members from engaging with the service-user in attendance. Whilst Link Workers are recommended to support service-user attendance at a group (Moffatt et al., 2017), once at the group they must take a step back to enable the service-user to interact with other group members and integrate into the group. Thus, this research advances the SIAH and social prescribing literature by highlighting the complexity required in supporting service-user integration into a group by connecting service-users to compatible groups that can support positive social experiences. Capacity to facilitate social identification during social prescribing may vary in complexity dependant on a service-user's prior social experiences and the potential for service-users to disrupt existing group dynamics or not be welcomed by a group, as experienced by service-users in Study's One and Two. Careful considerations need to be placed when identifying a service-user's needs and expectations regarding social connection and which groups or social activities may best support those needs.

The Community Prescribing Toolkit's potential to support positive social experiences

The Community Prescribing Toolkit may be useful for supporting social prescribing service-users to engage with positive social experiences that facilitate social identification. The potential wellbeing benefits of the toolkit were not lost on most of the participants documented in this thesis. Participants in Study's One and Two were supportive of a toolkit to minimise disengagement by improving the likelihood of a service-user identifying with a socially prescribed community group. Link Workers in Study Two perceived the toolkit to be beneficial for finding out and understanding what type of group would be beneficial to a service-user. However, whilst Link Workers on average perceived the Community Prescribing Toolkit to be a useful resource in Study Three, they also perceived that two other toolkits would be useful in supporting social prescribing's recovery from the coronavirus pandemic. Specifically, a toolkit supporting social prescriptions to statutory services and a toolkit supporting the relationship building between a Link Worker and service-user were also considered useful. Furthermore, a small proportion of participants indicated that they did not require any toolkit to support their role due to perceptions that they would not be helpful. Such contrasting perceptions on the utility of toolkits and the types of toolkits considered useful to the Link Worker role may be due to the variation and localisation of social prescribing schemes. Existing literature outlines contradictions on whether NHS Link Workers or Community-based Link Workers have better access to training and support relevant to their role (Pedro et al., 2021; Rhodes & Bell, 2021).

Consequently, the second strength of the research reported in this thesis is the developed Community Prescribing Toolkit which should provide Link Workers and community group leaders with a useful, theoretical, and practical tool they can utilise to optimise the health and wellbeing benefits of their service-users. Existing UK governmental and NHS policies, such as the NHS Long-term plan (Annual report of the Chief Medical Officer, 2018), the Model of Personalised Care (NHS England, 2019b), and the government's commitment to tackling

loneliness by connecting communities (Gov UK, 2023), outline a future commitment towards revitalising communities, funding social prescribing and resources that help mitigate loneliness and improve health and wellbeing following the coronavirus pandemic. For example, current investments are focused on mental health and wellbeing resources to support the health and social care system following the pandemic. Link Workers in Study Two and Study Three both agreed that the pandemic had impacted why people were accessing social prescribing, with perceived increases in statutory and mental health needs reported. Likewise, Link Workers in Study Two reported how service-users were initially reluctant to attend groups due to fear of mixing socially during relaxed stages of the pandemic where socialising was permissible in small groups (Institute for Government Analysis, 2022). By Study Three, Link Workers were reporting increases in emotional and mental health support and a desire for face-to-face group support, despite a low supply to meet the desire. Thus, to continue to support communities' recovery from the coronavirus pandemic, investments in mental health and wellbeing resources have never been more appropriate.

The theoretically based toolkit designed during this PhD, to improve social connections and minimise disengagement, could be a vital resource that mitigates loneliness by revitalising and reconnecting service-users to their communities. The toolkit's considerations on providing a good fit and satisfying a service-user's needs, alongside other group processes including providing a warm welcome to a group, should facilitate the development of a sense of belonging between a service-user and the community group they are connected to. New policies have also emerged following the coronavirus pandemic, such as the Mental Health Policy in England (House of Commons Library, 2023), outlining a commitment to jointly consider mental health conditions alongside physical health conditions within healthcare. Social prescribing is uniquely placed to support this endeavour as a community-based initiative that supports both mental and physical health and wellbeing. With the research conducted

throughout this PhD and the creation of the Community Prescribing Toolkit, there has never been a more relevant time to consider where and how we can belong to our communities.

To successfully explore whether the Community Prescribing Toolkit can be a useful tool, tensions between the SIAH applied within the toolkit and the current practice of social prescribers need to be addressed. A Link Worker who took part in Study One and Two, highlighted differing tensions between the SIAH and current social prescribing practice. During Study One the Link Workers trained in patient activation disagreed with the phrasing of a question regarding a service-users readiness for group engagement. Tarrant et al. (2020) outlines how prospective group members must have some degree of perceived readiness to engage with the group, through the group being perceived to be accessible. However, patient activation training suggests that a service-user needs to be motivated to manage their own health and wellbeing (NHS England, 2019a), rather than be psychologically ready to engage with a group. The same Link Worker misinterpreted the SIAH's psychological need for control (Greenaway et al., 2016; Kyprianides et al., 2019), perceiving it to contrast with their role in making service-users understand that life is not under their control. The psychological need for control refers to making one's own decisions or choices, not giving a service-user control over life (Greenaway et al., 2016; Kyprianides et al., 2019). Such conflicts are associated with the person-centred training that Link Workers receive (NHS England, 2019a) and may be due to the extent to which this Link Worker embodied a person-centred practice. New training in the Community Prescribing Toolkit and on the relevance of the SIAH for supporting successful social prescriptions could negate these tensions.

The SIAH can also overcome existing limitations of other theoretical approaches applied to social prescribing, such as occupational science (Bodell et al., 2019), by considering the wider referral process to resources, rather than the Link Worker assessment process alone (SSPH, 2020c). Occupational science focuses on human participation in meaningful and purpose-led

activities (Doble & Santha, 2008; Kielhofner, 2008), perceiving that successful social prescriptions rely on a balance between a person, their environment, and occupational activity (Bodell et al., 2019; Kielhofner, 2008; SSPH, 2020c). As such occupational science is useful for understanding what a person does and how it makes them feel. However, this approach is individualistic, focusing on how an environment or activity can be changed to suit an individual and often neglecting to consider the sociocultural and group-based contexts that influence health (Gallagher et al., 2015; Hocking & Whiteford, 2012; Phelan & Kinsella, 2009). By not considering the group-based contexts that influence health, occupational science does not account for the social factors that inform behaviour and engagement in activities (Gallagher et al., 2015; Hocking & Whiteford, 2012). Not accounting for social factors is concerning due to research highlighting the significant impact that social factors have on health and wellbeing (Steffens et al., 2016). Alternatively, the SIAH does account for sociocultural factors, emphasising the importance of group memberships for improving health and wellbeing (Jetten et al., 2012; Steffens et al., 2016; Wakefield et al., 2019). Thus, the SIAH embodies a more collective approach to understanding which social prescriptions can become psychologically meaningful and why they are meaningful through group identification (Haslam et al., 2018; Wakefield et al., 2019), as opposed to focusing on what is meaningful as with occupational science.

Understanding why a social prescription has the potential to become meaningful is important in accounting for the various stages of a social prescription and the group-based contexts surrounding it i.e., the Link Worker assessment stage, connection to a group stage (Runacres, 2022). An occupational science approach to social prescribing focuses on the service-user and how their needs can be met by the available resources in the community (Bodell et al., 2019; SSPH, 2020b; 2020c). However, the occupational science approach does not consider the group-context and whether a service-user themselves suits a community resource. Should

service-users be connected to community resources, such as community groups, they do not suit or are not welcomed by, this could increase disengagement with the group (Husk et al., 2019; Stuart et al., 2021) and disrupt the existing groups dynamics (Levine & Moreland, 1994). Prior research notes the importance of being welcomed into a group (Borek et al., 2019a; 2019b), a SIAH can provide guidance on supporting service-user integration into a group that an occupational science approach cannot and would not consider.

Implications

The utility of this COVID-19 situated research

Research collected during COVID-19, particularly long-term data, may be discounted for not being reflective of the usual role of social prescribing due to the crisis management that Link Workers engaged in (Polley & Sabey, 2022; Porter et al., 2022). However, the absence of social and group contact during the pandemic only served to highlight the necessity of such contact for one's health and wellbeing (Bowe et al., 2022; The British Academy, 2021). A report by The British Academy (2021) synthesised evidence of the impact of the coronavirus pandemic from several research and governmental sources during the Autumn of 2020. Despite not reporting effect sizes of their findings, The British Academy notes the longitudinal impacts of COVID-19 for communities and the vital role of communities to promote recovery and support health and wellbeing in the years to come after COVID-19. Health inequalities within communities need addressing to best provide the infrastructure to support recovery from COVID-19. Consequently, funding has been provided to revitalise communities following the pandemic (Gov UK, 2021b), and the continued support of social prescribing, particularly for green and blue nature-based environments (NHS England, 2022a). Going forward there is potential for the SIAH and the Community Prescribing Toolkit detailed in this thesis, to support this revitalisation of social prescribing and communities, by fostering social identification

within communities. Correlational evidence from Bowe et al. (2022) outline how voluntary helping within communities was a vital source of support during the pandemic, which improved wellbeing and reduced depression and anxiety through a built sense of community identification. Despite a lack of reported effect sizes, longitudinal research further showed that social identification with multiple groups pre-COVID, identity continuity, and identification with communities were the strongest predictors of social support during the pandemic, which mediated improved physical and mental health outcomes (Carter et al., 2022). Thus, rather than COVID-19 limiting the applicability of this research, COVID-19 has highlighted the importance of social and group relationships for one's health and wellbeing. This shift in recognition may explain the continued support from Studies One and Two for a SIAH-based toolkit that facilitates social identification.

The practical applications of this research

Practically, the Community Prescribing Toolkit is a resource that can be utilised by Link Workers and group leaders. Current governmental and NHS policies are set on utilising social prescribing as a foundation to address loneliness (Gov UK, 2021b; HM Government, 2018) and improve access to personalised care through community resources (NHS England, 2019b). Likewise, there is a greater awareness of the important impact that communities and groups have on one's health and wellbeing (Gov UK, 2021b). Consequently, funding has been made available by the UK government (Gov UK, 2023), to support the development of national resources that can better support improvements in health and wellbeing. The Community Prescribing Toolkit developed during this PhD programme of research could provide an appropriate resource that improves health and wellbeing by connecting service-users to groups that they can socially identify with.

The guidance within the toolkit created throughout this PhD programme of research could serve to improve group relations and support successful social prescriptions for service-users.

Training in the toolkit could support Link Workers and communities to foster group identification, build community belonging, and optimise the health and wellbeing benefits of service-users who access social prescribing. To fully explore the toolkits benefits, the toolkit now needs to be feasibility tested to determine its potential effectiveness, prior to a randomised controlled trial being conducted on the toolkit (Gadke et al., 2021). Typically, feasibility research involves determining whether an intervention is appropriate for further testing and does not involve measuring outcomes (Bowen et al., 2009; Blatch-Jones et al., 2018). Feasibility testing involves determining the demand, social validity, practicality, adaptability, acceptability, integration, implementation, and limited effectiveness of the intervention (Gadke et al., 2021). Often, feasibility research is considered interchangeable with pilot studies which involve a small-scale test of the intervention to determine its potential effectiveness prior to a randomised controlled trial (Blatch-Jones et al., 2018; Gadke et al., 2021).

To fully test the toolkits potential effectiveness as a feasible toolkit that minimises disengagement during social prescriptions to community groups, the toolkit needs to be trialled as a whole intervention as opposed to individual components as expected in traditional feasibility research (Gadke et al., 2021; Wuest et al., 2015). A six-month partially controlled feasibility trial assessing the acceptability, limited efficacy and implementation of the Community Prescribing Toolkit was considered appropriate to explore the feasibility of the toolkit in practice. All Link Worker participants would attend training in study expectations one week before the start of the trial, with Link Workers in the trial condition receiving additional training on how to utilise the toolkit. Link Workers would then support the recruitment of service-users and collect questionnaire data over three time points across a 12-week period. The questionnaire would contain seven validated scales equating to 17 items. To support the trial, Link Workers would need the capacity to recruit and follow service-users throughout their progress and those in the trial condition would be invited to take part in an

interview post-trial to share their experience of using the toolkit. Using a predicted effect size from a reported partial eta square in Kellezi et al. (2019c) that was converted to Cohens f, a sample size calculation was conducted in RStudio (version 4.1.2), using the WebPower package (V.0.6). Based on 80% power and an alpha of 0.05, it was calculated that a powered study would require a minimum of 59 service-user participants.

Regardless of the type of study conducted, collaborative working with the social prescribing services selected to trial the toolkit should occur throughout the design and distribution of the study, and during the analysis of the study if desired (Greenhalgh et al., 2019; Holmes et al., 2019). Stakeholder engagement in research is swiftly becoming recognised as vital for enhancing the depth, credibility, and applicability of research findings (Goodman & Thompson, 2017; Greenhalgh et al., 2019; Holmes et al., 2019; Morgan et al., 2016). Working with the social prescribing service supporting the trial should also minimise the burden they experience when engaged in the trial, encouraging greater engagement with the research (Greenhalgh et al., 2019; Rivas et al., 2019). The insight provided by such collaborative working could inform the further development and utilisation of the toolkit, so that it can be easily incorporated into existing social prescribing practice.

To further support the development of the toolkit, the feasibility trial and further research could gather in-depth feedback from group leaders and other social prescribing stakeholders such as service managers on the utility of the Community Prescribing Toolkit. There is potential to explore the value of the toolkit further with these individuals, which could be incorporated into a randomised controlled trial of the toolkit to triangulate data between the quantitative outcomes of its effectiveness and the qualitative outcomes of its perceived utility.

Finally, my research showed how life-long complex and often traumatic social experiences influenced service-user perceptions that community groups were not a suitable solution in

service-users from ethnic, mental health and poor socioeconomic status minority backgrounds. Service-users from minority backgrounds experienced multiple barriers influencing their ability to engage with social prescribing and recommended community groups, including social anxiety when engaging with groups (Knowles et al., 2015) and a lack of fit between the service-user and the community group due to perceived incompatibility between the recommended group and their sense of self (Cruwys et al., 2014b; Haslam et al., 2019b). Service-user's that had particularly traumatic social experiences struggled to perceive any recommended groups as suitable for their needs, suggesting that social prescribing may not be appropriate for every service-user. Greater consideration towards addressing a service-users wider health and wellbeing needs prior to recommending a service-user to a group may be required. Co-production research exploring the facilitators and barriers of migrants accessing health services and social prescribing supports the need for a holistic approach to addressing a service-users' needs (Kellezi et al., 2021). Through two roundtable discussions with migrants and community stakeholders that support migrants, Kellezi et al. (2021) report how migrants may disengage with social prescribing if it does not support their more immediate needs and concerns relating to their legal status to remain in the country and access support prior to accessing recommended community groups. Migrants also often have multiple complex and traumatic life experiences that may prevent full engagement with any community, group-based or volunteering initiatives (Kellezi et al., 2021). Volunteering, including via social prescribing, is considered to have many benefits to health and wellbeing by furnishing one with a sense of purpose, value, meaning and belonging (Bowe et al., 2022; Gray & Stevenson, 2020; McNamara et al., 2021b), which could foster social identification with the volunteer organisation or those they support (Turk et al., 2022). Kellezi et al. (2021) and Stuart et al. (2021) both note the potential benefit that volunteering could have for minority populations and social prescribing service-users. Service-users with traumatic social histories in Study Four also reported an interest in

volunteering over attending group-based activity, further indicating that volunteering opportunities within social prescribing may be beneficial for supporting service-users from minority backgrounds and/or who have complex needs. Therefore, future research should explore how social prescribing can best support service-users from minority backgrounds and explore the potential benefits of volunteering for service-users from minority backgrounds or who have negative social experiences.

Limitations of the research

Whilst the COVID-19 pandemic may not have undermined the utility of the research, it did disrupt the service provision of social prescribing and communities (Brown et al., 2021; Etheridge, 2020; Mahase, 2020). The aftermath of the pandemic had left both social prescribing and communities in a state of recovery as they attempted to manage high demand for community resources amidst a low, albeit increasing supply (Brown et al., 2021; Cunningham et al., 2022; Mak, 2021). The impacts of the pandemic were unfolding and ongoing throughout the PhD research programme and directly impacted recruitment for Study's One, Two, and Three. Study Three was particularly challenging due to the time-pressured and context-dependent nature of the questionnaire to explore if it was practical to trial the toolkit. The questionnaire was time-pressured because a quick assessment was required to design a feasibility study and recruit a service willing to support it. The questionnaire was also context dependent as it was conducted in response to the ongoing impacts of the coronavirus pandemic. However, it was necessary to explore if social prescribing had the capacity to support a feasibility trial of the Community Prescribing Toolkit whilst recovering from the pandemic.

Furthermore, the restriction on face-to-face interactions during the pandemic (Gov UK, 2021a) resulted in all studies being conducted remotely. Theoretically this should have provided access to a larger target sample, due to the ability to overcome geographical boundaries (Ball, 2019),

however with service-user participants, remote recruitment may have prevented recruitment from those who were digitally excluded (Carpenter et al., 2021). Additionally, remote research has been critiqued for lacking personability due to a lack of physical presence and may have required participants to source technological resources to take part (Hensen et al., 2021). Whilst remote interview methods such as telephone interviews have been utilised successfully for a long period of time, are cost-effective, and overcome geographical boundaries (Farooq, 2005; Novick, 2008), there remains concerns that remote data collection methods have a higher non-response than face-to-face data collection methods (Hensen et al., 2021). In Study Three, higher non-response with remote data collection may have been present due to an increasing desire for face-to-face social contact following prolonged periods of mandatory remote communications (Institute for Governmental Analysis, 2021). Furthermore, an increase in people pretending to meet a study's criteria for online research (Owens, 2022) made it challenging to recruit genuine participants in Study Four. Five participants were determined to be fraudulent at the start of an interview after cross-referencing answers to demographic and screening questions and were excluded from the study. Therefore, whilst remote methodologies supported the continuation of the research described in this thesis during the pandemic, the necessity to engage in remote contact may have limited access to an important sample population.

Concluding remarks

To summarise, this thesis aimed to apply the SIAH to a nationalised NHS investment in social prescribing, to understand how disengagement during social prescriptions could be minimised. In doing so, two concerns of social prescribing are addressed: the lack of theory guiding social prescribing practice and disengagement within social prescribing. Six aims supported the exploration of an overarching research question: How can the Social Identity Approach to

Health influence the social prescribing referral process to community groups? A Community Prescribing Toolkit was created to answer the overarching research question, due to its capacity to adapt to the variety of social prescribing services (Ladds, 2021). The research findings documented within this thesis indicate that the SIA and the SIAH are a useful theoretical framework that aligns with social prescribing processes, and that Link Workers would benefit from greater understanding on how to utilise group processes during a social prescription to a community group. Future research is required to explore whether the developed toolkit has the potential to be beneficial, before conducting a full-scale randomised controlled trial to determine the toolkits effectiveness. Future research should be done collaboratively with a social prescribing service to support the integration of the toolkit into practice during a trial and its continued development once trialled in situ. To help minimise loneliness and support the reconnection of communities by facilitating social identification, social prescribing needs access to resources that can support service-users to access groups that they can identify with. The Community Prescribing Toolkit is one such resource that, once tested, should minimise disengagement with social prescriptions and improve health and wellbeing through social identification.

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Conflicts of interest:

No conflicts of interest are reported.

Data availability statement:

Data supporting this study are available from NTU Data Archive at: (https://doi.org/10.17631/rd-2024-0004-ddat). Access to the data is limited to researchers affiliated with research organisations due to legal and ethical considerations. Requests to access the data should be

directed to LIBResearchTeam@ntu.ac.uk. Data supporting the development of the toolkit will be available from NTU Data Archive at: https://doi.org/10.17631/rd-2024-0005-ddat subject to an 18 month embargo to support future trialling of the toolkit.

References

Abrams, D., & Hogg, M. A. (1989). Comments on the motivational status of self-esteem in social identity and intergroup discrimination. European journal of social psychology, 18(4), 317-334.

Abrams, D., & Hogg, M. A., (1990). An Introduction to the Social Identity Approach. In *Social identity theory: Constructive and critical advances* (p. 1-11), Springer-Verlag Publishing.

Abrams, D., & Hogg, M. A. (1998). Prospects for research in group processes and intergroup relations. *Group Processes & Intergroup Relations*, *1*(1), 7-20.

Abrams, D., & Hogg, M. A. (2006). *Social identifications: A social psychology of intergroup relations and group processes*. Routledge.

Abrams, D., Lalot, F., & Hogg, M. A. (2021). Intergroup and intragroup dimensions of COVID-19: A social identity perspective on social fragmentation and unity. *Group Processes & Intergroup Relations*, *24*(2), 201-209.

Adams, C. W., (2015). Conducting semi-structured interviews. In K. E. Newcomer, H. P. Hatry & J. S. Wholey (Eds), *Handbook of practical program evaluation* (pp. *492-505)*. Jossey-Bass, San Francisco; CA.

Adarves-Yorno, I., Mahdon, M., Schueltke, L., Koschate-Reis, M., & Tarrant, M. (2020). Mindfulness and social identity: Predicting well-being in a high-stress environment. *Journal of Applied Social Psychology*, 720-732.

Adler, P. A., & Adler, P. (1995). Dynamics of inclusion and exclusion in preadolescent cliques. *Social Psychology Quarterly*, 145-162.

Adu-Ampong, E. A., & Adams, E. A. (2020). “But you are also Ghanaian, you should know”: negotiating the insider–outsider research positionality in the fieldwork encounter. *Qualitative Inquiry*, *26*(6), 583-592.

Age UK (2021). Loneliness and COVID-19. Retrieved from: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/consultation-responses-and-submissions/health--wellbeing/loneliness-and-covid-19---december-2021.pdf (Accessed: September 2023).

Al-Ababneh, M. M. (2020). Linking ontology, epistemology and research methodology. *Science & Philosophy*, *8*(1), 75-91.

Al-Khudairy, L., Ayorinde, A., Ghosh, I., Grove, A., Harlock, J., Meehan, E., Briggs, A., Court, R., & Clarke, A. (2022). Evidence and methods required to evaluate the impact for patients who use social prescribing: a rapid systematic review and qualitative interviews. National Institute for Health and Care Research, Southampton (UK); PMID: 36198023.

Allemang, B., Sitter, K., & Dimitropoulos, G. (2022). Pragmatism as a paradigm for patient-oriented research. *Health Expectations*, *25*(1), 38-47.

Allen, C., & Mehler, D. M. (2019). Open science challenges, benefits and tips in early career and beyond. *PLoS biology*, *17*(5), e3000246.

Alliance for Healthier Communities (2020). Rx Community: Social Prescribing in Ontario. Final Report. Retrieved from: https://www.eenet.ca/resource/promising-practice-addressing-older-adult-loneliness-through-rx-community-social (Accessed: January 2021).

Allport, F. H. (1954). The structuring of events: outline of a general theory with applications to psychology. *Psychological Review*, *61*(5), 281.

Anfilogoff, T., (2020a). Never waste a crisis: reflections on social prescribing and Covid-19 in West Hertfordshire. Retrieved from: https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/never-waste-a-crisis-reflections-on-social-prescribing-and-covid-19/ (Accessed: August 2020).

Anfilogoff, T. (2020b). Social Prescribing: Connecting People for Health and Well-Being. *Tackling Causes and Consequences of Health Inequalities: A Practical Guide*, 117.

Annual Report of the Chief Medical officer (2018). *Health 2040 – Better Health within Reach*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767549/Annual_report_of_the_Chief_Medical_Officer_2018_-_health_2040_-_better_health_within_reach.pdf (Accessed: June 2020).

Anstiss, T. (2021*). Introduction to Motivational Interviewing for Social Prescribing Link Workers.* Retrieved from: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiAu73Vx578AhWIbcAKHe8CCDkQFnoECAwQAQ&url=https%3A%2F%2Fwww.healthylondon.org%2Fwp-content%2Fuploads%2F2021%2F09%2FHandout-for-MI-for-Social-Prescribing-Link-Workers-1.pdf&usg=AOvVaw03DAqt6ngrdYQ5xX-MbHtd (Accessed: December 2022).

APA, (2022). *APA Dictionary of Psychology*. Retrieved from: https://dictionary.apa.org/identification (Accessed: September 2022).

Apter, C. (2019). The benefits of social prescribing – and a word of warning. Retrieved from: https://www.mentalhealthtoday.co.uk/news/awareness/the-benefits-of-social-prescribing-and-a-word-of-warning (Accessed: August 2021).

Ashforth, B. E., & Mael, F. A., (1989). Social Identity Theory and the Organisation. *Academy of Management Review*, 14(1), 20-39.

Aughterson, H., Baxter, L., & Fancourt, D. (2020). Social prescribing for individuals with mental health problems: a qualitative study of barriers and enablers experienced by general practitioners. *BMC Family Practice*, *21*(1), 1-17.

Badea, C., Jetten, J., Czukor, G., & Askevis-Leherpeux, F. (2010). The bases of identification: When optimal distinctiveness needs face social identity threat. *British Journal of Social Psychology*, *49*(1), 21-41.

Baker, T. D. (2012). Confidentiality and electronic surveys: How IRBs address ethical and technical issues. *Ethics & Human Research*, *34*(5), 8.

Bakolis, I., Stewart, R., Baldwin, D., Beenstock, J., Bibby, P., Broadbent, M., Cardinal, R., Chen, S., Chinnasamy, K., Cipriani, A., Douglas, S., Horner, P., Jackson, C. A., John, A., Joyce, D. W., Lee, S. C., Lewis, J., McIntosh, A., Nixon, N., Osborn, D., Phiri, P., Rathod, S., Smith, T., Sokal, R., Waller, R., & Landau, S. (2021). Changes in daily mental health service use and mortality at the commencement and lifting of COVID-19 'lockdown'policy in 10 UK sites: a regression discontinuity in time design. *BMJ open*, *11*(5), e049721.

Ball, H. L. (2019). Conducting online surveys. *Journal of Human Lactation*, *35*(3), 413-417.

Bantry-White, E., O'Sullivan, S., Kenny, L., & O'Connell, C. (2018). The symbolic representation of community in social isolation and loneliness among older people: Insights for intervention from a rural Irish case study. *Health & social care in the community*, *26*(4), e552-e559.

Banyard, P., & Grayson, A. (2017). *Introducing psychological research*. Bloomsbury Publishing.

Barefoot, J. C., Grønbæk, M., Jensen, G., Schnohr, P., & Prescott, E. (2005). Social network diversity and risks of ischemic heart disease and total mortality: findings from the Copenhagen City Heart Study. *American journal of epidemiology*, 161(10), 960-967.

Barnes, D. E. (2020). Social prescribing. *InnovAiT*, 1755738020950340.

Baxter, S., Barnes, A., Lee, C., Mead, R., & Clowes, M. (2020). Increasing Public Participation and Influence in Local Decision-making to Address Social Determinants of Health During Times of Resource Constraint: A Systematic Review Examining Initiatives and Theories. *Local Government Studies*, 1-27.

Beauchamp, M., Dunlop, W. L., Downey, S. M., & Estabrooks, P. A. (2012). First impressions count: perceptions of surface-level and deep-level similarity within postnatal exercise classes and implications for program adherence. *Journal of health psychology*, *17*(1), 68-76.

Beck, A. C., Campbell, D., & Shrives, P. J. (2010). Content analysis in environmental reporting research: Enrichment and rehearsal of the method in a British–German context. *The British Accounting Review*, *42*(3), 207-222.

Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open*, *2*, 8-14.

Bentley, S. V., Haslam, C., Haslam, S. A., Jetten, J., Larwood, J., & La Rue, C. J. (2021). GROUPS 2 CONNECT: An online activity to maintain social connection and well-being during COVID-19. *Applied Psychology: Health and Well-Being*, *14*(4), 1189-1210.

Berkman, L. F., & Glass, T. (2000). Social integration, social networks, social support, and health. *Social epidemiology*, *1*(6), 137-173.

Berkman, L. F., & Syme, L. (1979). Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology*, 109, 186-204.

Bertotti, M., & Temirov, M. O. (2020). Outcome and economic evaluation of City and Hackney Social Prescribing scheme.

Bertotti, M., Frostick, C., & Temirov, O. (2020b). An evaluation of Social Prescribing in the London Borough of Redbridge: Final evaluation report.

Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R., & Carnes, D. (2018). A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. *Primary health care research & development, 19*(3), 232-245.

Bertotti, M., Frostick, C., Sharpe, D., & Temirov, O. (2020c). A two-year evaluation of the Young People Social Prescribing (YPSP) pilot. *Institute for Connected Communities*, University of East London.

Bertotti, M., Frostick, C., Temirov, O., Sanusi, O., Dan-Ogosi, I., & Buscombe, R. (2020a). Evaluation of Redbridge Active Together. *Institute for Health and Human Development*, University of East London.

Bertotti, M., Haque, H., Lombardo, C., Potter, S., & Harden, A. (2019). 'A Systematic Map of the UK Literature on Navigation Roles in Primary Care: Social Prescribing Link Workers in Context'. London, University of East London.

Bhanu, C. (2019). Social prescribing: why a prescription?. *British Journal of General Practice*. Eletter.

Bickerdike, L., Booth, A., Wilson, P. M., Farley, K., & Wright, K. (2017). Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ open*, *7*(4), e013384.

Bild, E., & Pachana, N. A. (2022). Social prescribing: A narrative review of how community engagement can improve wellbeing in later life. *Journal of Community & Applied Social Psychology*, *32*(6), 1148-1215.

Blatch-Jones, A. J., Pek, W., Kirkpatrick, E., & Ashton-Key, M. (2018). Role of feasibility and pilot studies in randomised controlled trials: a cross-sectional study. *BMJ open*, *8*(9), e022233.

Block, J., & Robins, R. W. (1993). A longitudinal study of consistency and change in self-esteem from early adolescence to early adulthood. *Child development*, *64*(3), 909-923.

Bodell, S., Lawler, C., & Martin, R. (2019, June). Responding to the social prescribing agenda with occupational science. In *British Journal of Occupational Therapy (Vol. 82, pp. 39-39). 1 Olivers Yard, 55 City Road, London, EC17 1SP, England: Sage Publications LTD*. Retrieved from: https://www.rcot.co.uk/sites/default/files/Session%2063.1%20-%20Responding%20to%20the%20social%20prescribing%20agenda%20with%20occupational%20science.pdf (Accessed: May 2021).

Boden-Albala, B. Litwak, E., Elkind, M. S. V., Rundek, T., & Sacco, R. L. (2005). Social isolation and outcomes post stroke. *Neurology*, 64, 1888–1892.

Bodner, E. (2009). On the origins of ageism among older and younger adults. *International Psychogeriatrics*, *21*(6), 1003-1014.

Bolger, N., DeLongis, A., Kessler, R. C., & Schilling, E. A. (1989). Effects of daily stress on negative mood. *Journal of Personality and Social Psychology*, 57, 808-818.

Borek, A. J., & Abraham, C. (2018). How do small groups promote behaviour change? An integrative conceptual review of explanatory mechanisms. *Applied Psychology: Health and Well-Being*, *10*(1), 30-61.

Borek, A. J., Abraham, C., Greaves, C. J., Tarrant, M., Garner, N., & Pascale, M. (2019a). 'We're all in the same boat': A qualitative study on how groups work in a diabetes prevention and management programme. *British journal of health psychology*, *24*(4), 787-805.

Borek, A. J., Smith, J. R., Greaves, C. J., Gillison, F., Tarrant, M., Morgan-Trimmer, S. A., McCabe, R., & Abraham, S. C. S. (2019b). Developing and applying a framework to understand mechanisms of action in group-based, behaviour change interventions: the MAGI mixed-methods study. *Efficacy and Mechanism Evaluation*, *6*(3), 1-195.

Bosak, J., Asbrock, F., & Meyer, B. (2021). Salience of category. In *Encyclopedia of Evolutionary Psychological Science* (pp. 6786-6793). Cham: Springer International Publishing.

Boudreau, M. C., Nach, H., & Lejeune, A. M. (2016). Intergroup Collaboration: An Examination through the Lenses of Identity and It Affordances. *Thirty Seventh International Conference on Information Systems*, Dublin.

Bowe, M., Gray, D., Stevenson, C., McNamara, N., Wakefield, J. R., Kellezi, B., Wilson, I., Cleveland, M., Mair, E., Halder, M., & Costa, S. (2020). A Social Cure in the Community: A mixed-method exploration of the role of social identity in the experiences and well-being of community volunteers. *European Journal of Social Psychology*, *50*(7), 1523-1539.

Bowe, M., Wakefield, J. R., Kellezi, B., Stevenson, C., McNamara, N., Jones, B. A., Sumich, A., & Heym, N. (2022). The mental health benefits of community helping during crisis: Coordinated helping, community identification and sense of unity during the COVID-19 pandemic. *Journal of Community & Applied Social Psychology*, *32*(3), 521-535.

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan. C. P., Squiers, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American journal of preventive medicine*, *36*(5), 452-457.

Bozdag, E. (2013). Bias in algorithmic filtering and personalization. *Ethics and information technology*, *15*, 209-227.

Bragg, R., & Leck, C. (2017). Good practice in social prescribing for mental health: The role of nature-based interventions. *Natural England Commissioned Reports*, Number 228. York

Brandling, J., & House, W. (2009). Social Prescribing in General Practice: Adding meaning to medicine. *British Journal of General Practice*, p. 454-456.

Brandt, S. A., & Carmichael, C. L. (2020). Does online support matter? The relationship between online identity-related support, mattering, and well-being in sexual minority men. *Computers in human behavior*, *111*, 106429.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbooks in psychology®. APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (p. 57–71). American Psychological Association.

Braun, V., & Clarke, V., (2013). Successful qualitative research: A practical guide for beginners. *Successful qualitative research*, 1-400.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers?. *International journal of qualitative studies on health and well-being*, *9*.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597.

Braun, V., & Clarke, V. (2021a). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative research in sport, exercise and health*, *13*(2), 201-216.

Braun, V., & Clarke, V. (2021b). *Thematic analysis. A practical guide*. Sage

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, *24*(6), 641-654.

Brewer, M. B., Manzi, J. M., & Shaw, J. S. (1993). In-group identification as a function of depersonalization, distinctiveness, and status. *Psychological Science*, *4*(2), 88-92.

British Psychological Society (2018). Data protection regulation: Guidance for researchers. Retrieved from: https://explore.bps.org.uk/content/report-guideline/bpsrep.2018.inf316/chapter/bpsrep.2018.inf316.2 (Accessed: February 2023).

British Psychological Society (2021a). BPS Code of Human Research Ethics Guidance. Retrieved from: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf (Accessed: July 2020).

British Psychological Society (2021b). Ethics guidelines for internet-mediated research. Retrieved from: https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Ethics%20Guidelines%20for%20Internet-mediated%20Research.pdf (Accessed: July 2020).

British Red Cross (2020). *Life After Lockdown: Tackling loneliness among those left behind*. Retrieved from: https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/life-after-lockdown-tackling-loneliness (Accessed: December 2020).

Broomhead, C., & Mackin, S., (2020). How two new social prescribing link workers have become part of the PCN response to Covid-19 in Trafford. Retrieved from: https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/how-two-new-social-prescribing-link-workers-have-become-part-of-the-pcn-response-to-covid-19/ (Accessed: November 2020).

Brown, R., & Pehrson, S. (2019). *Group processes: Dynamics within and between groups*. John Wiley & Sons.

Brown, R. C., Mahtani, K., Turk, A., & Tierney, S. (2021). Social Prescribing in National Health Service Primary Care. *The Milbank Quarterly*, *99*(3), 610-628.

Brunton, L., Tazzyman, A., Ferguson, J., Hodgson, D., & Nelson, P. A. (2021). The challenges of integrating signposting into general practice: qualitative stakeholder perspectives on care navigation and social prescribing in primary care. *Healthy Ageing and Care Network*, 1-44.

Budd, J. M., Hill, H., & Shannon, B. (2010). Inquiring into the real: A realist phenomenological approach. *The Library Quarterly*, *80*(3), 267-284.

Bullack, A., Gass, C., Nater, U. M., & Kreutz, G. (2018). Psychobiological effects of choral singing on affective state, social connectedness, and stress: Influences of singing activity and time course. *Frontiers in Behavioral Neuroscience*, *12*, 223.

Byrne, B. M. (2010). Structural equation modeling with AMOS: Basic concepts, applications, and programming. New York: Routledge.

Byrne, D. (2022). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & quantity*, *56*(3), 1391-1412.

Cacioppo, J. T., & Hawkley, L. C. (2005). People thinking about people: The vicious cycle of being a social outcast in one's own mind. *The social outcast: Ostracism, social exclusion, rejection, and bullying*, 91-108.

Cakal, H., Halabi, S., Cazan, A. M., & Eller, A. (2021). Intergroup contact and endorsement of social change motivations: The mediating role of intergroup trust, perspective-taking, and intergroup anxiety among three advantaged groups in Northern Cyprus, Romania, and Israel. *Group Processes & Intergroup Relations*, *24*(1), 48-67.

Calderón-Larrañaga, S., Greenhalgh, T., Finer, S., & Clinch, M. (2022). What does the literature mean by social prescribing? A critical review using discourse analysis. Sociology of Health & Illness, 44(4-5), 848-868.

Calderón-Larrañaga, S., Milner, Y., Clinch, M., Greenhalgh, T., & Finer, S. (2021). Tensions and opportunities in social prescribing. developing a framework to facilitate its implementation and evaluation in primary care: a realist review. *BJGP open*, *5(3)*, 1-13.

Carpenter, J., Brett, J., Cho, Y., Spencer, B., & Moreira De Souza, T. (2021). Exploring lessons from Covid-19 for the role of the voluntary sector in Integrated Care Systems. *Health and Social Care in the Community*, *30*, e6689-e6689.

Carter, H., Dennis, A., Williams, N., & Weston, D. (2022). Identity-based social support predicts mental and physical health outcomes during COVID-19. *British Journal of Social Psychology*, *62*, 845-865.

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in Pharmacy Teaching and Learning*, *10*(6), 807-815.

Çelebi, E., Verkuyten, M., & Bagci, S. C. (2017). Ethnic identification, discrimination, and mental and physical health among Syrian refugees: The moderating role of identity needs. *European journal of social psychology*, 47(7), 832-843.

Chatterjee, H. J., Camic, P. M., Lockyer, B., & Thomson, L. J. (2018). Non-clinical community interventions: a systematised review of social prescribing schemes. Arts & Health, 10(2), 97-123.

Chng, N. R., Hawkins, K., Fitzpatrick, B., O'Donnell, C., MacKenzie, M., Wyke, S., & Mercer, S. (2021). Implementing social prescribing in primary care in areas of high socioeconomic deprivation: process evaluation of the 'Deep End'community links worker programme. *British Journal of General Practice*, 71(713), e912-e920.

Clark, F. A., Parham, D., Carlson, M. E., Frank, G., Jackson, J., Pierce, D., Wolfe, R. J., & Zemke, R. (1991). Occupational science: Academic innovation in the service of occupational therapy's future. The American Journal of Occupational Therapy, 45(4), 300-310.

Clark, V. L. P. (2019). Meaningful integration within mixed methods studies: Identifying why, what, when, and how. *Contemporary Educational Psychology*, *57*, 106-111.

Code, J. R., & Zaparyniuk, N. E. (2010). Social identities, group formation, and the analysis of online communities. In *Social computing: Concepts, methodologies, tools, and applications* (pp. 1346-1361). IGI Global.

Cohen, J. M. (1977). Sources of peer group homogeneity. *Sociology of education*, 227-241.

Cohen, S. (2004). Social relationships and health. *American Psychologist*, 59, 676-684.

Cole, L. (1954). Psychology of Adolescence, New York: Rinehart and Company. *Inc. studies in human development pg*, *311*.

Costa, A., Sousa, C. J., Sea-bra, P., Virgolino, A., Santos, O., Lopes, J., Henriques, A., Nogueira, P., & Alarcão, V. (2021). Effectiveness of Social Prescribing Programmes in the Primary Health Care Context: A Systematic Literature Review. *Sustainability, 13*, 2731.

Coughtrey, A., Birken, M., Steare, T., Bennett, S., Johnson, S., Pitman, A., McCloud, T., Harju-Seppanen, J., Lim, M., Scott, H., Welch, A., Zacharia, A., & Shafran, R. (2019). Initial evidence review-Strategies for encouraging psychological and emotional resilience in response to loneliness 2019.

Crane, M. F., Louis, W. R., Phillips, J. K., Amiot, C. E., & Steffens, N. K. (2018). Identity centrality moderates the relationship between acceptance of group-based stressors and well-being. *European journal of social psychology*, *48*(6), 866-882.

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. SAGE publications.

Creswell, J. W., & Plano Clark, V. L. (2007). Designing and conducting mixed methods research Thousand Oaks, CA: Sage Publications.

Creswell, J. W., & Plano Clark, V. L. (2018). Designing and conducting mixed methods research (3rd ed.). Sage Publications.

Crombie, I. K., & Coid, D. R. (2000). Voluntary organisations: from Cinderella to white knight?: We need evidence of effectiveness of those that deliver care directly. *British Medical Journal*, 320 – 392.

Cruwys, T., Dingle, G. A., Haslam, C., Haslam, S. A., Jetten, J., & Morton, T. A. (2013). Social group memberships protect against future depression, alleviate depression symptoms and prevent depression relapse. *Social science & medicine*, *98*, 179-186.

Cruwys, T., Dingle, G. A., Hornsey, M. J., Jetten, J., Oei, T. P., & Walter, Z. C. (2014b). Social isolation schema responds to positive social experiences: Longitudinal evidence from vulnerable populations. *British Journal of Clinical Psychology*, *53*(3), 265-280.

Cruwys, T., Haslam, C., Rathbone, J. A., Williams, E., Haslam, S. A., & Walter, Z. C. (2021). Groups 4 Health versus cognitive–behavioural therapy for depression and loneliness in young people: randomised phase 3 non-inferiority trial with 12-month follow-up. *The British Journal of Psychiatry*, 1-8.

Cruwys, T., Haslam, S. A., Dingle, G. A., Haslam, C., & Jetten, J. (2014a). Depression and social identity: An integrative review. *Personality and Social Psychology Review*, *18*(3), 215-238.

Cruwys, T., Ng, N. W., Haslam, S. A., & Haslam, C. (2020a). Identity Continuity Protects Academic Performance, Retention, and Life Satisfaction among International Students. *Applied Psychology*, *70*(3), 931-954.

Cruwys, T., Steffens, N. K., Haslam, S. A., Haslam, C., Hornsey, M. J., McGarty, C., & Skorich, D. P. (2020b). Predictors of social identification in group therapy. *Psychotherapy Research*, *30*(3), 348-361.

Cunningham, K. B., Rogowsky, R. H., Carstairs, S. A., Sullivan, F., & Ozakinci, G. (2022). Social prescribing and behaviour change: proposal of a new behaviour change technique concerning the ‘connection’step. *Health Psychology and Behavioral Medicine*, *10*(1), 121-123.

Davis, M. M., Howk, S., Spurlock, M., McGinnis, P. B., Cohen, D. J., & Fagnan, L. J. (2017). A qualitative study of clinic and community member perspectives on intervention toolkits:“Unless the toolkit is used it won’t help solve the problem”. BMC health services research, 17, 1-9.

Dayson, C., (2017). Social prescribing 'plus': a model of asset-based collaborative innovation? *People, Place and Policy, 11*(2), 90-104.

Dayson, C., & Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing pilot. *Centre for Regional Economic and Social Research, Sheffield Hallam University*.

Dayson, C., & Damm, C. (2020). Evaluation of the Rotherham Social Prescribing Service for Long Term Conditions. *Centre for Regional Economic and Social Research*, Sheffield Hallam University.

Dayson, C., & Leather, D. (2020). Evaluation of HALE Community Connectors Social Prescribing Service 2018-19. *Centre for Regional Economic and Social Research*, Sheffield Hallam University.

Dayson, C., Harris, C., & Woodward, A. (2020). Evaluation of Age Better in Sheffield: Qualitative insights into interventions to address social isolation and loneliness. *Centre for Regional Economic and Social Research*, Sheffield Hallam University.

Dayson, C., MacMillan, R., Paine, A. E., & Sanderson, E., (2017). Third sector capacity building: The institutional embeddedness of supply. *Voluntary Sector Review, 8*(2), 149-168.

Deci, E. L., & Ryan, R. M. (2000). The support of autonomy and the control of behavior. In E. T. Higgins & A. W. Kruglanski (Eds.), *Motivational Science: Social and personality perspectives* (pp. 128-145). Psychology Press.

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health, 7*(2), e000057.

Department of Health (2008). *Transforming Social Care*. Local Authority Circular (DH). Department of Health, London. Retrieved from: http://www.inclusivechoice.com/DH_082139%20-%20Transforming%20social%20care.pdf (Accessed: August 2020).

Department of Health (2011). *No Health Without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of all Ages*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf (Accessed: August 2020).

Department of Health (2012). *Health and Social Care Act 2012: fact sheets*. Retrieved from: https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets (Accessed: August 2020).

DeRose, K. (1999). Contextualism: An explanation and defense. *The Blackwell Guide to epistemology* (pp. 187-205).

Devlin, B., Daniels, M., & Roeder, K. (1997). The heritability of IQ. *Nature*, *388*(6641), 468-471.

Dingle, G. A., & Sharman, L. S. (2022). Social Prescribing: A Review of the Literature. *Existential Concerns and Cognitive-Behavioral Procedures: An Integrative Approach to Mental Health*, 135-149.

Dingle, G. A., Ingram, I., Haslam, C., & Kelly, P. J. (2021). Taking social identity into practice. In *The Handbook of Alcohol Use* (pp. 511-530). Academic Press.

Doble, S. E., & Santha, J. C. (2008). Occupational well-being: Rethinking occupational therapy outcomes. *Canadian Journal of Occupational Therapy*, *75*(3), 184-190.

Dollard, J., Doob, L. W., Miller, N. E., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression*. New Haven, CT: Yale University Press.

Doody, O., & Noonan, M. (2013). Preparing and conducting interviews to collect data. *Nurse researcher*, *20*(5), 1-10.

Doosje, B., Spears, R., & Ellemers, N. (2002). Social identity as both cause and effect: The development of group identification in response to anticipated and actual changes in the intergroup status hierarchy. *British Journal of Social Psychology*, *41*(1), 57-76.

Dovidio, J. F., Eller, A., & Hewstone, M. (2011). Improving intergroup relations through direct, extended and other forms of indirect contact. *Group processes & intergroup relations*, *14*(2), 147-160.

Draper, G., & Dingle, G. A. (2021). "It's not the same": A comparison of the psychological needs satisfied by musical group activities in face to face and virtual modes. *Frontiers in Psychology*, *12*, 646292.

Dunn, D. S. (2019). Outsider privileges can lead to insider disadvantages: Some psychosocial aspects of ableism. *Journal of Social Issues*, *75*(3), 665-682.

Dunphy, D. C. (1963). The social structure of urban adolescent peer groups. *Sociometry*, 230-246.

Eagly, A. H., & Wood, W. (2013). The nature–nurture debates: 25 years of challenges in understanding the psychology of gender. *Perspectives on Psychological Science*, *8*(3), 340-357.

Eikemo, T. A., & Øversveen, E. (2019). Social Inequalities in health: Challenges, knowledge gaps, key debates and the need for new data. Scandinavian journal of public health, 47(6), 593-597.

Eldridge, S. M., Chan, C. L., Campbell, M. J., Bond, C. M., Hopewell, S., Thabane, L., & Lancaster, G. A. (2016). CONSORT 2010 statement: extension to randomised pilot and feasibility trials. *bmj*, *355*.

Ellard-Gray, A., Jeffrey, N. K., Choubak, M., & Crann, S. E. (2015). Finding the hidden participant: Solutions for recruiting hidden, hard-to-reach, and vulnerable populations. *International Journal of Qualitative Methods*, *14*(5), 1609406915621420.

Ellender, G., & Bonner, M. (2021). All the lonely people, where do they all belong? *Journal of Mental Health Disorders*, *1*(1), 15-28.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of advanced nursing*, *62*(1), 107-115.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE open*, *4*(1), 2158244014522633.

Elston, J., Gradinger, F., Asthana, S., Lilley-Woolnough, C., Wroe, S., Harman, H., & Byng, R. (2019). Does a social prescribing 'holistic'link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation. *Primary health care research & development*, *20*, e135.

Emerson, R. W. (2017). ANOVA and t-tests. *Journal of Visual Impairment & Blindness*, *111*(2), 193-196.

Emmel, N., Monaghan, M., Manzano, A., & Greenhalgh, J. (2018). Doing realist research. *Doing Realist Research*, 1-272.

Erlingsson, C., & Brysiewicz, P. (2017). A hands-on guide to doing content analysis. *African Journal of Emergency Medicine*, *7*(3), 93-99.

Etheridge, H., (2020). *Partnership working and social prescribing: Be Well in Manchester on their response to Covid-19*. Retrieved from: https://www.england.nhs.uk/personalisedcare/social-prescribing/case-studies/partnership-working-and-social-prescribing/ (Accessed: January 2021).

Evans, J. (2023). Exercise, inequalities and social prescribing: An individual approach to population health. Journal of the Royal College of Physicians of Edinburgh, 14782715231176779.

Evans, J. R., & Mathur, A. (2005). The value of online surveys. *Internet research, 15*(2), 195-219.

Evans, J. R., & Mathur, A. (2018). The value of online surveys: A look back and a look ahead. *Internet research*, *28*(4), 854-887.

Fancourt, D., Baxter, L., & Lorencatto, F. (2020). Barriers and enablers to engagement in participatory arts activities amongst individuals with depression and anxiety: quantitative analyses using a behaviour change framework. *BMC Public Health*, *20*, 1-12.

Farooq, M. B. (2015). Qualitative telephone interviews: Strategies for success.

Fazlıoğulları, O. (2012). Scientific research paradigms in social sciences. *International Journal of Educational Policies*, *6*(1), 41-55.

Featherstone, C., Sharpe, R. A., Axford, N., Asthana, S., & Husk, K. (2021). Health and wellbeing outcomes and social prescribing pathways in community-based support for autistic adults: A systematic mapping review of reviews. *Health & social care in the community*, 1-15.

Ferguson, A. J., & Peterson, R. S. (2015). Sinking slowly: Diversity in propensity to trust predicts downward trust spirals in small groups. *The Journal of applied psychology*, *100*(4), 1012.

Festinger, L. (1954). A theory of social comparison processes. *Human relations, 7*(2), 117-140.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. sage.

Finch, H., Lewis, J., & Turley, C. (2013). Focus Groups. In Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. sage.

Fink-Hafner, D., Dagen, T., Doušak, M., Novak, M., & Hafner-Fink, M. (2019). Delphi method: strengths and weaknesses. Advances in Methodology and Statistics, 16(2), 1-19.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Fixsen, A., Barrett, S., & Shimonovich, M. (2021). Weathering the storm: A qualitative study of social prescribing in urban and rural Scotland during the COVID-19 pandemic. *SAGE Open Medicine, 9*, 20503121211029187.

Fixsen, A., Seers, H., Polley, M., & Robins, J. (2020). Applying critical systems thinking to social prescribing: a relational model of stakeholder "buy-in". *BMC health services research, 20*(1), 1-13.

Fleming, J., Wellington, C., Parsons, J., & Dale, J. (2020). Collaboration between primary care and a voluntary, community sector organisation: Practical guidance from the parkrun practice initiative. *Health & Social Care in the Community*, *30*(2), e514-e523.

Folkman, S., & Lazarus, R. S. (1984). *Stress, appraisal, and coping* (pp. 150-153). New York: Springer Publishing Company.

Fortune, D., Aubin, G., Timm-Bottos, J., & Hebblethwaite, S. (2021). The art hive as a 'frame of belonging'for older adults. *Leisure/Loisir*, 1-22.

Foster, A., Thompson, J., Holding, E., Ariss, S., Mukuria, C., Jacques, R., Akparido, R., & Haywood, A. (2021). Impact of social prescribing to address loneliness: A mixed methods evaluation of a national social prescribing programme. *Health & Social Care in the Community*, *29*(5), 1439-1449.

Freak-Poli, R., Ryan, J., Tran, T., Owen, A., McHugh Power, J., Berk, M., Stocks, N., Gonzalez-Chica, D., Lowthian, J. A., Fisher, J., & Byles, J. (2021). Social isolation, social support and loneliness as independent concepts, and their relationship with health-related quality of life among older women. *Aging & Mental Health*, 1-10.

Frings, D., Gleibs, I. H., & Ridley, A. M. (2020). What moderates the attainment gap? The effects of social identity incompatibility and practical incompatibility on the performance of students who are or are not Black, Asian or Minority Ethnic. *Social Psychology of Education*, *23*(1), 171-188.

Frostick, C., & Bertotti, M. (2019). The frontline of social prescribing– How do we ensure Link Workers can work safely and effectively within primary care?. *Chronic Illness*, 1742395319882068.

Fuchs, C., & Diamantopoulos, A. (2009). Using single-item measures for construct measurement in management research: Conceptual issues and application guidelines. *Die Betriebswirtschaft*, *69*(2), 195.

Gadke, D. L., Kratochwill, T. R., & Gettinger, M. (2021). Incorporating feasibility protocols in intervention research. *Journal of School Psychology*, *84*, 1-18.

Gallagher, L. M. (2020). *HeRe We Arts™: Utilizing the Arts to Improve Health, Resilience, and Well-Being* (Doctoral dissertation, Northcentral University).

Gallagher, M., Muldoon, O. T., & Pettigrew, J. (2015). An integrative review of social and occupational factors influencing health and wellbeing. *Frontiers in psychology*, *6*, 1281.

Gardner, T., & Fraser, C. (2021*). Elective care: How has COVID-19 affected the waiting list? The health foundation*. Retrieved from: https://www.health.org.uk/news-and-comment/charts-and-infographics/elective-care-how-has-covid-19-affected-the-waiting-list (Accessed: December 2021).

Garside, R., Orr, R., Short, R., Lovell, R., Husk, K., McEachan, R., Rashid, R., & Dickie, I. (2020). Therapeutic Nature: nature-based social prescribing for diagnosed mental health conditions in the UK. *Final Report for DEFRA*.

Giebel, C., Hassan, S., Harvey, G., Devitt, C., Harper, L., & Simmill-Binning, C. (2022). Enabling middle-aged and older adults accessing community services to reduce social isolation: Community Connectors. *Health & Social Care in the Community*, *30*(2), e461-e468.

Golubinski, V., Wild, E. M., Winter, V., & Schreyögg, J. (2020). Once is rarely enough: can social prescribing facilitate adherence to non-clinical community and voluntary sector health services? Empirical evidence from Germany. *BMC Public Health*, *20*, 1-9.

Goodman, M. S., & Sanders Thompson, V. L. (2017). The science of stakeholder engagement in research: classification, implementation, and evaluation. *Translational behavioral medicine*, *7*(3), 486-491.

Gould, V. F. (2021). ARTS for Brain Health. Social prescribing transforming the diagnostic narrative for dementia from despair to desire: Findings from Arts 4 Dementia's two-year programme to help advance social prescribing at the onset of dementia symptoms.

Gov UK (2021a). *Coronavirus (Covid-19)*. Retrieved from: https://www.gov.uk/coronavirus (Accessed: February 2023).

Gov UK (2021b). *Emerging Together: The Tackling Loneliness Network Action Plan*. Retrieved from: https://www.gov.uk/government/publications/emerging-together-the-tackling-loneliness-network-action-plan/emerging-together-the-tackling-loneliness-network-action-plan (Accessed: February 2023).

Gov UK (2022). *England Returns to Plan A as regulations on face coverings and Covid passes change today*. Retrieved from: https://www.gov.uk/government/news/england-returns-to-plan-a-as-regulations-on-face-coverings-and-covid-passes-change-today#:~:text=To%20help%20do%20your%20bit,you%20do%20not%20normally%20meet (Accessed: December 2022).

Gov UK (2023). *Government's work on tackling loneliness*. Retrieved from: https://www.gov.uk/guidance/governments-work-on-tackling-loneliness#:~:text=The%20main%20strands%20of%20government's,talk%20and%20act%20on%20loneliness (Accessed: August, 2023).

Grant, C., Goodenough, T., Harvey, I., & Hine, C. (2000). A randomised controlled trial and economic evaluation of a referrals facilitator between primary care and the voluntary sector. *Bmj*, *320*(7232), 419-423.

Grant, G., Machaczek, K., Pollard, N., & Allmark, P. (2017). Walking, sustainability and health: findings from a study of a walking for health group. *Health & social care in the community*, *25*(3), 1218-1226.

Gray, D., & Stevenson, C. (2020). How can 'we'help? Exploring the role of shared social identity in the experiences and benefits of volunteering. *Journal of Community & Applied Social Psychology*, *30*(4), 341-353.

Grayer, J., Cape, J., Orpwood, L., Leibowitz, J., & Buszewicz, M. (2008). Facilitating access to voluntary and community services for patients with psychosocial problems: a before-after evaluation. *BMC Family Practice*, *9*(1), 1-8.

Greenaway, K. H., Cruwys, T., Haslam, S. A., & Jetten, J. (2016). Social identities promote well-being because they satisfy global psychological needs. *European Journal of Social Psychology*, *46*(3), 294-307.

Greenaway, K. H., Haslam, S. A., Cruwys, T., Branscombe, N. R., Ysseldyk, R., & Heldreth, C. (2015). From "we" to "me": Group identification enhances perceived personal control with consequences for health and well-being. *Journal of personality and social psychology*, *109*(1), 53.

Greenhalgh, T., Hinton, L., Finlay, T., Macfarlane, A., Fahy, N., Clyde, B., & Chant, A. (2019). Frameworks for supporting patient and public involvement in research: systematic review and co-design pilot. *Health expectations*, *22*(4), 785-801.

Griffiths, C., Hina, F., & Jiang, H. (2022). Social prescribing through primary care: a systematic review of the evidence. *Open Journal of Preventive Medicine*, *12*(2), 31-58.

Grotz, J., Dyson, S., & Birt, L. (2020). Pandemic policy making: The health and wellbeing effects of the cessation of volunteering on older adults during the COVID-19 pandemic. *Quality in Ageing and Older Adults*, *21*(4), 261-269.

Guest, G., Namey, E., & McKenna, K. (2017). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field methods*, *29*(1), 3-22.

Guyon, H., Kop, J. L., Juhel, J., & Falissard, B. (2018). Measurement, ontology, and epistemology: Psychology needs pragmatism-realism. *Theory & Psychology*, *28*(2), 149-171.

Haile, Z. T. (2023). Power analysis and exploratory research. *Journal of Human Lactation*, *39*(4), 579-583.

Hair, J., Black, W. C., Babin, B. J. & Anderson, R. E. (2010) *Multivariate data analysis* (7th ed.). Upper Saddle River, New Jersey: Pearson Educational International.

Halabi, S., Dovidio, J. F., & Nadler, A. (2021). When intergroup helping helps intergroup relations: The moderating role of trust in the outgroup. *Journal of Experimental Social Psychology*, *95*, 104141.

Halder, M. M., Mair, E., Wakefield, J., Kellezi, B., McNamara, N., Bowe, M., Wilson, I., & Stevenson, C. (2019). Evaluation of the Let's Live Well in Rushcliffe Initiative: Final Report. Full report with technical appendices.

Halder, M. M., Wakefield, J. R., Bowe, M., Kellezi, B., Mair, E., McNamara, N., Wilson, I., & Stevenson, C. (2018). Evaluation and exploration of a social prescribing initiative: study protocol. *Journal of health psychology,* 1359105318814160.

Hall, R. (2013). Mixed methods: In search of a paradigm. *Conducting research in a changing and challenging world*, 71-78.

Hamilton-West, K., Milne, A., & Hotham, S. (2020). New horizons in supporting older people's health and wellbeing: is social prescribing a way forward?. *Age and Ageing*, 1-8.

Hanlon, P., Gray, C. M., Chng, N. R., & Mercer, S. W. (2021). Does Self-Determination Theory help explain the impact of social prescribing? A qualitative analysis of patients' experiences of the Glasgow 'Deep-End'Community Links Worker Intervention. *Chronic illness*, *17*(3), 173-188.

Hari, J. (2018). Reconnection Two: Social Prescribing. Lost Connections: Uncovering the Real Causes of Depression—and the Unexpected Solutions. New York: Bloomsbury.

Harkin, L., Stuart, A., Stevenson, C., Talbot, C., Daly, R., Park, M. S. A., Katz, D., Gooch, D., & Price, B. (2023). Being cut off from social identity resources has shaped loneliness during the coronavirus pandemic: A longitudinal interview study with medically vulnerable older adults from the United Kingdom. *Journal of Community & Applied Social Psychology*.

Harris, J., Abualbashir, A., Akparibo, R., Ariss, S., Haywood, A., Messina, F., Soady, J., & Young, T. (2017). Shifting Demand for Non-Medical Services: An evaluation for the People Keeping Well in the Community programme. https://doi.org/10.15131/shef.data.5629204.v1.

Haslam, C., Cruwys, T., Chang, M. X. L., Bentley, S. V., Haslam, S. A., Dingle, G. A., & Jetten, J. (2019a). GROUPS 4 HEALTH reduces loneliness and social anxiety in adults with psychological distress: Findings from a randomized controlled trial. *Journal of consulting and clinical psychology*, *87*(9), 787.

Haslam, C., Cruwys, T., Haslam, S. A., Dingle, G., & Chang, M. X. L. (2016). Groups 4 Health: Evidence that a social-identity intervention that builds and strengthens social group membership improves mental health. *Journal of affective disorders*, *194*, 188-195.

Haslam, C., Haslam, S. A., Jetten, J., Cruwys, T., & Steffens, N. K. (2021a). Life change, social identity, and health. *Annual Review of Psychology*, *72*, 635-661.

Haslam, C., Holme, A., Haslam, S. A., Iyer, A., Jetten, J., & Williams, W. H. (2008). Maintaining group memberships: Social identity continuity predicts well-being after stroke. *Neuropsychological Rehabilitation*, *18*(5-6), 671-691.

Haslam, C., Jetten, J., Cruwys, T., Dingle, A. G., & Haslam, S. A. (2018). *Chapter 2: The Social Identity Approach to Health*. In The New Psychology of Health: Unlocking the Social Cure (pp. 33-56). Routledge.

Haslam, C., Lam, B. C., Yang, J., Steffens, N. K., Haslam, S. A., Cruwys, T., Boen, F., Mertin, N., De Brandt, K., Wang, X., Mallet, C. J., & Fransen, K. (2021b). When the final whistle blows: Social identity pathways support mental health and life satisfaction after retirement from competitive sport. *Psychology of Sport and Exercise*, *57*, 102049.

Haslam, C., Steffens, N. K., Branscombe, N. R., Haslam, S. A., Cruwys, T., Lam, B. C., Pachana, N. A., & Yang, J. (2019b). The importance of social groups for retirement adjustment: Evidence, application, and policy implications of the social identity model of identity change. *Social issues and policy review*, 13(1), 93-124.

Haslam, S. A. (2004). *Psychology in Organizations: The Social Identity Approach*. London: Sage.

Haslam, S. A., Haslam, C., Cruwys, T., Jetten, J., Bentley, S. V., Fong, P., & Steffens, N. K. (2021a). Social identity makes group-based social connection possible: Implications for loneliness and mental health. *Current Opinion in Psychology*.

Haslam, S. A., Haslam, C., Cruwys, T., Jetten, J., Dingle, G. A., & Greenaway, K. (2017). Applying the social identity approach in clinical and health domains: Key principles and insights. *Addiction, Behavioral Change and Social Identity: The Path to Resilience and Recovery*, 14-33.

Haslam, S. A., hogg, J., O'Brien, A., & Jacobs, E. (2004). Social identity, social influence and reactions to potentially stressful tasks: Support for the self-categorization model of stress. *Stress and Health: Journal of the International Society for the Investigation of Stress*, 20(1), 3-9.

Haslam, S. A., Jetten, J., & Waghorn, C. (2009). Social identification, stress, and citizenship in teams: A five-phase longitudinal study. *Stress and Health*, *25*, 21–30.

Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology*, *58*(1), 1-23.

Haslam, S. A., O'Brien, A., Jetten, J., Vormedal, K., & Penna, S. (2005). Taking the strain: Social identity, social support, and the experience of stress. *British Journal of Social Psychology*, 44(3), 355-370.

Haslam, S. A., Turner, J. C., Oakes, P. J., McGarty, C., & Hayes, B. K. (1992). Context dependent variation in social stereotyping 1: The effects of intergroup relations as mediated by social change and frame of reference. *European Journal of Social Psychology*, 22, 3–20.

Häusser, J. A., Junker, N. M., & van Dick, R. (2020). The how and the when of the social cure: A conceptual model of group-and individual-level mechanisms linking social identity to health and well-being. *European Journal of Social Psychology*, *50*(4), 721-732.

Hawkley, L. C., & Cacioppo, J. T. (2010). Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Annals of behavioral medicine*, *40*(2), 218-227.

Hawkley, L. C., Browne, M. W., & Cacioppo, J. T. (2005). How can I connect with thee? Let me count the ways. *Psychological Science*, *16*(10), 798-804.

Hayes, S., Carlyle, M., Haslam, S. A., Haslam, C., & Dingle, G. (2022). Exploring links between social identity, emotion regulation, and loneliness in those with and without a history of mental illness. *British Journal of Clinical Psychology*, *61*(3), 701-734.

Hempel, S., O'Hanlon, C., Lim, Y. W., Danz, M., Larkin, J., & Rubenstein, L. (2019). Spread tools: a systematic review of components, uptake, and effectiveness of quality improvement toolkits. Implementation Science, 14, 1-46.

Hensen, B., Mackworth-Young, C. R. S., Simwinga, M., Abdelmagid, N., Banda, J., Mavodza, C., Doyle, A. M., Bonell, C., & Weiss, H. A. (2021). Remote data collection for public health

research in a COVID-19 era: ethical implications, challenges and opportunities. *Health Policy and Planning*, *36*(3), 360-368.

Herrmann, W., Napierala, H., Kanehl, D., Krüger, K., & Holzinger, F. (2021). The evidence of social prescribing–Challenges found in conducting a systematic review. *European Journal of Public Health*, *31*(Supplement_3), ckab164-440.

Hibbard, J. H., Stockard, J., Mahoney, E. R., & Tusler, M. (2004). Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. *Health services research*, *39*(4p1), 1005-1026.

HM Government (2018). *A connected society: A strategy for tackling loneliness – laying the foundations for change*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf (Accessed: April 2020).

HM Government (2021). *Covid-19 Response – Spring 2021*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/963491/COVID-19_Response_-_Spring_2021.pdf (Accessed: December 2021).

HM Government (2022). *Covid-19 Response – Living with Covid.* Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1056229/COVID-19_Response_-_Living_with_COVID-19.pdf (Accessed: February 2023).

Ho, K. H., Chiang, V. C., & Leung, D. (2017). Hermeneutic phenomenological analysis: the 'possibility'beyond 'actuality'in thematic analysis. *Journal of advanced nursing*, *73*(7), 1757-1766.

Hocking, C., & Whiteford, G. E. (2012). Introduction to critical perspectives in occupational science. *Occupational science: Society, inclusion, participation*, 1-7.

Hoffmann, P., Platow, M. J., Read, E., Mansfield, T., Carron-Arthur, B., & Stanton, M. (2020). Perceived self-in-group prototypicality enhances the benefits of social identification for psychological well-being. *Group Dynamics: Theory, Research, and Practice*, *24*(4), 213.

Hogg, M. A. (2000). Subjective uncertainty reduction through self-cate-gorization: A motivational theory of social identity processes. *European Review of Social psychology*, *11*(1), 223–255.

Hogg, M. A. (2015). Constructive Leadership across Groups: How Leaders Can Combat Prejudice and Conflict between Subgroups. In *Advances in Group Processes*, S. R. and E. J (eds.). Emerald Group Publishing Limited, pp. 177-207.

Hogg, M. A., & Abrams, D. (1990). Social motivation, self-esteem and social identity. In D. Abrams & M. A. Hogg (Eds.), *Social Identity Theory: Constructive and Critical Advances*. New York: Springer-Verlag.

Hogg, M. A., & Abrams, D. E. (1993). *Group motivation: Social psychological perspectives*. Harvester Wheatsheaf.

Hogg, M. A., & Reid, S. A. (2006). Social identity, self-categorization, and the communication of group norms. *Communication theory*, *16*(1), 7-30.

Hogg, M. A., & Rinella, M. J. (2018). Social identities and shared realities. *Current opinion in Psychology*, *23*, 6-10.

Hogg, M. A., & Terry, D. I. (2000). Social identity and self-categorization processes in organizational contexts. *Academy of Management Review*, *25*(1), 121-140.

Hogg, M. A., & Turner, J. C. (1987). Intergroup behaviour, self-stereotyping and the salience of social categories. *British Journal of Social Psychology*, *26*(4), 325-340.

Hogg, M. A., & Williams, K. D. (2000). From I to we: Social identity and the collective self. *Group dynamics: Theory, research, and practice*, *4*(1), 81.

Hohman, Z. P., Gaffney, A. M., & Hogg, M. A. (2017). Who am I if I am not like my group? Self-uncertainty and feeling peripheral in a group. *Journal of Experimental Social Psychology*, *72*, 125-132.

Holmes, L., Cresswell, K., Williams, S., Parsons, S., Keane, A., Wilson, C., Islam, S., Joseph, O., Miah, J., Robinson, E., & Starling, B. (2019). Innovating public engagement and patient involvement through strategic collaboration and practice. *Research involvement and engagement*, *5*, 1-12.

Holt, N., Elliot, C., & Jenkinson, E. (2021). "Nobody can fail at it, everybody succeeds": Perceived processes of change following attendance at an arts on prescription programme. In *Culture, Health and Wellbeing International Conference 2021 CHW21 Research Proceedings* (pp. 66-68).

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, *7*(7), 1-20.

Holt-Lunstad, J., Uchino, B. N., Glanz, K., Rimer, B. K., & Viswanath, K. (2015). Health behavior: Theory, research, and practice.

Hornsey, M. J. (2006). Ingroup critics and their influence on groups. *Individuality and the group: Advances in social identity*, *74*-91.

Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. *Social and personality psychology compass*, 2(1), 204-222.

Hornsey, M. J., & Hogg, M. A. (2000). Assimilation and diversity: An integrative model of subgroup relations. *Personality and Social Psychology Review*, *4*(2), 143-156.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social relationships and Health. *Science*, *241*(4865), 540-545.

House, J. S., Robbins, C., & Metzner, H. L. (1982). The association of social relationships and activities with mortality: Prospective evidence from the Tecumseh community health study. A*merican Journal of Epidemiology*, *116*, 123-140.

House of Commons Library (2023). *Mental health policy in England*. Retrieved from: https://commonslibrary.parliament.uk/research-briefings/cbp-7547/ (Accessed: August 2023).

Howarth, M. L., & Donovan, H. (2019). Social prescribing: the whys, wherefores and implications. *Journal of Prescribing Practice*, *1*(2), 94-98.

Howarth, M., & Leigh, J. (2020b). Social prescribing: collaboration in times of stability and crisis. *British Journal of Nursing*, *29*(10), 578-579.

Howarth, M. L., Bayley, K., Brown, L. A., Dunn, J., Evans, H., Farrah, A., Farrington, R., Hamilton-Ball, M., Heggs, K., Jackson, C., Kershaw, M., Leigh, J. A., Lindley, R., Sharp, S., Stephens, M., Sullivan, E., Ward, J., Williams, A., & Williamson, T. (2021). Personalised Care Interprofessional Education Framework (PerCIE): social prescribing placement curriculum document and guiding principles for undergraduate/postgraduate health and social care students.

Howell, D. C. (2007). The treatment of missing data. *The Sage handbook of social science methodology*, *208*, 224.

Htun, H. L., Teshale, A. B., Cumpston, M. S., Demos, L., Ryan, J., Owen, A., & Freak-Poli, R. (2023). Effectiveness of social prescribing for chronic disease prevention in adults: a

systematic review and meta-analysis of randomised controlled trials. *J Epidemiol Community Health*, *77*(4), 265-276.

Husk, K., Blockley, K., Lovell, R., Bethel, A., Lang, I., Byng, R., & Garside, R. (2020). What approaches to social prescribing work, for whom, and in what circumstances? A realist review. *Health & social care in the community*, *28*(2), 309-324.

Husk, K., Elston, J., Gradinger, F., Callaghan, L., & Asthana, S. (2019). Social prescribing: where is the evidence?. *British Journal of General Practice*, *69*(678), 6-7.

Ingram, I., Kelly, P. J., Haslam, C., O'Neil, O. J., Deane, F. P., Baker, A. L., & Dingle, G. A. (2020). Reducing loneliness among people with substance use disorders: Feasibility of 'Groups for Belonging'. *Drug and Alcohol Review*, *39*(5), 495-504.

Institute for Government Analysis (2022). *Timeline of UK government coronavirus lockdowns and measures, March 2020 – December 2021*. Retrieved from: https://www.instituteforgovernment.org.uk/sites/default/files/timeline-coronavirus-lockdown-december-2021.pdf (Accessed: April 2022).

Islam, M. M. (2020). Social prescribing—an effort to apply a common knowledge: impelling forces and challenges. *Frontiers in public health*, *8*, 515469.

Israel, Glenn D. (1992). Sampling the Evidence of Extension Program Impact. Program Evaluation and Organizational Development, IFAS, University of Florida.

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T., & Haslam, S. A. (2009). The more (and the more compatible) the merrier: Multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology*, 48, 707-733.

Jackall, R. (1978). *Workers in a labyrinth: Jobs and survival in a bank bureaucracy*. Allanheld & Schram.

Jackson, L. A., Sullivan, L. A., Harnish, R., & Hodge, C. N. (1996). Achieving positive social identity: Social mobility, social creativity, and permeability of group boundaries. *Journal of personality and social psychology*, *70*(2), 241.

Jani, A., Bertotti, M., Lazzari, A., Drinkwater, C., Addarii, F., Conibear, J., & Gray, M. (2020). Investing resources to address social factors affecting health: the essential role of social prescribing. *Journal of the Royal Society of Medicine*, *113*(1), 24-27.

Jetten, J. (2014). The social cure: Why groups make us healthier and how policy makers can capitalise on these curing properties. *LSE American Politics and Policy*.

Jetten, J., Branscombe, N., Haslam, S. A., Haslam, C., Cruyws, T., Jones, J. M., Cui, L., Dingle, G., Liu, J., Murphy, S. C., Thai, A., Walter, Z., & Zhang, A. (2015). Having a lot of a good thing: Multiple important group memberships as a source of self-esteem. *PLoS One*, 10, 1–29.

Jetten, J., Haslam, C., Haslam, S. A., & Branscombe, N. R. (2009). The social cure. *Scientific american mind*, *20*(5), 26-33.

Jetten, J., Haslam, C., Haslam, S. A., Dingle, G., & Jones, J. M. (2014). How groups affect our health and well-being: The path from theory to policy. *Social Issues and Policy Review*, *8*(1), 103-130.

Jetten, J., Haslam, C., Pugliese, C., Tonks, J., & Haslam, S. A. (2010). Declining autobiographical memory and the loss of identity: Effects on well-being. *Journal of clinical and experimental neuropsychology*, *32*(4), 408-416.

Jetten, J., Haslam, S. A., & Haslam, C. (2012). The case for a social identity analysis of health and well-being. In J. Jetten, C. Haslam & S. A. Haslam (Eds.) *The social cure: Identity, health and well-being*, (p. 3-19). East Sussex, UK: Psychology Press.

Jetten, J., Haslam, S. A., Cruwys, T., Greenaway, K. H., Haslam, C., & Steffens, N. K. (2017). Advancing the social identity approach to health and well-being: Progressing the social cure research agenda. *European Journal of Social Psychology*, *47*(7), 789-802.

Jetten, J., Iyer, A., Tsivrikos, D., & Young, B. M. (2008). When is individual mobility costly? The role of economic and social identity factors. *European Journal of Social Psychology*, *38*(5), 866-879.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, *33*(7), 14-26.

Jones, A. (2022). *The oversimplification of tackling loneliness in social prescribing. British Society of lifestyle medicine*. Retrieved from: https://bslm.org.uk/my-loneliness-is-killing-me-the-oversimplification-of-tackling-loneliness-in-social-prescribing/ (Accessed March 2023).

Jones, C., (2020). *East Midlands Social Prescribing Scoping Project*. University of Leicester. East Midlands Academic Health Science Network. Retrieved from: https://emahsn.org.uk/images/Social_Prescribing_tool_-_Univeristy_of_Leicester.pdf (Accessed March 2021).

Jones, G., Meegan, R., Kennett, P., & Croft, J. (2016). The uneven impact of austerity on the voluntary and community sector: A tale of two cities. Urban Studies, 53(10), 2064-2080.

Jones, J. M., Williams, W. H., Jetten, J., Haslam, S. A., Harris, A., & Gleibs, I. H. (2012). The role of psychological symptoms and social group memberships in the development of post-traumatic stress after traumatic injury. *British Journal of Health Psychology*, 17, 798–811.

Jones, M., Beardmore, A., & White, J. (2021). Effects of Bristol Ageing Better Projects for Older People. *UWE Centre for Public Health and Wellbeing*.

Juster-Horsfield, H. H., & Bell, S. L. (2021). Supporting 'blue care'through outdoor water-based activities: practitioner perspectives. *Qualitative Research in Sport, Exercise and Health*, 1-14.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965.

Kamberelis, G., & Dimitriadis, G. (2011). Focus groups: Contingent articulations of pedagogy, politics, and inquiry. In N. K. Denzin & Y. S. Lincoln (Eds), *The Sage handbook of qualitative research*, Sage Thousand Oaks, CA, p. 545-561.

Karunanithi, S. (2022). Omicron and the NHS: we need to look beyond hospital care to solve the pressures. *bmj*, *376*:o185. Doi: 10.1136/bmj.0185.

Kellezi, B., & Reicher, S. (2012). Social cure or social curse? The psychological impact of extreme events during the Kosovo conflict. In J. Jetten, C. Haslam & S. A. Haslam (Eds.) *The Social Cure: Identity Health and Well-being* (P. 217-233). East Sussex, UK: Psychology Press.

Kellezi, B., Bowe, M., Wakefield, J. R., McNamara, N., & Bosworth, M. (2019b). Understanding and coping with immigration detention: Social identity as cure and curse. *European Journal of Social Psychology*, *49*(2), 333-351.

Kellezi, B., Frings, D., Gray, D., Bowe, M., Wakefield, J. McNamara, N. Stevenson, C. Wilson, I., Cleveland, Vangeli, E. M. (2019a). The Social Psychology of Social Prescribing: A toolkit.

Kellezi, B., Reicher, S., & Cassidy, C. (2009). Surviving the Kosovo conflict: A study of social identity, appraisal of extreme events, and mental well-being. *Applied Psychology*, 58(1), 59-83.

Kellezi, B., Wakefield, J., Bowe, M., Bridger, K., & Teague, K. (2021). Adapting social prescribing to meet the needs of migrant populations: challenges and solutions to service access and effectiveness. *Community Psychology in Global Perspective*, *7*(2), 1-21.

Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., Wilson, I., & Halder, M. M. (2019c). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *BMJ open*, *9*(11), e033137.

Kelly, D., Steiner, A., Mason, H., & Teasdale, S. (2021). Men's sheds as an alternative healthcare route? A qualitative study of the impact of Men's sheds on user's health improvement behaviours. *BMC Public Health*, *21*(1), 1-9.

Kendall, M., Murray, S. A., Carduff, E., Worth, A., Harris, F., Lloyd, A., Cavers, D., Grant, L., Boyd, K., & Sheikh, A. (2009). Use of multiperspective qualitative interviews to understand patients' and carers' beliefs, experiences, and needs. *Bmj*, *339*.

Khan, K., Ward, F., Halliday, E., & Holt, V. (2022). Public perspectives of social prescribing. *Journal of Public Health*, *44*(2), e227-e233.

Khan, S. S., Tarrant, M., Kos, K., Daly, M., Gimbuta, C., & Farrow, C. V. (2020). Making connections: Social identification with new treatment groups for lifestyle management of severe obesity. *Clinical psychology & psychotherapy*, *27*(5), 686-696.

Kielhofner, G. (Ed.) (2008). Model of human occupation: Theory and application (4th ed.) Baltimore: Lippincott Williams & Wilkins.

Kiely, B., Clyne, B., Boland, F., O'Donnell, P., Connolly, D., O'Shea, E., & Smith, S. M. (2021b). Link workers providing social prescribing and health and social care coordination for

people with multimorbidity in socially deprived areas (the LinkMM trial): protocol for a pragmatic randomised controlled trial. *BMJ open*, *11*(2), e041809.

Kiely, B., Connolly, D., Clyne, B., Boland, F., O'Donnell, P., Shea, E. O., & Smith, S. M. (2021a). Primary care-based link workers providing social prescribing to improve health and social care outcomes for people with multimorbidity in socially deprived areas (the LinkMM trial): Pilot study for a pragmatic randomised controlled trial. *Journal of Multimorbidity and Comorbidity*, *11*, 26335565211017781.

Kiely, B., Croke, A., O'Shea, E., Connolly, D., & Smith, S. M. (2019). Effectiveness of link workers providing social prescribing on health outcomes and costs for adult patients in primary care and community settings. A protocol for a systematic review of the literature. *HRB Open Research*, *2*(21), 21.

Kiely, B., Croke, A., O'Shea, M., Boland, F., O'Shea, E., Connolly, D., & Smith, S. M. (2022). Effect of social prescribing link workers on health outcomes and costs for adults in primary care and community settings: a systematic review. *BMJ open*, *12*(10), e062951.

Kilgarriff-Foster, A., & O'Cathain, A. (2015). Exploring the components and impact of social prescribing. *Journal of Public Mental Health*, 14(3), 127-134.

Kim, T. K. (2017). Understanding one-way ANOVA using conceptual figures. *Korean journal of anesthesiology*, *70*(1), 22.

Kimberlee, R. (2015). What is social prescribing? *Advances in Social Sciences Research Journal*, 2(1), 102-110.

Kimberlee, R. (2016). What is the value of social prescribing?. *Advances in Social Sciences Research Journal*, *3*(3).

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of higher education*, *6*(5), 26-41.

Knowles, M. L., Lucas, G. M., Baumeister, R. F., & Gardner, W. L. (2015). Choking under social pressure: Social monitoring among the lonely. *Personality and Social Psychology Bulletin*, *41*(6), 805-821.

Koudenburg, N., Jetten, J., & Dingle, G. A. (2017). Personal autonomy in group-based interventions. *European Journal of Social Psychology*, *47*(5), 653-660.

Krane, V., Barber, H., & McClung, L. R. (2002). Social psychological benefits of Gay Games participation: A social identity theory explanation. *Journal of Applied Sport Psychology*, *14*(1), 27-42.

Kraut, R., Burke, M., Riedl, J., & Resnick, P. (2010). Dealing with newcomers. *Evidencebased Social Design Mining the Social Sciences to Build Online Communities*, *1*, 42.

Krippendorff, K. (2018). *Content analysis: An introduction to its methodology*. Sage publications.

Kyngäs, H. (2004). Support network of adolescents with chronic disease: adolescents' perspective. *Nursing & health sciences*, *6*(4), 287-293.

Kyprianides, A., & Easterbrook, M. J. (2020). Social factors boost well-being behind bars: The importance of individual and group ties for prisoner well-being. *Applied Psychology: Health and Well-Being*, *12*(1), 7-29.

Kyprianides, A., Easterbrook, M. J., & Brown, R. (2019). Group identities benefit well-being by satisfying needs. *Journal of Experimental Social Psychology*, *84*, 103836.

Ladds, E. (2021). The role of the healthcare system in social prescribing. In *A Prescription for Healthy Living* (pp. 61-73). Academic Press. 61-73.

Laenen, F. V. (2021). Focus groups. *The encyclopedia of research methods in criminology and criminal justice*, *1*, 402-404.

Laing, K., Steer, M., Lawson, S., Penn, L., O'Brien, N., & Wildman, J. (2017). How Ways to Wellness social prescribing is improving the health and wellbeing of people with long term conditions: Evaluation report to the Cabinet Office. University of Newcastle, UK: Institute of Health & Society, 2017.

Lakens, D. (2013). Calculating and reporting effect sizes to facilitate cumulative science: a practical primer for t-tests and ANOVAs. *Frontiers in psychology*, *4*, 863.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson education.

Lauri, S., & Kyngas, H. (2005). Developing nursing theories. *Vantaa, Finland: Werner Söderström, Dark Oy*.

Lawrence, R., Smith, K., Carey, N., & Hotham, S. (2021). Social prescribing during and after COVID-19: Mapping changes, impact and opportunities for working with older adults. *Poster presentation*. Campaign to End Loneliness International Conference (November 2021).

Leach, C. W., Van Zomeren, M., Zebel, S., Vliek, M. L., Pennekamp, S. F., Doosje, B., Ouwerkerk, J. W., & Spears, R. (2008). Group-level self-definition and self-investment: a hierarchical (multicomponent) model of in-group identification. *Journal of personality and social psychology*, *95*(1), 144.

Lee, K. H., Low, L. L., Lu, S. Y., & Lee, C. E. (2022). Implementation of social prescribing: Lessons learnt from contextualising an intervention in a community hospital in Singapore. *The Lancet Regional Health-Western Pacific*, 100561.

Lee, S., & Lee, D. K. (2018). What is the proper way to apply the multiple comparison test?. *Korean journal of anesthesiology*, *71*(5), 353-360.

Levine, J. M., & Moreland, R. L. (1994). Group socialization: Theory and research. *European review of social psychology*, *5*(1), 305-336.

Levine, J. M., Moreland, R. L., & Hausmann, L. R. (2004). Managing group composition: Inclusive and exclusive role transitions. In *Social psychology of inclusion and exclusion* (pp. 155-178). Psychology Press.

Levine, M., Prosser, A., Evans, D., & Reicher, S. (2005). Identity and emergency intervention: How social group membership and inclusiveness of group boundaries shape helping behavior. *Personality and social psychology bulletin*, *31*(4), 443-453.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist*, *73*(1), 26.

Liebmann, M., Pitman, A., Hsueh, Y. C., Bertotti, M., & Pearce, E. (2022). Do people perceive benefits in the use of social prescribing to address loneliness and/or social isolation? A qualitative meta-synthesis of the literature. *BMC health services research*, *22*(1), 1264.

Little, R. J. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American statistical Association*, *83*(404), 1198-1202.

Lloyd, C. E. (2023). Stories matter: A novel approach to exploring perceptions, discourses, and the symbolic social order in pastoral psychology. *Pastoral Psychology*, *72*(2), 317-336.

Longwill, A. (2014). Independent evaluation of Hackney WellFamily service. *Improving health and wellbeing UK*. Family Action.

Maarouf, H. (2019). Pragmatism as a supportive paradigm for the mixed research approach: Conceptualizing the ontological, epistemological, and axiological stances of pragmatism. *International Business Research*, *12*(9), 1-12.

MacIntosh, E., & Law, B. (2015). Should I stay or should I go? Exploring the decision to join, maintain, or cancel a fitness membership. *Managing Sport and Leisure*, *20*(3), 191-210.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Mahase, E. (2020). Covid-19: Charity cuts could put the NHS under even more pressure. *bmj*, *370*.

Mak, J. K., Kuja-Halkola, R., Wang, Y., Hägg, S., & Jylhävä, J. (2021). Frailty and comorbidity in predicting community COVID-19 mortality in the UK Biobank: the effect of sampling. *Journal of the American Geriatrics Society*, *69*(5), 1128-1139.

Makanjuola, A. (2021). *An Evaluation Study to Investigate Recruitment into Social Prescribing Interventions and Explore the Skills Sets of Link Workers in Dealing with Complex Case Referrals* (Doctoral dissertation, Bangor University (United Kingdom).

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative health research*, *26*(13), 1753-1760.

Marmot, M. (2010). *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*. London: The Marmot Review.

Marshall, M. S. (1964). Jogging the Jargon. *Improving College and University Teaching*, *12*(4), 216-218.

Martin, L., Bruner, M., Eys, M., & Spink, K. (2014). The social environment in sport: selected topics. *International Review of Sport and Exercise Psychology*, *7*(1), 87-105.

McDaid, D., Damant, J., & Park, A. L. (2019). *Identifying the potential value of sustained participation in community activities arising from referral through social prescribing*. Personal Social Services Research Unit, Department of Health Policy, London School of Economics and Political Science, London.

Mckenzie, K., Diston, R., & Murray, K. (2021). Which elements of socially prescribed activities most improve wellbeing?. *Nursing Times*, *117*(7), 39-41.

McKim, C. A. (2017). The value of mixed methods research: A mixed methods study. *Journal of Mixed Methods Research*, *11*(2), 202-222.

McLeish, K. N., & Oxoby, R. J. (2011). Social interactions and the salience of social identity. *Journal of Economic Psychology*, *32*(1), 172-178.

McNamara, N., Mühlemann, N. S., Stevenson, C., Haslam, C., Hill, R., Steffens, N. K., & Bentley, S. (2021b). *"I Was a Firefighter": Preserving Identities, meaning, and purpose in the Retirement Transition*. Retrieved from: https://osf.io/4xmpz/ (Accessed: February 2022).

McNamara, N., Stevenson, C., Costa, S., Bowe, M., Wakefield, J., Kellezi, B., Wilson, I., Halder, M., & Mair, E. (2021a). Community identification, social support, and loneliness: The benefits of social identification for personal well-being. *British Journal of Social Psychology*, *60*(4), 1379-1402.

McQuaid, R. J., Cox, S. M., Ogunlana, A., & Jaworska, N. (2021). The burden of loneliness: Implications of the social determinants of health during COVID-19. *Psychiatry research*, *296*, 113648.

Melam, C. and Sanderson, J. (2020) *How social prescribing has adapted during the COVID-19 pandemic, NHS Confederation*. Retrieved from: https://www.nhsconfed.org/blog/2020/06/how-social-prescribing-adapted-during-thecovid19-pandemic (Accessed: December 2021).

Mercer, S. W., Fitzpatrick, B., Grant, L., Chng, N. R., McConnachie, A., Bakhshi, A., James-Rae, G., O'Donell, C. A., & Wyke, S. (2019). Effectiveness of community-links practitioners in areas of high socioeconomic deprivation. *The Annals of Family Medicine*, *17*(6), 518-525.

Michell, J. (2003). The quantitative imperative: Positivism, naïve realism and the place of qualitative methods in psychology. *Theory & Psychology*, *13*(1), 5-31.

Miller, K., Wakefield, J. R., & Sani, F. (2015). Identification with social groups is associated with mental health in adolescents: Evidence from a Scottish community sample. *Psychiatry Research*, *228*(3), 340-346.

Milligan, C., Chalfont, G., Kaley, A., & Lobban, F. (2021). Wilderness as therapeutic landscapes in later life: Towards an understanding of place-based mechanisms for wellbeing through nature-adventure activity. *Social Science & Medicine*, *289*, 114411.

Mills, C. F., Lowrie, E., Kinloch, K., & Hall, E. (2021). Community Connectors (CCx): the strategies employed by peer-to-peer connectors to foster relationships with early years caregivers to improve universal early child health and development. *BMC health services research*, *21*(1), 1-12.

Mind Cymru. (2021, November). Mind Cymru's Social Prescribing Service: Evaluation Findings. Cardiff: Mind Cymru.

Mitchell, E. (2020). “Much more than second best”: Therapists’ experiences of videoconferencing psychotherapy. *European Journal for Qualitative Research in Psychotherapy*, *10*, 121-135.

Moffatt, S., Steer, M., Lawson, S., Penn, L., & O’Brien, N. (2017). Link Worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ open*, *7*(7), 1-12.

Moffatt, S., Wildman, J., Pollard, T. M., Gibson, K., Wildman, J. M., O’Brien, N., Griffith, B., Morris, S. L., Moloney, E., Jeffries, J., Pearce, M., & Mohammed, W. (2023). Client experiences of the intervention. In Impact of a social prescribing intervention in North East England on adults with type 2 diabetes: the SPRING_NE multimethod study. National Institute for Health and Care Research.

Moore, C., Unwin, P., Evans, N., & Howie, F. (2022). Social prescribing: Exploring general practitioners' and healthcare professionals' perceptions of, and engagement with, the NHS model. *Health & Social Care in the Community*, *30*(6), e5176-e5185.

Moore, C., Unwin, P., Evans, N., & Howie, F. (2023). “Winging It”: An Exploration of the Self-Perceived Professional Identity of Social Prescribing Link Workers. *Health & Social Care in the Community*, *2023*.

Morgan, D. L. (1996). Focus groups. *Annual review of sociology*, *22*(1), 129-152.

Morgan, D. L. (2014). Pragmatism as a paradigm for social research. *Qualitative inquiry*, *20*(8), 1045-1053.

Morgan, H., Thomson, G., Crossland, N., Dykes, F., & Hoddinott, P. (2016). Combining PPI with qualitative research to engage ‘harder-to-reach’ populations: service user groups as co-applicants on a platform study for a trial. *Research involvement and engagement*, *2*(1), 1-26.

Morris, S. L., Gibson, K., Wildman, J. M., Griffith, B., Moffatt, S., & Pollard, T. M. (2022). Social prescribing during the COVID-19 pandemic: a qualitative study of service providers' and clients' experiences. *BMC Health Services Research*, *22*(1), 1-13.

Morse, D. F., Sandhu, S., Mulligan, K., Tierney, S., Polley, M., Giurca, B. C., Slade, S., Mahtani, K. R., Wells, L., Wang, H., Zhao, B., De Figueireudo, C. E. M., Meijs, J. J., Nam, H. K., Lee, K. H., Wallace, C., Elliott, M., Mendive, J. M., Robinson, D., Palo, M., Hermann, W., Nielsen, R. Ø., & Husk, K. (2022). Global developments in social prescribing. *BMJ Global Health*, *7*(5), e008524.

Muhl C., Mulligan K., Bayoumi I., Ashcroft R., & Godfrey C. (2023). Establishing internationally accepted conceptual and operational definitions of social prescribing through expert consensus: A Delphi study. *BMJ Open*, 13:e070184. doi:10.1136/bmjopen-2022-070184

Mukuria, C., Rowen, D., Peasgood, T., & Brazier, J. E. (2016). An empirical comparison of well-being measures used in the UK. Project Report. Policy Research Unit in Economic Evaluation of Health and Care Interventions (EEPRU) (27).

Nanjundeswaraswamy, T. S., & Divakar, S. (2021). Determination of sample size and sampling methods in applied research. *Proceedings on engineering sciences*, *3*(1), 25-32.

Nardi, P. M. (2018). Doing survey research: A guide to quantitative methods. Routledge.

National Academy for Social prescribing (2021). *Thriving Communities: Unleashing the power of social prescribing*. Retrieved from: https://socialprescribingacademy.org.uk/thriving-communities/ (Accessed: July 2022).

National Academy for Social Prescribing (2022). *Social Prescribing Around the World. A World map of Global Developments in Social Prescribing Across Different Health Systems*

Contexts. Retrieved from: https://socialprescribingacademy.org.uk/media/4lbdy5ip/social-prescribing-around-the-world.pdf (Accessed September 2023).

National Association of Link Workers (2019a). *Getting to know the link worker workforce: understanding link workers knowledge, skills, experiences and support needs*. Connect Link. Retrieved from: https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/8-use-social-prescribing/285510759/36453776/released_nalw_link-worker-report_march-2019_opt (Accessed: November 2020).

National Association of Link Workers (2019b). *Peer Group Clinical Supervision: Review & Evaluation*. Connect Link. Retrieved from: https://www.nalw.org.uk/social-prescribing-toolkit-resources-link-workers/ (Accessed: November 2020).

National Association of Link Workers (2019c). *Code of Practice for employers of social prescribing link workers and social prescribing link workers*. Connect link. Retrieved from: https://www.nalw.org.uk/wp-content/uploads/2019/06/Released_NALW_Code-of-Practice-for-employers-of-social-prescribing-link-workers-and-social-prescribing-link-workers_12-June-2019.pdf (Accessed: November 2020).

Nayak, M. S. D. P., & Narayan, K. A. (2019). Strengths and weakness of online surveys. *IOSR Journal of Humanities and Social Science*, *24*(5), 31-38.

Newman, B. M., & Newman, P. R. (2001). Group identity and alienation: Giving the we its due. *Journal of youth and adolescence*, *30*(5), 515-538.

Nguyen, T. V. T., Ryan, R. M., & Deci, E. L. (2018). Solitude as an approach to affective self-regulation. *Personality and social psychology bulletin*, *44*(1), 92-106.

NHS England & NHS Improvement (2019). *Social Prescribing Link Workers: Reference guide for primary care networks*. Retrieved from: https://www.england.nhs.uk/wp-

content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf (Accessed: February 2020).

NHS England & NHS Improvement (2020): *Health Coaching: Implementation and quality summary guide: Technical Annexes*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2020/03/hc-summary-guide-technical-annexes.pdf (Accessed: February 2021).

NHS England (2014). *Five Year Forward View*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (Accessed: October 2020).

NHS England (2019a). *Network Contract Directed Enhanced Services*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-specification-2019-20-v1.pdf (Accessed: October 2020).

NHS England (2019b). *Social Prescribing and Community-based Support: Summary Guide*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf (Accessed: February 2020).

NHS England (2019c). *Link Worker Welcome pack*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2019/09/social-prescribing-link-worker-welcome-pack-web-2.pdf (Accessed: February 2020).

NHS England (2020). *Social prescribing*. Retrieved from: https://www.england.nhs.uk/personalisedcare/social-prescribing/ (Accessed: October 2020).

NHS England (2022a). *Green Social Prescribing.* Retrieved from: https://www.england.nhs.uk/personalisedcare/social-prescribing/green-social-prescribing/ (Accessed: March 2023).

NHS England (2022b). *Network Contract Directed Enhanced Services*. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2022/03/B1963_i_Network-Contract-DES-Specification_171022.pdf (Accessed: September 2023).

NIHR, (2021). *Loneliness is strongly linked to depression among older adults, a long-term study suggests*. Retrieved from: https://evidence.nihr.ac.uk/alert/loneliness-strongly-linked-depression-older-adults/ (Accessed: March 2023).

Nottingham Trent University (2021). *Further Education Student Code of Behaviour*. Retrieved from: https://www.ntu.ac.uk/__data/assets/pdf_file/0017/1221254/FE-Student-Code-of-Behaviour.pdf (Accessed: September 2022).

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research?. *Research in nursing & health*, *31*(4), 391-398.

Nowak, D. A., & Mulligan, K. (2021). Social prescribing: A call to action. *Canadian Family Physician*, *67*(2), 88-91.

O'Callaghan, D. (2021). *Understanding the Social Prescribing Approach: Insights from the Health and Well-Being Community Referral Service in Cork* [online]. University College Cork, Ireland. Retrieved from: http://www.ucc.ie/en/scishop/completed/ (Accessed: January 2022).

O'Connor, C., CCG, S. W. L., Sekeram, M., Patel, P., & Mulimba, A. (2021). A study of the upscaling of the Social Prescribing Service in Merton. *Healthy Dialogues.* London, UK: South West London Clinical Commissioning Group.

O'HARA, C. H. L. O. E. (2020). *Examining the impact of a social prescribing service on the health & wellbeing of individuals living with and beyond cancer* (Doctoral dissertation, Trinity College Dublin. School of Medicine. Discipline of Occupational Therapy).

Oakes, P. J., Turner, J. C., & Haslam, S. A. (1991). Perceiving people as group members: The role of fit in the salience of social categorizations. *British Journal of Social Psychology, 30,* 125–144.

Oakes, P. J., Haslam, S. A., & Turner, J. C. (1994). *Stereotyping and social reality*. Blackwell Publishing.

Office for National Statistics (2021). *Measuring loneliness: guidance for use of the national indicators on surveys*. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/mappinglonelinessduringthecoronaviruspandemic/2021-04-07 (Accessed: June 2023).

Ogden, J. (2020). Social prescribing in a time of Covid-19 and social isolation…. *Progress in Neurology and Psychiatry*, *24*(3), 4-5.

Oliveira, M., Bitencourt, C., Teixeira, E., & Santos, A. C. (2013, July). Thematic content analysis: Is there a difference between the support provided by the MAXQDA® and NVivo® software packages. In *Proceedings of the 12th European Conference on Research Methods for Business and Management Studies* (p. 304-314).

Owens, L. L. (2022). An Implausible Virtual Interview: Conversations with a Professional Research Subject. *Sociological Methodology*, *52*(2), 121-140.

Ozuem, W., Willis, M., & Howell, K. (2022). Thematic analysis without paradox: sensemaking and context. *Qualitative Market Research: An International Journal*.

Pallister, C., Avery, A., Stubbs, J., & Lavin, J. (2009). Influence of Slimming World's lifestyle programme on diet, activity behaviour and health of participants and their families. *Journal of human nutrition and dietetics*, *22*(4), 351-358.

Park, H. M. (2009). *Comparing group means: t-tests and one-way ANOVA using Stata, SAS, R, and SPSS*. Working paper. The university Information Technology Services (UITS) Center for Statistical and Mathematical Computing, Indiana University.

Parker, E. C. (2014). The process of social identity development in adolescent high school choral singers: A grounded theory. *Journal of Research in Music Education*, *62*(1), 18-32.

Parums, D., (2015). *Community referral social prescribing*. Healthcare Arena. Retrieved from: https://healthcare-arena.co.uk/tag/community-referral/ (Accessed: August 2022).

Patoko, N., & Yazdanifard, R. (2014). The impact of using many jargon words, while communicating with the organization employees. *American Journal of industrial and business management*, *4*(10), 567.

Pearce, E., Launay, J., van Duijn, M., Rotkirch, A., David-Barrett, T., & Dunbar, R. I. (2016). Singing together or apart: The effect of competitive and cooperative singing on social bonding within and between sub-groups of a university Fraternity. *Psychology of music*, *44*(6), 1255-1273.

Pedro, L., Cole, A., Baylin, E., & Boys, A. (2021). *Social Prescribing: The role and experiences of local voluntary sector infrastructure organisations*. National Association for Voluntary and Community Action. Retrieved from: https://navca.org.uk/health-and-wellbeing (Accessed: December 2021).

Percival, A., Newton, C., Mulligan, K., Petrella, R. J., & Ashe, M. C. (2022). Systematic review of social prescribing and older adults: where to from here?. *Family Medicine and Community Health*, *10*(Suppl 1), e001829.

Pescheny, J. V., Pappas, Y., & Randhawa, G. (2018a). Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. *BMC health services research*, *18*(1), 86.

Pescheny, J., Randhawa, G., & Pappas, Y. (2018b). Patient uptake and adherence to social prescribing: a qualitative study. *BJGP open*, *2*(3).

Phelan, S., & Kinsella, E. A. (2009). Occupational identity: Engaging socio-cultural perspectives. *Journal of Occupational Science*, *16*(2), 85-91.

Pilkington, K., Loef, M., & Polley, M. (2017). Searching for real-world effectiveness of health care innovations: Scoping study of social prescribing for diabetes. *Journal of Medical Internet Research*, *19*(2), e20.

Plotnik, R., & Kouyoumdjian, H. (2013). *Introduction to psychology*. Cengage Learning.

Polley, M., & Sabey, A. (2022). COVID-19, mental health, and the role of arts and cultural engagement.

Polley, M. J., Bertotti, M., Kimberlee, R., Pilkington, K., & Refusm, C. (2017a). *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications*. University of Westminster.

Polley, M., Fleming, J., Anfilogoff, T., Carpenter, A., (2017b). *Making sense of social prescribing*. London, UK: University of Westminster.

Polley, M., Whiteside, J., Elnaschie, S., & Fixsen, A. (2020). *What does successful social prescribing look like? Mapping meaningful outcomes*. London, UK: University of Westminster.

Polley M, Whiteside J, Pilkington K. (2018). What are the outcomes of social prescribing — a mixed methods approach? 1st International Social Prescribing Research Conference. University of Salford, 14th June 2018.

Porter, B., Belderson, P., Wood, C., Manning, C., Meadows, R., Sanderson, K., & Hanson, S. (2022). A Report on Current Views and Experiences of Social Prescribing in Men's Sheds.

Postmes, T., Haslam, S. A., & Swaab, R. I. (2005). Social influence in small groups: An interactive model of social identity formation. *European review of social psychology*, *16*(1), 1-42.

Public Health England (2019). *Social Prescribing: Applying All Our Health*. Retrieved from: https://www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health (Accessed: March 2020).

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. Simon and schuster.

Putnam, R. D., & Feldstein, L. (2004). *Better together: Restoring the American Community*. New York: Simon and Schuster.

Raifman, S., DeVost, M. A., Digitale, J. C., Chen, Y. H., & Morris, M. D. (2022). Respondent-driven sampling: a sampling method for hard-to-reach populations and beyond. *Current Epidemiology Reports*, *9*(1), 38-47.

Razai, M. S., Oakeshott, P., Kankam, H., Galea, S., & Stokes-Lampard, H. (2020). Mitigating the psychological effects of social isolation during the covid-19 pandemic. *Bmj*, *369*.

Reicher, S. D. (1987). Crowd behaviour as social action. In J. C. Turner, M. A. Hogg, P. J. Oakes, S. D. Reicher, & M. S. Wetherell (Eds.), *Rediscovering the Social Group: A self-categorisation Theory* (pp. 171–202). Oxford, UK: Basil Blackwell.

Reicher, S. D. (1996). ‘The Battle of Westminster’: Developing the social identity model of crowd behaviour in order to explain the initiation and development of collective conflict. *European journal of social psychology*, *26*(1), 115-134.

Reinhardt, G. Y., Vidovic, D., & Hammerton, C. (2021). Understanding loneliness: a systematic review of the impact of social prescribing initiatives on loneliness. *Perspectives in public health*, *141*(4), 204-213.

Relke, S., Fritsche, I., Masson, T., Kleine, A. K., Thien, K., von Glahn, L., Leuteritz, K., & Richter, D. (2022). Personal condition but social cure: Agentic ingroups elevate well-being in chronically ill patients through perceptions of personal control. *British Journal of Health Psychology*, *27*(3), 666-690.

Resnicow, K., & McMaster, F. (2012). Motivational Interviewing: moving from why to how with autonomy support. *International Journal of Behavioral Nutrition and Physical Activity*, *9*(1), 1-9.

Rhodes, J., & Bell, S. (2021). "It sounded a lot simpler on the job description": A qualitative study exploring the role of social prescribing link workers and their training and support needs (2020). *Health & Social Care in the Community*, *29*(6), e338-e347.

Rice, L. (2020). After Covid-19: Urban design as spatial medicine. *Urban Design International*, 1-6.

Riggle, E. D., Rostosky, S. S., & Reedy, C. S. (2005). Online surveys for BGLT research: Issues and techniques. *Journal of homosexuality*, *49*(2), 1-21.

Rivas, C., Tkacz, D., Antao, L., Mentzakis, E., Gordon, M., Anstee, S., & Giordano, R. (2019). Patient and public involvement. In *Automated analysis of free-text comments and dashboard*

representations in patient experience surveys: a multimethod co-design study. NIHR Journals Library, Southhampton (UK).

Roberts, B. W., Walton, K. E., & Viechtbauer, W. (2006). Patterns of mean-level change in personality traits across the life course: a meta-analysis of longitudinal studies. *Psychological bulletin*, *132*(1), 1.

Roberts, N. J., Kidd, L., Dougall, N., Patel, I. S., McNarry, S., & Nixon, C. (2016). Measuring patient activation: the utility of the patient activation measure within a UK context—results from four exemplar studies and potential future applications. *Patient education and counseling*, *99*(10), 1739-1746.

Roland, M., Everington, S., & Marshall, M. (2020). Social prescribing-transforming the relationship between physicians and their patients. *New England Journal of Medicine*, *383*(2), 97-99.

Rolewicz, L., Keeble, E., Paddison, C., & Scobie, S. (2020). Are the needs of people with multiple long-term conditions being met? Evidence from the 2018 General Practice Patient Survey. *BMJ open*, *10*(11), e041569.

Rough, N. W., (2021). Green Prescribing: Communities of Boundary Practice in Transectoral Collaboration. An Actor-Oriented Approach to Environmental and Public Health Intervention. *IIIEE Master Thesis*.

Runacres, J. (2022). The problem with the definition of 'social prescribing': Exploring the language used, and key roles within the concept. *4th international social prescribing conference*, 1-th – 11th March 2022, virtual poster presentation.

Russell, J., Greenhalgh, T., & Taylor, M. (2019). Patient and public involvement in NIHR research 2006–2019: policy intentions, progress and themes. *National Institute for Health Research: Oxford, UK*.

Ryba, T. V., Wiltshire, G., North, J., & Ronkainen, N. J. (2022). Developing mixed methods research in sport and exercise psychology: Potential contributions of a critical realist perspective. *International Journal of Sport and Exercise Psychology*, *20*(1), 147-167.

Salari, S., Brown, B. B., & Eaton, J. (2006). Conflicts, friendship cliques and territorial displays in senior centre environments. *Journal of Aging Studies*, *20*(3), 237-252.

Sale, J. E., Lohfeld, L. H., & Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality and quantity*, *36*, 43-53.

Salford Social Prescribing Hub (2020a). *Assessment and Planning Tool*. Retrieved from: http://hub.salford.ac.uk/ssph/salford-social-prescribing-assessment-and-planning-tool/ (Accessed: July 2020).

Salford Social Prescribing Hub (2020b). *Our projects*. Retrieved from: http://hub.salford.ac.uk/ssph/our-projects/ (Accessed: July 2020).

Salford Social Prescribing Hub (2020c). *Social prescribing tool and training*. Retrieved from: https://hub.salford.ac.uk/ssph/social-prescribing-tool-and-training/ (Accessed: December 2022).

Sandhu, S., Lian, T., Drake, C., Moffatt, S., Wildman, J., & Wildman, J. (2022b). Intervention components of link worker social prescribing programmes: a scoping review. *Health & Social Care in the Community*.

Sandhu, S., Lian, T., Smeltz, L., Drake, C., Eisenson, H., & Bettger, J. P. (2022a). Patient barriers to accessing referred resources for unmet social needs. *The Journal of the American Board of Family Medicine*, *35*(4), 793-802.

Sani, F. (2012). Group identification, social relationships, and health. In J. Jetten, C. Haslam & A. S. Haslam (Eds), *The social cure: Identity, health and well-being* (p. 21-37). East Sussex, UK: Psychology Press.

Sani, F., Herrera, M., & Bowe, M. (2009). *Group identification and perceived group cohesion and continuity: Implications for well-being and health*. Paper presented at the APA 117th Annual Convention; Toronto, Canada, 6-9 August.

Sani, F., Herrera, M., Wakefield, J. R. H., Boroch, O., & Gulyas, C. (2012). Comparing social contact and group identification as predictors of mental health. *British Journal of Social Psychology*, *51*, 781-790.

Sani, F., Madhok, V., Norbury, M., Dugard, P., & Wakefield, J. R. H. (2015a). Greater number of group identifications is associated with healthier behaviour: Evidence from a Scottish community sample. *British Journal of Health Psychology*, *20*(3), 466-481.

Sani, F., Madhok, V., Norbury, M., Dugard, P., & Wakefield, J. R. H. (2015b). Greater number of group identifications is associated with lower odds of being depressed: Evidence from a Scottish community sample. *Social Psychiatry and Psychiatric Epidemiology*, *50*(9), 1389-1397.

Saunders, M. N., Lewis, P., Thornhill, A., & Bristow, A. (2015). *Understanding research philosophy and approaches to theory development*. In: Research Methods for Buisness Students: Eight Edition. Pearson Education Limited, United Kingdom.

Schabert, J., Browne, J. L., Mosely, K., & Speight, J. (2013). Social stigma in diabetes. *The Patient-Patient-Centered Outcomes Research*, *6*(1), 1-10.

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1981). The health-related functions of social support. *Journal of behavioral medicine*, *4*(4), 381-406.

Scheffer, J. (2002). Dealing with missing data. *Res. Lett. Inf. Math. Sci.*, *3*, 153-160.

Schruijer, S. G. L., & Vansina, L., (2008). Working across organisational boundaries: understanding and working with intergroup dynamics. In L. Vansina, M-J. Vansina-Cobbaert (Eds.) *Psychodynamics for consultants and managers*, pp. 390-412. Wiley-Blackwell.

Schuurman, B., Lindenberg, J., Huijg, J. M., Achterberg, W. P., & Slaets, J. P. (2022). Expressions of self-ageism in four European countries: A comparative analysis of predictors across cultural contexts. *Ageing & Society*, *42*(7), 1589-1606.

Searle, A., Herbert, G., Ness, A., Foster, C., Waylen, A., & Jago, R. (2022). A qualitative exploration of attitudes to walking in the retirement life change. *BMC public health*, *22*(1), 1-11.

Sedikides, C., Wildschut, T., & Grouzet, F. (2018). On the temporal navigation of selfhood: The role of self-continuity. *Self and Identity*, *17*(3), 255-258.

Seymour-Smith, M., Cruwys, T., Haslam, S. A., & Brodribb, W. (2017). Loss of group memberships predicts depression in postpartum mothers. *Social Psychiatry and Psychiatric Epidemiology*, 52(2), 201-210.

Shah, S. (2021). Loneliness as a risk factor for chronic disease. In *A Prescription for Healthy Living* (pp. 111-120). Academic Press.

Shannon-Baker, P. (2016). Making paradigms meaningful in mixed methods research. *Journal of mixed methods research*, *10*(4), 319-334.

Sharman, L. S., Hayes, S., Chua, D., Haslam, C., Cruwys, T., Jetten, J., Haslam, S. A., McNamara, N., Baker, J. R., Johnson, T., & & Dingle, G. (2023). Report on the 18-month evaluation of social prescribing in Queensland.

Sharman, L. S., McNamara, N., Hayes, S., & Dingle, G. A. (2022). Social prescribing link workers—A qualitative Australian perspective. *Health & Social Care in the Community*, 30(6), e6376-e6385.

Sias, P. M., & Bartoo, H. (2007). Friendship, social support, and health. In L. L'Abate (Ed.) *Low-cost approaches to promote physical and mental health: theory, research and practice* (pp. 455-472). New York: NY. Springer.

Sim, J., & Waterfield, J. (2019). Focus group methodology: some ethical challenges. *Quality & Quantity*, *53*(6), 3003-3022.

Simpson, S., Furlong, M., & Giebel, C. (2021). Exploring the Enablers and Barriers to Social Prescribing for People Living with Long-Term Neurological Conditions: A Focus Group Investigation. *BMC health services research, 21*(1), 1-14.

Singh, A. S., & Masuku, M. B. (2014). Sampling techniques & determination of sample size in applied statistics research: An overview. *International Journal of economics, commerce and management*, *2*(11), 1-22.

Singing for Health Network (2021). *Social Prescribing to choirs and singing groups: a guide for leaders of choirs/singing groups*. Retrieved from: https://www.artshealthresources.org.uk/docs/social-prescribing-and-singing-a-guide-for-leaders-of-choirs-singing-groups/ (Accessed: March 2022).

Skivington, K., Smith, M., Chng, N. R., Mackenzie, M., Wyke, S., & Mercer, S. W. (2018). Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. *British Journal of General Practitioners*, *68*(672), e487-e494.

Smeekes, A., & Verkuyten, M. (2015). Perceived group continuity, collective self-continuity, and in-group identification. *Self and Identity*, *13*(6), 663-680.

Smith, E. R. (1993). Social identity and social emotions: Toward new conceptualizations of prejudice. In D. M. Mackie & D. L. Hamilton (Eds.), *Affect, Cognition, and Stereotyping: Interactive Processes in Group Perception* (pp. 297–315). San Diego, CA: Academic Press.

Smith, J. R., Louis, W. R., & Tarrant, M. (2017). University students' social identity and health behaviours. *Self and social identity in educational contexts*, 159-175.

Smith, K. (2021). Identifying Barriers to Accessing Community-Based Services for Clients of Fraser Health's Social Prescribing Program. University of Victoria.

Sobh, R., & Perry, C. (2006). Research design and data analysis in realism research. *European Journal of marketing*, *40*(11/12), 1194-1209.

Social Prescribing Network (2016). Report of the annual social prescribing network conference. London: University of Westminster.

Sonke, J., Manhas, N., Belden, C., Morgan-Daniel, J., Akram, S., Marjani, S., Oduntan, O., Hammond, G., Martinez, G., Davidson Carroll, G., Rodriguez, A. K., Burch, S., Colverson, A. J., Pesata, V., & Fancourt, D. (2023). Social prescribing outcomes: A mapping review of the evidence from 13 countries to identify key common outcomes. Frontiers in Medicine, 10, 1266429.

South, J., Higgins, J. T., Woodall, J., White, M. S., (2008). Can Social Prescribing Provide the Missing Link? *Primary Health Care & Research Development*, *9*, 310-318

Spears, R. (2011). Group identities: The social identity perspective. In *Handbook of identity theory and research* (pp. 201-224). New York, NY: Springer New York.

Spears, R., Jetten, J., & Doosje, B. (2001). 14 The (II) legitimacy of Ingroup Bias from Social Reality to Social Resistance. *The psychology of legitimacy: Emerging perspectives on ideology, justice, and intergroup relations*, 332.

Spencer, L. H., Lynch, M., & Thomas, G. (2021). Developing a conversation about identifying community needs to embrace wellbeing through social prescribing interventions: a qualitative study. *The Lancet*, *398*, S82.

Spencer, N., Markham, W., Johnson, S., Arpin, E., Nathawad, R., Gunnlaugsson, G., Homaira, N., Rubio, M. L. M., & Trujillo, C. J. (2022). The Impact of COVID-19 pandemic on inequity in routine childhood vaccination coverage: a systematic review. *Vaccines*, *10*(7), 1013.

SPRING Social Prescribing (2020). *A community approach to health and wellbeing: SPRING social prescribing project evaluation report July 2019 – October 2020*. Retrieved from: https://www.tnlcommunityfund.org.uk/media/insights/documents/SPRING_EvaluationReport.pdf?mtime=20210618134201&focal=none (Accessed September 2023).

Staley, K. (2013). There is no paradox with PPI in research. *Journal of medical ethics*, *39*(3), 186-187.

Steffens, N. K., Cruwys, T., Haslam, C., Jetten, J., & Haslam, S. A. (2016). Social group memberships in retirement are associated with reduced risk of premature death: evidence from a longitudinal cohort study. *BMJ open*, *6*(2), e010164.

Steffens, N. K., LaRue, C. J., Haslam, C., Walter, Z. C., Cruwys, T., Munt, K. A., Haslam, S. A., Jetten, J., & Tarrant, M. (2019). Social identification-building interventions to improve health: a systematic review and meta-analysis. *Health Psychology Review*, 1-28.

Steinel, W., van Kleef, G. A., van Knippenberg, D., Hogg, M. A., Homan, A. C., & Moffitt, G. (2010). How intragroup dynamics affect behavior in intergroup conflict: The role of group norms, prototypicality, and need to belong. *Group Processes & Intergroup Relations*, *13*(6), 779-794.

Stevens, M., Cruwys, T., Haslam, C., & Wang, V. (2021). Social group memberships, physical activity, and physical health following retirement: A six-year follow-up from the English Longitudinal Study of Ageing. *British Journal of Health Psychology*, *26*(2), 505-524.

Stevenson, C., Bowe, M., Kellezi, B., McNamara, N., Wakefield, J. & Asmal, A. (2020b). The Mid-Notts Social Prescribing Pathway: A scoping Study. *Nottingham Trent University*.

Stevenson, C., McNamara, N., & Muldoon, O. (2014). Stigmatised identity and service usage in disadvantaged communities: Residents', community workers' and service providers' perspectives. *Journal of Community and Applied Social Psychology*, *24*(6), 453-466.

Stevenson, C., Wilson, I., McNamara, N., Wakefield, J., Kellezi, B., & Bowe, M. (2020a). Social prescribing: A practice in need of a theory.

Stewart, D. W., & Shamdasani, P. (2017). Online focus groups. *Journal of Advertising*, *46*(1), 48-60.

Stewart, M. J., Makwarimba, E., Reutter, L. I., Veenstra, G., Raphael, D., & Love, R. (2009). Poverty, sense of belonging and experiences of social isolation. *Journal of Poverty*, *13*(2), 173-195.

Stickley, T. (2020). Arts, health and wellbeing across the age span. *Perspectives in Public Health*, *140*(5), 243-244.

Stuart, A., Stevenson, C., Koschate, M., Cohen, J., & Levine, M. (2021). 'Oh no, not a group!'The factors that lonely or isolated people report as barriers to joining groups for health and well-being. *British Journal of Health Psychology*, *27*(1), 179-193.

Swancutt, D., Tarrant, M., Ingram, W., Baldrey, S., Burns, L., Byng, R., Cailitri, R., Creanor, S., Dean, S., Evans, L., Gill, L., Goodwin, E., Hawkins, L., Hayward, C., Hind, S., Hollands, L., Hosking, J., Lloyd, J., Moghadam, S., Neilens, H., O'Kane, M., Perry, S., Sheaff, R., Spencer, A., Taylor, A., Ward, T., Watkins, R., Wilding, J., & Pinkney, J. (2022). A group-based behavioural intervention for weight management (PROGROUP) versus usual care in adults with severe obesity: a feasibility randomised controlled trial protocol. *Pilot and Feasibility Studies*, *8*(1), 206.

Swift, H. J., & Chasteen, A. L. (2021). Ageism in the time of COVID-19. *Group Processes & Intergroup Relations*,network *24*(2), 246-252.

Tabery, J. (2014). *Beyond versus: The struggle to understand the interaction of nature and nurture*. mit Press.

Tajfel, H. (1972). Social categorization, English manuscript of La catégorization sociale. *Introduction à la psychologie sociale*, *1*.

Tajfel, H. (1978). *Differentiation between social groups. Studies in the social psychology of intergroup relations*. London, UK: Academic Press.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual review of psychology*, *33*(1), 1-39.

Tajfel, H. (2010). Social Identity and Intergroup Relations (vol 7). Cambridge University Press.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-47). Monterey, CA: Brooks/Cole.

Tajfel, H., & Turner, J. C. (1986). The social Identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp.7-24). Chicago, IL: Nelson.

Tajfel, H., Billig, M., Bundy, R. P., & Flament, C. (1971). Social categorization and intergroup behaviour. *European Journal of Social Psychology*, **1**, 149–178.

Tan, W. J., Lim, X. Y. H., Lee, T., Wong, S. C., Koh, H. J., & Yeo, D. (2022). The impact of the Arts and Dementia Program on short-term well-being in older persons with dementia from Singapore. *Australasian Journal on Ageing*, *41*(1), 81-87.

Tanis, M., & Postmes, T. (2005). A social identity approach to trust: Interpersonal perception, group membership and trusting behaviour. *European journal of social psychology*, *35*(3), 413-424.

Tarrant, M., Haslam, C., Carter, M., Calitri, R., & Haslam, S. A. (2020). Social Identity Interventions. In: Hagger, M. S., Cameron, L. D., Hamilton, K., Hankonen, N., & Lintunen, T. (Eds.). *The handbook of behavior change*. Cambridge University Press.

Tarrant, M., Khan, S. S., Farrow, C. V., Shah, P., Daly, M., & Kos, K. (2017). Patient experiences of a bariatric group programme for managing obesity: A qualitative interview study. British journal of health psychology, 22(1), 77-93.

Tarrant, M., Warmoth, K., Code, C., Dean, S., Goodwin, V. A., Stein, K., & Sugavanam, T. (2016). Creating psychological connections between intervention recipients: development and

focus group evaluation of a group singing session for people with aphasia. *BMJ open*, *6*(2), e009652.

Thangaratinam, S., & Redman, C. W. (2005). The delphi technique. *The obstetrician & gynaecologist*, *7*(2), 120-125.

The British Academy (2021). *The COVID Decade: Understanding the long-term societal impacts of COVID-19.* Retrieved from: https://www.thebritishacademy.ac.uk/publications/covid-decade-understanding-the-long-term-societal-impacts-of-covid-19/ (Accessed: March 2023).

The First Word (2022). *Readability test*. Retrieved from: https://thefirstword.co.uk/readabilitytest/ (Accessed: December 2022).

The King's Fund (2017). *What is Social Prescribing?* Retrieved from: https://www.kingsfund.org.uk/publications/social-prescribing (Accessed: May 2020).

Thoele, K., Ferren, M., Moffat, L., Keen, A., & Newhouse, R. (2020). Development and use of a toolkit to facilitate implementation of an evidence-based intervention: a descriptive case study. Implementation Science Communications, 1(1), 1-12.

Thoits, P. A. (1983). Multiple identities and psychological well-being: A reformulation and test of the social isolation hypothesis. *American Sociological Review*, 48, 174-187.

Thomas, D. R., Hodges, I. D., Hoyle, L., Orr-Walker, B. J., Kenealy, T. W., Orr-Walker, B., & Kenealy, T. (2021). *Managing diabetes: A synthesis of social and community interventions*. Technical report.

Thomas, G., Lynch, M., & Spencer, L. H. (2021). A Systematic Review to Examine the Evidence in Developing Social Prescribing Interventions That Apply a Co-Productive, Co-

Designed Approach to Improve Well-Being Outcomes in a Community Setting. *International Journal of Environmental Research and Public Health*, *18*(8), 3896.

Thomas, T., Baker, J., Massey, D., D'Appio, D., & Aggar, C. (2020). Stepped-Wedge Cluster Randomised Trial of Social Prescribing of Forest Therapy for Quality of Life and Biopsychosocial Wellbeing in Community-Living Australian Adults with Mental Illness: Protocol. *International Journal of Environmental Research and Public Health*, *17*(23), 9076.

Thompson, R., Duncan, A., & Sack, J. (2021). Arts in Mind: A Multidisciplinary Approach to Museum Programs for Persons Living with Young-Onset and Early-Stage Alzheimer's Disease. *International Journal of Lifelong Learning in Art Education*, *4*(1), 10.

Thompson, V. L. S., Ackermann, N., Bauer, K. L., Bowen, D. J., & Goodman, M. S. (2021). Strategies of community engagement in research: definitions and classifications. *Translational Behavioral Medicine*, *11*(2), 441.

Thomson, L., Camic, P. M., & Chatterjee, H. (2015). *Social prescribing: a review of community referral schemes*. Canterbury Christ Church University.

Tierney, S., Potter, C., Eccles, K., Akinyemi, O., Gorenberg, J., Libert, S., Wong, G., Turk, A., Husk, K., Chatterjee, H. J., Webster, E., McDougall, B., Warburton, H., Shaw, L., & Mahtani, K. R. (2022). Social prescribing for older people and the role of the cultural sector during the COVID-19 pandemic: What are link workers' views and experiences?. *Health & Social Care in the Community*, *30*(6), e5305-e5313.

Tierney, S., Wong, G., Roberts, N., Boylan, A. M., Park, S., Abrams, R., Reeve, J., Williams, V., & Mahtani, K. R. (2020). Supporting social prescribing in primary care by linking people to local assets: a realist review. *BMC medicine*, *18*, 1-15.

Trepte, S., & Loy, L. S. (2017). Social identity theory and self-categorization theory. *The international encyclopedia of media effects*, 1-13.

Tubey, R. J., Rotich, J. K., & Bengat, J. K. (2015). Research Paradigms: Theory and Practice. Research on Humanities and Social Sciences, 5(5), 224-229.

Turk, A., Tierney, S., Wong, G., Todd, J., Chatterjee, H. J., & Mahtani, K. R. (2022). Self-growth, wellbeing and volunteering-Implications for social prescribing: A qualitative study. *SSM-Qualitative Research in Health*, *2*, 100061.

Turner, J. C. (1982). Towards a cognitive redefinition of the social group. In H. Tajfel (Ed.), *Social identity and intergroup relations* (pp. 15-40). Cambridge, UK: Cambridge University Press.

Turner, J. C. (1984). Social identification and psychological group formation. *The social dimension: European developments in social psychology*, *2*, 518-538.

Turner, J. C. (1991). *Social Influence*. Milton-Keynes, UK: Open University Press.

Turner, J. C., & Haslam, S. A. (2001). Social identity, organizations, and leadership. *Groups at work: Theory and research*, 25-65.

Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group*. Oxford, UK: Blackwell.

UK Parliament. (2023). *House of commons library. NHS Key Statistics: England, July 2023*. Retrieved from: https://commonslibrary.parliament.uk/research-briefings/cbp-7281/ (Accessed September 2023).

Van Oort, L., Schröder, C., & French, D. P. (2011). What do people think about when they answer the Brief Illness Perception Questionnaire? A 'think-aloud'study. *British journal of health psychology*, *16*(2), 231-245.

Vaughan, A. (2021). Omicron emerges. *New Scientist*, 252[3363], 7.

Verkuyten, M., & Hagendoorn, L. (1998). Prejudice and self-categorization: The variable role of authoritarianism and in-group stereotypes. *Personality and social psychology bulletin*, *24*(1), 99-110.

Vidovic, D., Reinhardt, G. Y., & Hammerton, C. (2021). Can Social Prescribing Foster Individual and Community Well-Being? A Systematic Review of the Evidence. *International journal of environmental research and public health*, *18*(10), 5276.

Wakefield, J. R., Bowe, M., Kellezi, B., McNamara, N., & Stevenson, C. (2019). When groups help and when groups harm: Origins, developments, and future directions of the "Social Cure" perspective of group dynamics. *Social and Personality Psychology Compass*, *13*(3), e12440.

Wakefield, J. R. H., Kellezi, B., Stevenson, C., McNamara, N., Bowe, M., Wilson, I., Halder, M. M., & Mair, E. (2022). Social Prescribing as 'Social Cure': A longitudinal study of the health benefits of social connectedness within a Social Prescribing pathway. *Journal of Health Psychology*, *27*(2), 386-396.

Wakefield, J. R., Hopkins, N., Cockburn, C., Shek, K. M., Muirhead, A., Reicher, S., & van Rijswijk, W. (2011). The impact of adopting ethnic or civic conceptions of national belonging for others' treatment. *Personality and Social Psychology Bulletin*, 37(12), 1599-1610.

Wallace, C., Davies, M., Elliott, M., Llewellyn, M., Randall, H., Owens, J., Phillips, J., Teichner, L., Sullivan, S., Hannah, V., Jenkins, B., & Jesurasa, A. (2021). UNDERSTANDING SOCIAL PRESCRIBING IN WALES: A MIXED METHODS STUDY. Wales for social prescribing (WSSPR). Prime Centre Wales.

Walsh, R. S., Muldoon, O. T., Gallagher, S., & Fortune, D. G. (2015). Affiliative and "self as-doer" identities: Relationships between social identity, social support, and emotional status

amongst survivors of acquired brain injury (ABI). *Neuropsychological Rehabilitation*, 25, 555–573.

Wann, D. L., & Branscombe, N. R. (1990). Person perception when aggressive or nonaggressive sports are primed. *Aggressive Behavior*, *16*(1), 27-32.

Ward, A., Asif, A., Cattermole, R., Chima, J., Ebbatson, T., Mahi, I., Richardson, N., & Sheikh, H. (2020). Social prescribing by students: the design and delivery of a social prescribing scheme by medical students in general practice. *Education for Primary Care*, *31*(5), 318-322.

Westlake, D., Elston, J., Gude, A., Gradinger, F., Husk, K., & Asthana, S. (2022). Impact of COVID-19 on social prescribing across an Integrated Care System: A Researcher in Residence study. *Health & Social Care in the Community*.

Westland, G. (2020). Beyond interpretative phenomenological analysis: Using body awareness and mindfulness meditation practices to research body psychotherapy. In *The Art and Science of Embodied Research Design* (pp. 153-164). Routledge.

White, B. (2020). Promising practice: Addressing older adult loneliness through the Rx Community social prescribing pilot.

WHO (2018). *Health Inequalities and their causes*. Retrieved from: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes (Accessed October 2022).

WHO (2022). *Social determinants of health*. Retrieved from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (Accessed October 2022).

Wildman, J., & Wildman, J. M. (2021). Evaluation of a Community Health Worker Social Prescribing Program Among UK Patients with Type 2 Diabetes. *JAMA network open*, *4*(9), e2126236-e2126236.

Wildman, J. M., Moffatt, S., Penn, L., O'Brien, N., Steer, M., & Hill, C. (2019a). Link workers' perspectives on factors enabling and preventing client engagement with social prescribing. *Health & social care in the community*, *27*(4), 991-998.

Wildman, J. M., Moffatt, S., Steer, M., Laing, K., Penn, L., & O'Brien, N. (2019b). Service-users' perspectives of link worker social prescribing: a qualitative follow-up study. *BMC public health*, *19*(1), 98.

Wilkerson, J. M., Iantaffi, A., Grey, J. A., Bockting, W. O., & Rosser, B. S. (2014). Recommendations for internet-based qualitative health research with hard-to-reach populations. *Qualitative health research*, *24*(4), 561-574.

Williams, K. D. (2009). Ostracism: A temporal need-threat model. *Advances in Experimental Social Psychology*, *41*, 275–314.

Williams, M. (2003). The problem of representation: Realism and operationalism in survey research. *Sociological research online*, *8*(1), 81-91.

Williams, T., Lakhani, A., & Spelten, E. (2022). Interventions to reduce loneliness and social isolation in rural settings: a mixed-methods review. *Journal of rural studies*, *90*, 76-92.

Willig, C. (2013). *EBOOK: introducing qualitative research in psychology*. McGraw-hill education (UK).

Wuest, J., Merritt-Gray, M., Dubé, N., Hodgins, M. J., Malcolm, J., Majerovich, J. A., Scott-Storey, K., Ford-Gilboe, M., & Varcoe, C. (2015). The process, outcomes, and challenges of feasibility studies conducted in partnership with stakeholders: a health intervention for women survivors of intimate partner violence. *Research in nursing & health*, *38*(1), 82-96.

Xu, W., & Zammit, K. (2020). Applying thematic analysis to education: A hybrid approach to interpreting data in practitioner research. *International Journal of Qualitative Methods*, *19*, 1609406920918810.

Yitka, G., Plouviez, A., Clelland, A., Fox, A., Fowler, G., Sargent, J., & Hayes, C. (2022). Applied Social Prescribing Practice: A Focused Arts Based Participatory Action Research Study of Military Veteran Transition Into Civilian Life. *Journal of Participatory Research Methods*, *3*(2).

Younan, H. C., Junghans, C., Harris, M., Majeed, A., & Gnani, S. (2020). Maximising the impact of social prescribing on population health in the era of COVID-19. *Journal of the Royal Society of Medicine*, *113*(10), 377-382.

Zalantai, B., Holt, N., Chase, M., & Jenkinson, E. (2021). A mixed-methods evaluation of the longitudinal impact of arts on prescription.

Zamawe, F. C. (2015). The implication of using NVivo software in qualitative data analysis: Evidence-based reflections. *Malawi Medical Journal*, *27*(1), 13-15.

Zander, A. (1976). The psychology of removing group members and recruiting new ones. *Human Relations*, *29*(10), 969-987.

Zhang, C. X., Wurie, F., Browne, A., Haworth, S., Burns, R., Aldridge, R., Zenner, D., Tran, A., & Campos-Matos, I. (2021). Social prescribing for migrants in the United Kingdom: A systematic review and call for evidence. *Journal of Migration and Health*, *4*, 100067.

Zhu, Y., & Stephens, K. K. (2019). Online support group participation and social support: Incorporating identification and interpersonal bonds. *Small Group Research*, *50*(5), 593-622.

Zotzmann, K., Barman, E., Porpora, D. V., Carrigan, M., & Elder-Vass, D. (2022). Round table: is the common ground between pragmatism and critical realism more important than the differences?. *Journal of Critical Realism*, *21*(3), 352-364.

Zuell, C., Menold, N., & Körber, S. (2015). The influence of the answer box size on item nonresponse to open-ended questions in a web survey. *Social Science Computer Review*, *33*(1), 115-122.

Appendix A: Study One interview schedules

Link Workers:

Collect demographic information prior to starting interview.

1. Can you tell me a little bit about your role and how you became involved in it?
    a. How long have you been involved in social prescribing or worked link to this role?

2. Can you describe the nature of service-user appointments and what they involve?
    a. How do you build rapport with the service-user?
    b. How do you assess the needs of service-users?
    c. How do you assess the strengths of service-users?
    d. How do you assess the challenges of service-users?

3. How many referrals would you say you make in an average week in general?
    a. How many of these referrals would you say are to community groups?

4. What are your views about the variety and number of community groups available for service-users to be referred to? Can you give me some examples?
    a. What type of groups are in your area?
    b. How do you access lists of groups?
    c. Do you have any way of accessing/linking with groups not listed?
    d. Are you involved in the creation of new groups?

5. What does the process of recruiting a community group for SP involve?
    a. Do you meet the group leader and their members prior?
    b. What do you think makes a good community group/activity?
    c. How do you decide that?
    d. What sort of atmosphere are you looking for?

6. What does the referral process to a community group look like and are there any challenges?
    a. What does a typical first session attendance at a community group look like?
    b. Do you attend the group with them and if so, under what circumstances?
    c. Why do you attend groups with them?
    d. How do you make sure that the community group and the service user will be a good match?
    e. Why do you think that a good match is important?

7. Do you monitor continued attendance with a group and if so, how and why do you monitor this?
    a. How do you handle the situation if the service-user does not like the group?
    b. Why do you think people keep going or stop going to community groups?
    c. Do you think the activity of a group is important when linking service-users to them?
    d. What dynamics do you think are important for a social prescribing community group?

e. To what extent do you think practical issues impact whether service-users continue to attend groups or not? i.e., transport, timings, costs etc.

8. When assessing new groups, what do you look for in a group that makes you think they would be a good addition for social prescribing referrals?

9. Are there any questions you would like to ask, or anything else you want to add before we end the interview?

Close interview and debrief participant.

G**roup Leaders:**

Collect demographic information prior to starting interview.

1. Can you tell me a little bit about yourself and how you became involved with the group?

2. How long has your group been running?
    a. How many members do you typically have in your group and what do they typically do?
    b. How do they relate to each other?
    c. What are their typical needs?
    d. How does the group help?
    e. What issues do they face?

3. How does one become a member?

4. What do you know about social prescribing?
    a. [If relevant] To what extent do you interact with link workers?
    b. Do you know about any other referral pathways?

5. Are you aware that some people may be referred into your group?
    a. What are your experiences so far with new members who could have been referred in?
    b. What are your concerns about people being referred into the group, going forward?
    c. Do you see any benefits in having people referred into your group?

6. What do you think needs to be considered if someone was to be referred into your group?
    a. What activities need to be considered?
    b. Does accessibility need to be considered?
    c. What about the people being referred into the group needs to be considered?
    d. What aspects of the group need to be considered?

7. How do you ensure that new members feel they can join the group and will feel part of the group?
    a. As a group leader, how do you maintain fairness or stability in the group? Can you provide any examples?
    b. How would you describe the atmosphere of the group? Can you provide any examples?

8. Have you experienced cases where some people do not engage or fit with the group?
    a. Why do you think the group did not suit that person?

9. Are there any questions you would like to ask, or anything else you want to add before we end the interview?

Close interview and debrief participant.

Service-users:

Collect demographic information prior to starting interview.

1. Can you tell me a little bit about yourself and how you became involved in your group?

2. How did you get connected to the group?
    a. How did you meet?
    b. Where did you meet and for how long?
    c. What was discussed during these interactions that led to being linked to the group?

3. Thinking about the community group recommended to you, what was your experience with the group?
    a. How did the group make you feel?
    b. Thinking back to the reasons why you were linked to the group, do you feel the group suited your needs?

4. Why do you think that particular group was suggested?
    a. Have you been to other groups before this one? If so, what were they like?
    b. Why did you not stay with previous groups?
    c. Do you feel that your interests were taken into consideration when being referred to this/the current community group?

5. Where there any barriers to attending or joining the group?
    a. [if relevant] what about the group made you feel that you did not want to attend/join?
    b. [If relevant] what about the group made you feel that it was easy to join/attend?
    c. Did you know anyone there?
    d. [if relevant] what would encourage you to join/attend the group?

6. Do you intend to continue attending the group and remain a member?

a. What has changed since you started going to the group?
b. Why do you think things have changed? i.e., have you met new people, joined other groups etc?
c. What made you decide to remain a member of the group?

7. If you were to be linked to a community group again, what would you like to be considered before being referred to the group?

8. Is there anything about the group itself that would put you off attending?
    a. What do you think needs to be considered before service-users are linked to groups?

9. Are there any questions you would like to ask, or anything else you want to add before we end the interview?

Close interview and debrief participant.

Appendix B: Study Two focus group and questionnaire schedule

Welcome to the focus group and thank you for participating.

As a reminder, the aim of this focus group is to discuss and refine which topics should be included in a community prescribing toolkit for social prescribing referrals to community groups, and to refine how these should be explained and presented within the proposed toolkit. These topics are the ones found in the documents sent to you, which you should have looked over to formulate your opinions on them prior to this focus group.

House rules:

- Regarding participation instructions, we ask that what is said during this focus group is kept between members so that confidentiality is not breached.
- Where possible please respect the person who is speaking. Everyone will be given the opportunity to voice their opinions, with debates welcome, especially where disagreement for inclusion is present.
- Mobile phones should be switched to silent or turned off for the duration of the focus group, where suitable.
- A reminder that participation is voluntary, and everyone has the right to withdraw at any point during and after this focus group until the specified date.
- This focus group will be primarily participant led, with some input from the researcher to ensure all topics are discussed, that all participants have the opportunity to voice their opinions and that participants are guided back to topics discussion, should conversation move away from the main aim of this study.
- There are no wrong or right answers to this focus group as your opinions will help guide the refinement of the toolkit, to ensure it is something you would be beneficial for group leaders looking to engage in social prescribing.

Topics to cover during focus group: (Questions imported into a questionnaire for group leaders)

1. Introductions and welcome. Go over housekeeping rules and reminders. Gather verbal consent from all participants.

2. Start discussion requesting opinions on the general overview of the toolkit:
    - What are your initial thoughts on the layout and structure of the toolkit?
    - How do you feel about the language used?
    - is it easy to understand?
    - Where there any unclear sections, instructions or phrases?
    - Did you have any concerns or thoughts on the terminology used, for example, what is your preferred terminology for a service-user?
    - Did you have any thoughts or concerns about the psychological arguments or technical terms used?
    - Did you find the arguments made about connecting with groups convincing?
    - Did you find the arguments made about connecting with groups accessible?
    - Do you think the instructions for link workers are clear?
    - Do you think the instructions for group leaders are clear?

3. Continue discussion by focusing on the individual sections in turn.

- What did we think about each component of the toolkit?
    i. The overview section
    ii. The community group guidance section
    iii. The link worker guidance section
- Do you feel this toolkit is something that would be beneficial?
- What do you think should remain?
- What would you change or reword, if anything?
- Is there anything you would remove?

4. Do you think using this toolkit will benefit LWs, service-users and group leaders?
    - Why?

5. Is there anything else anyone would like to add or say about topics for inclusion or not in the toolkit?

6. Are there any topics you think should be included in the toolkit which have not been discussed today or have not been presented in the topic list to refine? Please justify your answers.

Prompts for full coverage:

- What do we think about [Insert topic] for inclusion/exclusion?
- What do you think would be better instead of [insert topic] since there is some disagreement about it?

Appendix C: Study Three questions

Demographics

This section gathers general information about a link worker, to provide an overview of those taking part in the questionnaire. This information provides insight into the reach of the questionnaire and the potential differences between services across the United Kingdom.

Please provide your:

- Are you a link worker? (yes/no – if no, skip to the end)
- Age: [textbox]
- Sex/gender: (drop down bar – male, female, transgender, non-binary, prefer not to say)
- Country: (drop down bar – England, Scotland, Wales & Northern Ireland)
- Please specify the region or county the service is located in, i.e., Nottinghamshire [textbox]
- How long you have been in your current link worker role [textbox]
- Do you have any previous experience in a social prescribing link worker role elsewhere? – fixed Yes/No response.
- If yes, how long in total have you been a link worker for? [textbox]

Mapping Social Prescribing

This section gathers information about the social prescribing service you work for. Questions will be asked reflecting how the service operated before the pandemic, how it operated during the pandemic and how it operated in the recovery period following the pandemic. This recovery period can be conceptualised as the current working conditions of the service as we begin to ease out of the national lockdowns.

Social Prescribing Service type

- Is your service: (single choice - GP based, voluntary sector based, local authority based or other: please specify [textbox]

Referral reasons for accessing Social Prescribing

- Please indicate how often service-users were referred into your service, before the pandemic, for the following reasons (6-point Likert. 1 = Never, 2 = very rarely, 3 = rarely, 4= occasionally, 5 = frequently, 6 = very frequently – debt, housing support, domestic violence, social isolation, loneliness, mental ill-health, anxiety, depression, bereavement, chronic ill-health, weight management, other).

- Please indicate how often service-users are referred into your service now, in the current working environment, for the following reasons (6-point Likert. 1 = Never, 2 = very rarely, 3 = rarely, 4= occasionally, 5 = frequently, 6 = very frequently – debt, housing support, domestic violence, social isolation, loneliness, mental ill-health, anxiety, depression, bereavement, chronic ill-health, weight management, other).

Access to Community Resources

- Please indicate how often a service-user would be referred to one of the following community resources, before the pandemic. (6-point Likert. 1 = Never, 2 = very rarely, 3 = rarely, 4= occasionally, 5 = frequently, 6 = very frequently – citizens advice bureau, housing support, financial advisor, counselling, other therapy, health coach, volunteering, gym, local community groups, online community groups, exercise classes, other: please specify).
- Please indicate how often a service-user may be referred to one of the following community resources, now, during the current working environment. (6-point Likert. 1 = Never, 2 = very rarely, 3 = rarely, 4= occasionally, 5 = frequently, 6 = very frequently – citizens advice bureau, housing support, financial advisor, counselling, other therapy, health coach, volunteering, gym, local community groups, online community groups, exercise classes, other: please specify).
- Would you like to say a bit more about the current referral process? (Textbox answer)

Accessing community groups

- Please indicate how well you agree with the following statements (5-point Likert, 1=strongly disagree, 2= somewhat disagree, 3- neither disagree nor agree, 4= somewhat agree, 5= strongly agree):
    - I am able to refer service-users to community groups.
    - Community groups are accepting referrals.
    - There are no community groups available to refer service-users to (R).
    - I am able to refer service-users to online community groups.
    - Online community groups are accessible to service-users.
    - Service-users want to attend online community groups.

Would you like to say a bit more about the availability of community groups for social prescribing at the moment? (Textbox answer)

Accessing community groups within next 6-months

- How likely do you think it is that referrals to face-to-face community groups will return to normal capacity within the next 6 months? (5-point Likert. 1= very unlikely, 2 =somewhat unlikely, 3=neutral, 4=somewhat likely, 5=very likely)
    - If possible, please explain your answer: [textbox]

Useful support for the role

The following set of questions are interested in understanding what type of support you feel would be beneficial in aiding the social prescribing referral process. The outcomes of these questions will be influential in informing what type of toolkit will be most beneficial to trial within social prescribing.

- Please indicate how useful you think each of the following psychologically informed support resources would be for social prescribing link workers, based on your current and foreseeable working practice (5-point Likert. 1= not at all useful, 2 =slightly useful, 3= moderately useful, 4= very useful, 5= extremely useful)
    - A psychologically informed toolkit designed to increase the likelihood of link workers and service-users finding the right community group to improve a service-user's health and wellbeing.
    - A psychologically informed toolkit designed to support the referral process to other community and health resources or services (e.g., counselling, citizen's advice, housing support) that are not community groups.
    - A psychologically informed toolkit designed to support the referral process to online community groups.
    - A psychologically informed toolkit designed to support the current one-to-one support offered by social prescribing link workers to service-users (e.g., supporting the relationship building process between link workers and service-users).
    - Please outline the reasons for your choices: [textbox]

What type of referral support would be useful to you within the current working environment, if community groups are still not fully accessible? [textbox]

Social Identity and Social Prescribing

The following section explores your thoughts and opinions about the relevance of certain social psychological processes that you experience in your work, such as social connection and social relationships, when you connect service-users to local community groups.

- How important is it to provide a good match, where the service-user enjoys and fits in with the group? (5-point Likert, 1= not at all important, 2 =slightly important, 3= moderately important, 4= very important, 5= extremely important. *Higher scores = right match important*).

- Based on this current working period, please indicate how much you agree with the following statements (5-point Likert, 1=strongly disagree, 2= somewhat disagree, 3-neither disagree nor agree, 4= somewhat agree, 5= strongly agree):

Identity matching in practice (higher scores = greater identity matching ability)

- I am usually able to connect people to community groups they can integrate into.
- I am usually able to connect people to community groups they can belong to.
- I am usually able to connect people to community groups that fit their needs.

Identity matching theory (higher scores = higher agreement that identity matching theory is important)

- Connecting people to community groups that foster a sense of belonging is important.
- Connecting people to community groups that fit their needs is important.

- Connecting people to community groups that include them in the groups session or activities is important.

Please explain a little bit about why you think it is important that people can develop a sense of belonging in groups they are referred to: (textbox answer).

Face-to-face groups Vs online groups (higher scores = F2F groups better for identification than online groups)

- Face-to-face groups are easier to integrate into than online groups.
- Face-to-face groups offer a greater sense of belonging than online groups.
- Face-to-face groups are more inclusive than online groups.
- Online groups are more inclusive than face-to-face groups.
- Online groups offer a greater sense of belonging than face-to-face groups.
- Online groups are easier to integrate into than face-to-face groups.
- I think both face-to-face and online groups are equally easy to integrate into.
- I think both face-to-face and online groups are equally inclusive.
- I think both face-to-face and online groups equally offer a sense of belonging.

Would you like to say a little more about the use of online groups during social prescribing? (Textbox answer).

Appendix D: Recruitment pathways for Study Four

Recruitment Plan A: Inspiring Ashfield Evaluation

Study Four initially recruited service-users who had declined to engage from the Inspiring Ashfield social prescribing service. Inspiring Ashfield was a one-year project funded by the Thriving Community's Fund (National Academy for Social Prescribing, 2021). Service-users were referred through Inspiring Ashfield, to Ashfield Voluntary Action (AVA), who connected them to appropriate community groups. This Study was part of a larger series of studies focused on evaluating Inspiring Ashfield which ended in July 2022. A gatekeeper at AVA supported recruitment by sharing a researcher flyer with potential participants on the researcher's behalf. Interested participants emailed the researcher for information.

Recruitment Plan B: Broadening recruitment

Ethical approval to recruit service-users outside of the Inspiring Ashfield initiative was sought in August 2022. Recruiting outside of the Inspiring Ashfield evaluation was considered necessary to increase access to the target population. Figure 9.1 shows the recruitment process for Plan A and Plan B. Plan B involved opportunistic sampling (through social media and public locations), and purposeful sampling. 125 non-NHS organisations were asked to share a research flyer during purposeful sampling, of which ten organisations agreed to help whilst two could not.

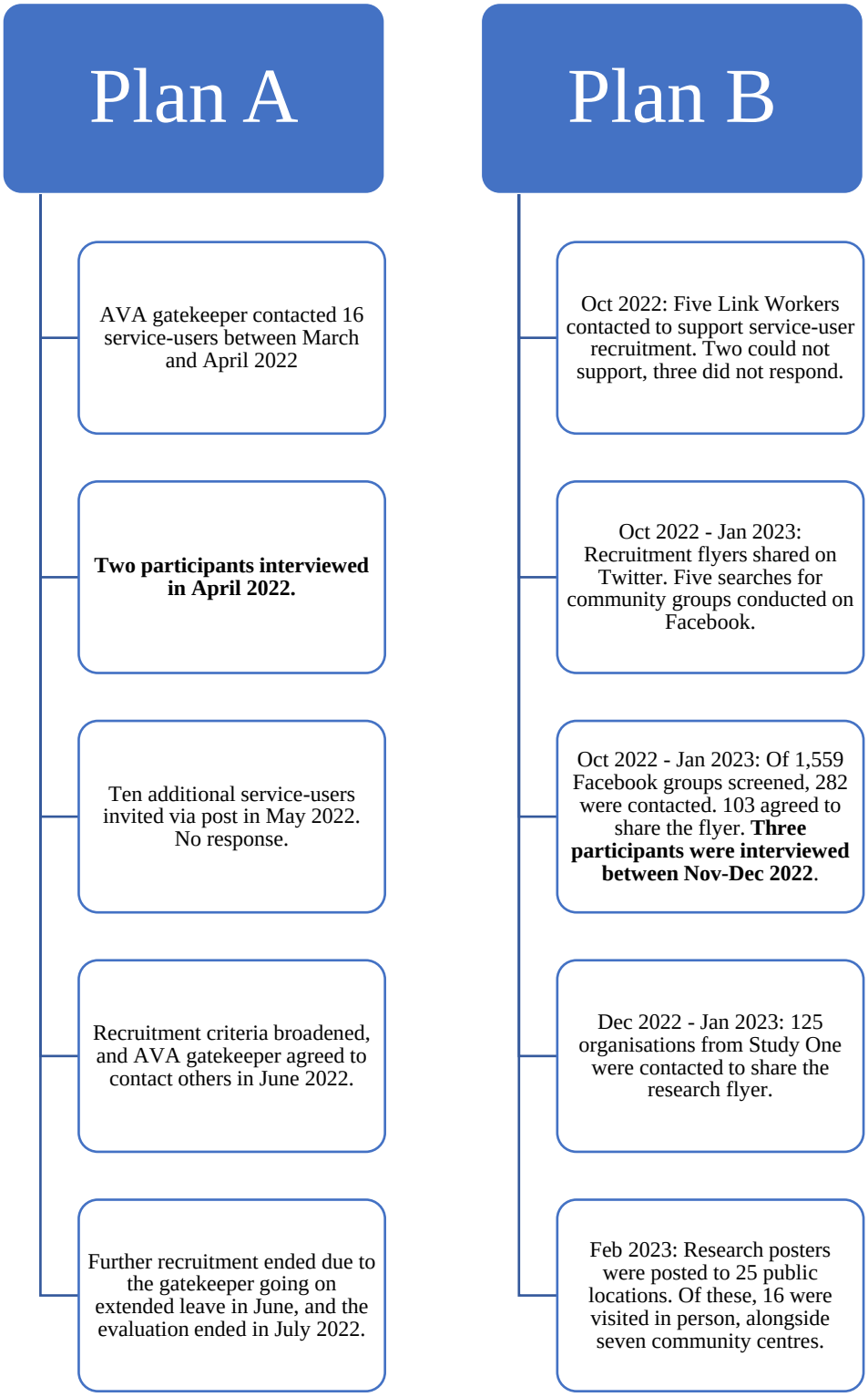
In January 2023 105 organisations were recontacted about the flyer. Eight more agreed to help, whilst two others could not. The remaining organisations did not reply. The remaining organisations did not reply. For opportunistic sampling, permission to share a research flyer was sought from group admins of Facebook community groups. Facebook groups were deemed appropriate if they were activity, social or community focused. For example, a Facebook group called 'Wollaton community group' would be considered appropriate as it should contain community members located in the Wollaton borough of Nottingham. Five Facebook groups declined to help because the research did not fit the purpose of their group. Opportunistic sampling was considered appropriate for reaching service-users in the community who may no longer be involved with social prescribing.

For example, a Facebook group called 'Wollaton community group' would be considered appropriate as it should contain community members located in the Wollaton borough of Nottingham. Five Facebook groups declined to help because the research did not fit the purpose of their group. Opportunistic sampling was considered appropriate for reaching service-users in the community who may no longer be involved with social prescribing.

Ethical approval to broaden recruitment from public locations was granted in February 2023 following poor uptake. Local public spaces were asked to display a research poster via post or in-person visits until the end of February 2023. The poster contained the researcher's contact information and a QR code that could be scanned to access more information about the study. Of the 23 public spaces visited, three declined to display the poster due to the venue being refurbished (one) and the research not being council based (two).

Figure 1.1

Recruitment processes for Plan A and Plan B.


Plan A
AVA gatekeeper contacted 16 service-users between March and April 2022
Two participants interviewed in April 2022.
Ten additional service-users invited via post in May 2022. No response.
Recruitment criteria broadened, and AVA gatekeeper agreed to contact others in June 2022.
Further recruitment ended due to the gatekeeper going on extended leave in June, and the evaluation ended in July 2022.
Plan B
Oct 2022: Five Link Workers contacted to support service-user recruitment. Two could not support, three did not respond.
Oct 2022 - Jan 2023: Recruitment flyers shared on Twitter. Five searches for community groups conducted on Facebook.
Oct 2022 - Jan 2023: Of 1,559 Facebook groups screened, 282 were contacted. 103 agreed to share the flyer. Three participants were interviewed between Nov-Dec 2022.
Dec 2022 - Jan 2023: 125 organisations from Study One were contacted to share the research flyer.
Feb 2023: Research posters were posted to 25 public locations. Of these, 16 were visited in person, alongside seven community centres.

Appendix E: Study Four interview schedule

Introduction

Thank you for agreeing to be interviewed today. This study is looking at the experiences of people who have declined or disengaged from a community group social prescription or recommendation, or who have declined to attend a meeting with a Link Worker following referral. I would like to talk to you today about your experience of the interactions with the people who recommended the social prescription, community group or activity to you, whether you thought the group or activity they recommended was a good fit, what your experiences were of any groups or activities that you may have joined (if relevant), and what areas, if any, you think would have supported you to engage or continue to engage with a community group or activity.

Our hope is that this will help us improve social prescriptions to community groups, by providing a series of recommendations that support a wider range of people.

- I would like to remind you that all you tell me will be anonymised. All of the information collected from today will be stored on a computer with each person identified by a false name. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation to help with later analysis? Nobody outside the research team will hear the recordings. The data will be securely stored at NTU in a locked and security protected storage facility.
- To make the research most useful, I would be interested in hearing all views you have of your social prescription process.

Introductions

How has your day been so far?

Do you have any concerns about today?

How long have you lived in your area?

- How do you find living in your area?
    - Do you enjoy the area?
    - Do you feel safe in your area?
    - Do you feel part of your community?

Social Prescription

Could you tell me the story about how you first came to receive a social prescription or a recommendation to a community group/activity?

How were you referred to social prescribing?

- How was social prescribing described to you?
- Did you attend the Link Worker meeting?
    - What were your first impressions?

[If Referral from Link Worker]

How did the Link Worker suggest the recommended group(s)/activity to you during conversation?

- Were you aware of the community group/activity before the Link Worker suggested it?
- What information were you provided?
    - What did you think about this initially?
    - What did you expect?

What happened after you were recommended the group/activity?

- Did you attend the recommended group/activity?

[if declined]

- [If no] Why did you decide not to attend the group/activity?
    - Where there any barriers preventing you from attending the group/activity?
    - Would anything have supported you to attend the group/activity?
    - What do you think would have been a good fit for you?

[if disengaged]

- Why did you choose the recommended group/activity you attended, instead of other places?
    - What were your expectations of that recommended group/activity?
    - What were your first impressions of the recommended group/activity?
    - How welcoming did you find the group/activity?
- Why did you decide to stop attending the group/activity?
    - Do you feel you were supported enough to engage with the group/activity?
    - would you say the group or activity was right for you?
        - Do you feel the group or activity suited your needs?
        - What would be a good fit for you?
    - Where there any barriers preventing you from attending the group/activity?
    - Would anything have supported you to keep attending the group/activity?

Could the Link Worker have done anything differently during your social prescription to support you to access a community group/activity?

- What type of information do you think would have been useful to know about the recommended group/activity?

[If other source]

How was the recommended group/activity described to you?

- Were you aware of the community group/activity before it was suggested to you?
- What information were you provided?
    - What did you think about this initially?
    - What did you expect?

What happened after you were recommended the group/activity?

- Did you attend the recommended group/activity?

[if declined]

- [If no] Why did you decide not to attend the group/activity?
    - Where there any barriers preventing you from attending the group/activity?
    - Would anything have supported you to attend the group/activity?

[if disengaged]

- Why did you choose the recommended group/activity you attended, instead of other places?
    - What were your expectations of that recommended group/activity?
    - What were your first impressions of the recommended group/activity?
    - How welcoming did you find the group/activity?
- Why did you decide to stop attending the group/activity?
    - Do you feel you were supported enough to engage with the group/activity?
    - would you say the group or activity was right for you?
        - Do you feel the group or activity suited your needs?
    - Where there any barriers preventing you from attending the group/activity?
    - Would anything have supported you to keep attending the group/activity?

Have you tried to access any other groups or activities (before or after the recommended group/activity)?

- Would you consider joining community groups/activities in the future?
    - What would need to be considered for you to join the group/activity?
    - What type of groups or activities would you consider accessing?

Is there anything else you would like to add about your experience before we end the interview?