

## HEALTH AND SPORT COMMITTEE

### SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

#### SUBMISSION FROM Dr Andrew Soundy, Lecturer in Physiotherapy at the University of Birmingham

#### To what extent does social prescribing for physical activity and sport increase *sustained* participation in physical activity and sport for health and wellbeing?

1. This is a broad question and it likely depends on who is doing the prescribing, the particular group of individuals in question and the greater physical, internal, social, environmental and cultural factors which can influence physical activity and sport engagement.
2. Much of the research from groups I work with has been based around individuals with chronic illnesses that face multiple barriers. There is evidence that particular professional groups such as physiotherapists or exercise physiologists can be effective e.g. [1,2] and our group has generated review evidence to support the use of these professionals to prevent drop out from physical activity interventions, for instance for people with depression [3].
3. However, specialised training and knowledgeable staff are required, because where a lack of knowledge exists this can act as a barrier to prescription e.g., [4], as does an ability to involve individuals within decision making [5].
4. My most recent work has focused on the value of storytelling and the use of peers as leads within behavioural interventions e.g., [6]. The benefits of such interventions are attributed as follows; (1) individuals can feel accepted and can engage fully in revealing their own experience of illness within a safe environment of trust, (2) they could share stories of coping and management with one another, (3) they could be motivated by social comparisons which could have a positive impact on social identity (especially when in a positive group environment; see below for more evidence that supports this). The benefit of such an approach is that it can be delivered quickly and in a cost effective way, but most importantly I believe it is sustainable. I would like to consider three primary examples that I have been a part of.
  - a. A peer-led storytelling intervention for people with Parkinson's [7]. This work uses a two day training program mainly led by peers. It has been so successful that it is beginning to be rolled out across the UK (<https://www.parkinsons.org.uk/professionals/news/first-steps-programme-improving-experience-diagnosis>).
  - b. A peer led intervention for people with Multiple Sclerosis [8]. This work highlights the benefit of sustained participation with the group being developed at no cost (except the start-up welcome session where three health care professionals were briefly present). After the initial session participants have managed and organised the group for over a year.

- c. Physiotherapy student supported rehabilitation for people with Stroke [9]. This work was initiated by using trained physiotherapy students to provide one-to-one rehabilitation under the supervision of an experience neurological physiotherapist. The benefits were extensive for the student and patient. One of the core benefit was the ability to provide exceptional patient centred care.

**Who should decide whether a social prescription for physical activity is the most appropriate intervention, based on what criteria? (e.g. GP, other health professional, direct referral from Community Link Worker or self-referral)**

5. As above I can understand that there is evidence for a lead from specialised clinicians for people with chronic and palliative diseases. But I believe peer led intervention which can reveal what is on offer locally, what is possible for people in a similar situation and the ability to consider broader aspects of living and lifestyle i.e., how to cope and manage with an illness can provide greater access for the individual e.g., [7-9]. I believe people with chronic or palliative illness can decide themselves or be referred by a clinician. For those newly diagnosis this could be based on a perceived readiness to receive information.

**What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?**

6. People with chronic or palliative illnesses there is a larger context that needs to be considered. Isolation, self-stigma, a lack of physical activity self-efficacy, low motivation, illness focused social identity and current dominating culture and social influences, socio-economic factor, life style choices, a definition of what is physical activity for the person and the level of importance within their life, unknown environments with limited support, experience of fear or anxiety at undertaking physical activity and sport needs to be overcome e.g., [7-9].
7. Social support acts as a positive facilitator, being part of a group and experiencing cohesion and relatedness positively impact on mental well-being [7-10].
8. Illness particular barriers exist such as fluctuations in symptoms for people with mental illness [11], social physique anxiety or side effects of medication [12], illness related fatigue in individuals with Multiple Sclerosis [13]. These barriers can be overcome by peers sharing knowledge of how they cope and through knowledgeable health care professionals [7-10]. Indeed recovery and hope can be established through developing closer social relationships which can influence social identity and positively impact mental well-being e.g., [14-20].
9. Further to this understanding the factors that influence recovery [14] or hope [15] are important as these will impact on the interaction patients have with the health care professionals. For instance, exacerbation in symptoms, failure to achieve goals in rehabilitation, waiting for change or slowing, isolation and lack of support

improvement act to remove hope [15] whereas internal strategies such as acceptance, seeing possibility and identifying and engaging in meaningful activities promotes hope and recovery [14, 15].

10. Ineffective ability to listen and understand peoples experiences may be a central barrier to interactions [5,15]. Poor interactions can prevent rehabilitation compliance. Our research has developed further understanding on the psychology of stories and the need to use stories to understand individuals and as evidence of why positive peer interactions can be so valuable (see our model at [www.meah.rocks](http://www.meah.rocks))
11. One of the values of storytelling intervention is that people can share the barriers that have been experienced and identify how these were overcome people's lives [7]. This type of intervention appears to benefit individuals through psychosocial mechanism which can impact on the physical and mental health of the individual [7-9].

### **How should social prescribing for physical activity and sport initiatives be monitored and evaluated?**

12. Mixed methods approaches are needed for interventions which support individuals with chronic illness which can determine the effectiveness of interventions and understand why and how changes occur.
13. Qualitative data will help understand why the benefits occur and what outcome measures should be focused on so measurement can be taken to document the value of the experience.

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