Scientific Research Publishing

Open Journal of Preventive Medicine, 2023, 13, 41-56
https://www.scirp.org/journal/ojpm
ISSN Online: 2162-2485
ISSN Print: 2162-2477

Understanding the Underlying Mechanisms of Action for Successful Implementation of Social Prescribing

Kate Walker*, Chris Griffiths, Harmony Jiang

Northamptonshire Healthcare NHS Foundation Trust, Berrywood Hospital, Northampton, England
Email: *Kate.Walker@nhft.nhs.uk

How to cite this paper: Walker, K., Griffiths, C. and Jiang, H. (2023) Understanding the Underlying Mechanisms of Action for Successful Implementation of Social Prescribing. *Open Journal of Preventive Medicine*, **13**, 41-56.
https://doi.org/10.4236/ojpm.2023.132004

Received: January 6, 2023
Accepted: February 25, 2023
Published: February 28, 2023

Abstract

There is growing evidence for the use of social prescribing as a means of facilitating healthy lifestyle behavior changes by linking patients to sources of support in the community. However, there are gaps in understanding about what works to facilitate and enable this behavior change *i.e.*, the mechanisms of actions underpinning social prescribing delivery. This study used a qualitative approach involving interviews with 18 Social Prescription Link Workers (SPLWs). Reflective thematic analysis was used to analyze the data. Through this, an overall theme of "*Theoretical underpinning*: *Solution-focused and strengths-based*" was identified. This was made up of sub-themes relating to mechanisms underpinning: the SPLWs' role (comprising asking questions, motivational interviewing and the therapeutic alliance); the patients' role, (empowerment and active engagement); and the approach adopted (solution building, goal and action orientated). To formalize this, a framework could be developed for SPLWs that encapsulates the solution-focused strengths-based approach for application within social prescribing. This framework can then be embedded into practice facilitating more successful healthy lifestyle behavior change for social prescribing patients.

Keywords

Social Prescribing, Behaviour Change, Solution-Focused, Goal and Action Orientation

1. Introduction

Due to financial pressures in healthcare; innovative approaches to healthcare are required to safeguard the long-term future of the National Health Service (NHS)

[1]. Social prescribing (SP) is a relatively new and innovative model, developed mostly in the UK that has been promoted as a way of supporting the sustainability of the health system [2]. SP is the provision of a service that links patients in primary care to different sources of support within the community. It operates as a non-medical, social referral (that can be provided alongside medical referral and treatment) as a means of improving health and wellbeing for patients [1]. SP works on the premise that health is determined synergistically by biological, social, economic, psychological, and environmental factors. SP aims to work with patients in a holistic way and facilitate health self-management [2]. SP evolves around the creation of referral pathways to community-based resources, which are utilized to connect individuals who have health, social or practical needs with accessible local providers of services and support [3].

SP utilizes interconnection and integration of health, social care, commercial, charity, and community services and resources to meet patient needs, thereby reducing the demand on primary, secondary, and acute healthcare services [4]. Evidence-based theories that underly SP practice indicate that accessing community-based social, cultural, activity, support services, and green spaces are beneficial [5]. SP is not one single intervention, but a pathway [6]. It comprises input that is asset-based and person-centered [7]. The theoretical basis of SP recognizes that a purely disease-orientated biomedical model of treatment is not sufficient and cannot fully meet all health and wellbeing needs, and so promotes a shift towards disease prevention and health promotion, through the adoption of healthy behaviors and lifestyles which are driven by the patients themselves with support where required [8].

There are two different referral pathways for SP: 1) Direct referral from primary care; and 2) Referral by primary care to a Social Prescription Link Worker (SPLW) [6]. In the latter case SPLW's role and work with a patient can vary from referring and signposting, to a more hands-on and involved approach over a period of time (typically three months, but this can vary dependent on need and requirements). This involves a formal engagement process, working with the patient to identify and set health and wellbeing goals, facilitate behavior change, and then develop supporting connections and the use of community resources, whilst providing practical and emotional support [9]. The role of the SPLW is therefore to guide patients, interview and assess their needs, and then enable them to take advantage of community-based options available [5]. SPLWs are able to give people time, to focus on "what matters" to an individual patient, and by doing so, offers a holistic approach with the aim of improving people's health and wellbeing [10]. The SPLW's role is recognized as an approach for facilitating behavior change [10]. Part of this process involves enhancing individuals' motivation to change, connecting them with their appropriate community-based organization and opportunity, thereby assisting with turning motivation into action [11]. It has been suggested for successful implementation and intervention efficacy, SP needs to be developed in-line with complex intervention approaches and underpinned by a behavior change framework [6].

There is no ascribed theoretical model of the social prescribing pathway [12]. Two existing theories may explain mechanisms underpinning SP: social capital (resources that can be accessed through social connections) and patient activation (enactment of people's confidence, motivation, and ability [skills/knowledge] to manage their health and wellbeing) [13]. SP shares many features of the asset-based theory of salutogenesis (health promoting through building resilience resources) [14]. What remains under-researched is what works to facilitate and enable service user behavior changes, goal achievement, and what are the effective underlying mechanisms that support and implement this [15]. The aim of the current research was to understand the mechanisms of action underpinning the SP pathway, by exploring the experiences of SPLWs working in the community supporting patients to link with their communities and implement positive healthy lifestyle behavior change.

2. Method

2.1. Design

Interpretative-descriptive qualitative methods [16] using a one-to-one interviewing approach were used to generate rich exploratory data of SPLWs' experiences of the application of social prescribing. A critical realist position was adopted encapsulating a realist ontology (the assumption there is an external reality independent of human minds which operates separately to our knowledge of it [17]) and epistemologically relativist (different methods produce diverse perspectives on reality and that reality is a finite subjective experience [18]). From a critical realism perspective, while the world exists independently of the human mind it can't be accessed wholly, only in glimpses and partial fragments [19]. The purpose is to identify phenomena and formulate agreement of the whole description of it based on these glimpses accessed [20]. In the current research interviews were with SPLWs, and so the data reflect these individual perspectives, and the interpretations of the researchers based on their experience and knowledge.

2.2. Participants and Procedures

Sampling was non-probabilistic, accessible, and purposive [21]. A sample of 18 SPLWs was recruited (see **Table 1** for participant characteristics). The SPLWs were primary healthcare professionals working in community organizations ("providers"). The providers were GP federations/Primary Care Networks (PCNs; NHS) or part of SPRING (a countywide initiative, delivered by four partners through a collaboration of funding from Public Health, NHS and local community sector). Emails were sent to SPLWs inviting them to take part in the research. They were given participant information sheets and the project was verbally explained to them. Informed written consent was collected from the participants prior to interviews.

One-to-one interviews were conducted via video calls. Interview length ranged from 37 to 72 minutes ($M = 53.9$, $SD = 9.6$). A topic guide and questions

Table 1. SPLWs' characteristics.

Gender	Male	2 (11%)
	Female	16 (89%)
Age	*Range* 33 - 60 years	*M* = 47 years (*SD* = 8.4)
Length of time doing role	*Range* 5 to 30 months	*M* = 17.4 months (*SD* = 8.44)
Location of work	Town location only	8 (44.5%)
	Rural location only	2 (11%)
	Town and rural mixed	8 (44.5%)

for the interviews were developed following a review of the literature. The questions topics included areas such as understanding the role, the implementation of SP, the skills required by SPLWs and the impact and outcomes from SP. The participants were also able to explore specific questions in more detail as appropriate and to discuss topics that they felt were pertinent to their role and the delivery of SP. Interviews were transcribed verbatim and analyzed thematically. Recordings were deleted once transcribed and anonymised.

2.3. Data Analysis

Reflective Thematic Analysis (RTA) was used to analyze the data, to enable the researcher to interpret individuals' narratives of their experiences, and to analyze their perspectives, drawing out similarities and differences and generating unanticipated insights [22]. An inductive approach was taken as a means of identifying patterns in the data and so that the themes were driven by and linked strongly to the data [22]. Such themes are constructed by the researcher based on their knowledge, experiences and beliefs [23]. For the RTA, the six steps as advocated by Braun and Clarke [22] were followed. Coding was undertaken by two members of the research team. To ensure rigor of the coding and strength of the interpretation and theorizing, a third member of the research team discussed the analysis and findings. A balanced presentation of those interviewed was included to support the themes generated and promote trustworthiness of the data and verbatim quotes were captured to promote verifiability [24]. To promote credibility and confirmability of the research, and to make sure that the findings were the experiences of those interviewed, Shenton's [25] guidelines were followed.

3. Results

3.1. Theoretical Underpinning: Solution-Focused, Strengths-Based

Through the RTA it was identified that the theoretical underpinning and framework for SP and the process of change was based on a "*Solution-focused and strengths-based approach*". In total there were nine themes that represented different elements of the approach which were found in the narratives and the in-

terview data. Three of these related to the mechanisms underpinning the SPLWs' role, three to the patients' role, and three associated with the mechanisms of the approach itself. This is presented in Figure 1.

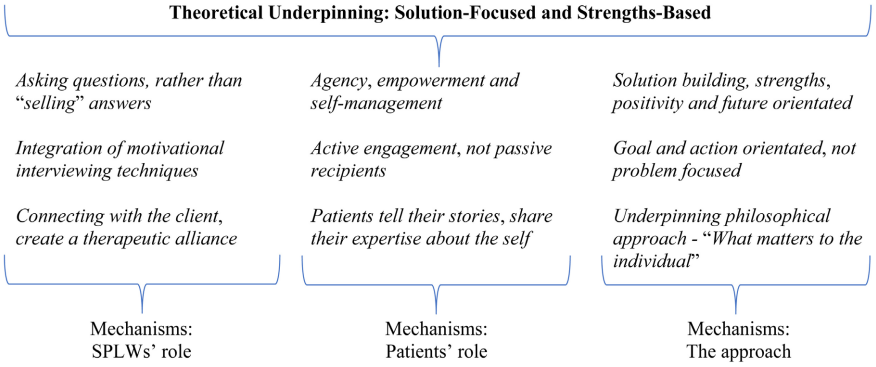

Figure 1. Themes representing mechanisms underpinning SP.

3.2. Mechanisms: SPLWs' Role

Asking questions rather than "selling" answers

Underpinning a solution-focused approach is enabling the client to discover and decide their own solutions. A major tenet of the approach is asking questions rather than telling clients what to do or "selling answers"; this was observed in the SPLWs' narratives. In solution-focused approaches, questions are the primary tool of communication and form part of the intervention. Asking the right, appropriate and probing questions can help the patient to identify what they need.

P16: *Yes, it's about asking the right questions, the better the questions, the more clarity they can sort of get for their own.*

One of the key principles of asking questions is that it elicits answers from the clients to find the solutions, as opposed to simply offering a statement that tells the client what they should do.

P6: *So, it's not, it's not telling people it's questioning them. So, they can give their own answers, I would never tell them to, you know, attend this group, it will be great for you. Because it might not be. You know, they will know the answer to it, I'm not going to know the answer to, because everyone's different.*

The SPLWs used questioning techniques that were aligned to a solution-focused approach and the principles that inform it, such as questioning about patients preferred futures:

P2: *I like to ask people, you know, things like, if there's one thing that you could do, what would it be? One thing you could change, what would it be? What would you really love to do? If you could do one, something what would it be? I just love to know what you know, what is it that makes you, you? And how you enable you to be more you?*;

Asking people about what they are already doing well and their current successes:

P1: *I ask them*, *you know*, *the things that they've been*, *the successes they've had in their lives*, *the strengths*, *who are their support network*, *those kinds of things*, *you know*, *what are the*, *what are the good things*, *the positive things*;

And questioning about positivity and hope for the future:

P3: *We ask them about their*, *their sense of positivity*, *their sense of hope for the future*, *where they feel at moment there*.

Integration of motivational interviewing techniques

The use of motivational interviewing (MI) techniques was perceived as important by the majority of the SPLWs. MI techniques can be integrated into solution-focused approaches, and this was seen to be a mechanism underpinning SP. MI was used by the SLPWs to engage clients, identify, and clarify their strengths and to promote autonomy. Some SLPWs valued their training in MI and its application.

P14: *So*, *a lot of us have been trained on motivational interviewing*. *So*, *you kind of use that*. *So*, *we do*, *we do use the motivational interviewing kind of skills that way*. *I think you need to have some sort of motivational interviewing massively*.

Others stated they would like and benefit from the training (P2: *What you need is motivational interviewing on a good level*, *and*, *and that hadn't been provided*); some seemed to use MI although not necessarily knowingly.

P7: *I think I do use them* [MI techniques], *but without actually knowing*, *or didn't know what they*, *that I was actually doing it*. *Just person-led and*, *you know*, *showing empathy to*, *to the person and listening and taking the time*.

Specific MI techniques were also found to be used by the SPLWs, who referred to different techniques they found helpful, including open questioning, affirmation, and reflective active listening. The SPLWs work on the basis that they should listen more than talk, drawing out client's own perceptions and not imposing perceptions on them (which also links to *asking questions*, *not* "*selling*" *answers*). In MI, reflective listening is a primary skill, and this was observed in the narratives.

P6: *I'm very much a listener*. *I like to sit back*, *listen to them*, *listen to what they have to say… and then I'll go*, *oh*, *well*, *like you said this*, *and then you said this*, *and then turn it round… I think it's about that repeating stuff back*. *I mean motivational interviewing is really good*.

One other principle associated with MI expressed by SPLWs was empathy. In MI interviewing, clinicians express empathy through careful listening and non-judgmental curiosity about the clients' problems and issues.

P12: *I mean*, *you have to have empathy*, *for sure*. *You've got to have patience and empathy*. *You've got to be a kind person*. *Listening skills for sure*. *You've got to be non-judgmental and resourceful*.

Connecting with the client, creating a therapeutic alliance

Developing a cooperative therapeutic alliance is pivotal for solution-focused therapy. If the SPLW does not connect with the patient, there is little scope for collaborative solution-focused goal setting. This theme reflects this; the SPLWs

seek to get to know and understand each patient. Part of this process is about the development of a trusting relationship which can act as a platform for a strong working relationship.

P4: *This role, is building that relationship, it's very, you build a trusting relationship with people.*

It is important that the SPLWs and patients build rapport, enabling them to engage in an open and honest relationship which is more likely to allow for the right conversations (and questioning) to take place.

P7: *So, just have an open conversation. And because you've invested the time, building that rapport and that confidence with that person, then it does mean that you can have more real-world conversations with them. You don't have to tread on eggshells, you can be quite direct about certain things, because you have got that bond.*

SPLWs and patients establish a therapeutic alliance; the SPLWs can seek to provide patient-centered care, as they get to know the patients well and can then understand their wants and needs.

P8: *So, it's that delicate balance I will always try and build that trust first. Asking them, seeing what they like, what their routine looks like, building a picture of them as a person trying to place myself in their shoes, to develop that relationship, first and foremost.*

3.3. Mechanisms: Patients' Role

Agency, autonomy, empowerment, and self-management

One of the mechanisms underpinning social prescribing is enabling the patient to change and not trying to enforce change on the person. The underlying framework to this is that the process is based on agency, autonomy, and empowering patients to make decisions for change.

P7: *It's empowering the person to take control of their life and their situation and know how to cope when you're not there. Whereas a traditional kind of support worker role would go in and do things for people, we don't, it's about empowering them or helping them find how they can get over that hurdle without the reliance of someone coming in and doing it for them.*

Linked to this empowerment is the philosophy that the patients have agency, and in doing so decide themselves what they require, implement a plan and are accountable to the self and not reliant on and accountable to others.

P12: *It's about personal empowerment, people taking their health and really self-care, self-care tips, you know, do something for yourself, taking the agency for yourself, go for a walk, there's a lot of people that are relying on everybody else to sort things for them. But really, we're accountable for ourselves, we're responsible for ourselves.*

Part of the process is that the patients need to make their own choices and self-manage; this is about the patients taking control.

P8: *They have a choice and some control over their own healthcare. I think lots of people have become maybe quite conditioned to do as the doctor says, so*

I must do, rather than let me think about what I can do with this, it's developing a different mindset and helping them realize that actually, there is a lot you can do for yourself.

What is clear from the narratives is that there is a move away from telling the patients what to do and being reliant on SPLWs to come up with the solutions. This is the patients' role, to identify what they need based on them being the expert on themselves, and the SPLW is there to initiate the conversation of change and facilitate the process, not dictate it.

P2: *Well, it's a personal plan. It's not my plan. It's their plan. So, I will talk about would you like to give something a try. It is the patient's plan that I facilitate. It's this whole approach of it's not, you're not doing something to someone.*

Active engagement, not passive recipients

Linked to the previous theme, given that patients are responsible for leading the process and being empowered, patients must actively engage with the SPLWs and with their "prescriptions", and not simply be passive recipients. Patients need to have willingness and a want to engage, to change and try new things.

P15: *They need to want to engage, and they want to be able to make the change. For some people, they do have to be willing to change their current thinking their current behavior and look at it and be willing to go and, you know, do different things to make that difference.*

Part of this is also about motivation on the part of the patient, being actively motivated to engage, change, take part, try new things, and put in the time and effort.

P7: *They have to be motivated to make change… otherwise, it's never it's never going to happen. I think they need to be prepared to try new things that might take them out of their comfort zone. And I think they have to put in some time and effort.*

The patients need to be proactive. This includes with the resources, or prescriptions that are put in place. The patients must engage as an active participant otherwise change is unlikely to occur.

P8: *If we're giving them resources, it's the willingness and the proactive process to engage in those. If there are problems engaging, please do say, and we will help you overcome those boundaries. But actually, if you're just not doing it, nothing's going to change.*

Patients tell their stories, share their expertise about the self

From a solution-focused approach, it is assumed that patients are experts in themselves, and by being given an opportunity to tell their own stories they can embrace being this expert and observe themselves. This theme is about the in-depth discussion that the patients can have with SPLWs, sharing their knowledge about themselves. The key to this is about giving the patients a voice, hearing their stories and their personal narratives. This was a consistent feature through the interview data.

P16: *I think it's listening. It's listening to their story. That makes a massive difference to be able to hear their story, but also hear it well enough that they*

know that you're properly listening.

This means an opportunity is provided to get an in-depth understanding of each person's circumstances and who they are. This is based on what they want to tell you and what is important and relevant to them. This enables patients to share the meaning they attach to their lives and what they want to change.

P1: *So, it's quite a rich, see, really, for me around social prescribing, it's quite a lot of depth, it feels like it's quite a profound thing about talking to someone, hearing their story, hear what matters to them, the meaning that they give to their lives, and what they would like to be different*.

One of the key aspects with social prescribing is that SPLWs have more time than a GP would have with a patient. Patients are given the space and time to speak; it is an in-depth conversation and exploration, to understand the patient's situation, needs and goals.

P9: *The main benefit is the time, is, is you know what I can give them is time that the GPs can't, and to, for them to, to feel that they've been listened to, and that, that I understand what they're going through. So, it's literally, they, they allow you the gift of being in their shoes*.

3.4. Mechanisms: The Approach

Solution building, strengths-based, positivity and future-orientated

The approach taken by SPLWs aligns to several principles underpinning the solution-focused approach. Many did not know the solution-focused approach per se, but their approach aligned to solution-focused intervention. There are different tenets and underlying principles that serve as a foundation for implementing a solution-focused approach and inform the delivery of such a model; within the narratives of the SPLWs, some examples of these included, building on strengths and assets:

P3: *We use an assets and strength-based approach. So, people very easily get into that "I can't do" and this is all, these are my issues, and they get so caught up in, in thinking and feeling all of this negative stuff that they, they don't necessarily focus on, on the things that they have got going on that are good. And when you support them to recognize their strengths and their assets, that can be really empowering for them*;

Taking a future focus:

P3: *We ask them about their, their sense of positivity, their sense of hope for the future, where they feel at moment there*;

Looking for and working with the positives:

P16: *Yeah, I guess there is the sort of, sort of positive how to change things into positives… They're very negative—I call them "yes, but patients", yes, but I can't do that. So, you're constantly in turn, saying, yes, you can't do that, but you can do this*;

And offering praise and encouragement throughout:

P9: *Encouraging them, praising them for what they have done so far. You know, when somebody has low esteem and have anxiety or depression, they tend*

to forget what successes they've had, and so when, when they are telling you their story, is to actually, you know, you know, pick out good things and just say, you know, well done, this is what you've done.

Goal and action-orientated

When taking a solution-focused approach, all therapeutic activities are goal-driven, and are a purposive activity that is "negotiated" between the patient and the SPLW. This theme captures how the mechanism underlying the approach is about facilitating goal setting, enabling patients to put actions in place, allowing them to move forward.

P1: *So, then it's really about helping them to achieve that goal. It doesn't really matter what the goal is. It's about getting them to move, getting them unstuck. Because all these, they tend to, just be stuck. And we just, once they can do one thing, then they can then extrapolate and go and do other things. We use goal setting, yeah goal-setting all the time.*

A key factor in this is that the goals are based on what patient themselves identify and not goals that are "set" by the SPLW.

P3: *They set their, it's their goals that they set… It's helping someone to reflect on the issues that they want to deal with now, and they're ready to make changes on… and then supporting them to keep that focus on that goal and praising them when they have made a step towards that goal to support and encourage them to continue.*

When using the solution-focused approach in relation to goal setting, clear, concrete, specific and measurable goals are important as this facilitates clarity around the solutions that need to be implemented, what is required, and when they have been achieved. This process was observed in the interview data from the SPLWs.

P9: *So, we do a lot of reflection back, summarizing what they've said, clarifying what they've said, helping them to set some goals that are realistic. Often people have got high expectations of themselves. So, the goal setting, SMART goal setting element of it. Lots of feedback and reassurance.*

The SPLWs also facilitate incremental goals and behavioral changes for the patients to work on. If goals seem unattainable, they may be overwhelming for the patient, so the premise taken is to have small achievable goals to work towards.

P12: *It will be small, bite-sized goals like look you know, I want you to sign up, you said you want to do yoga, you said you're going with your Mum, I want you to book it by next week, next time I speak to you. It's small things like that.*

Underpinning philosophical approach—"What matters to the individual"

The foundation and mechanism underpinning the social prescribing approach was about identifying and establishing "*What matters to the patient*": what is important to each patient based on what the patient themselves identify.

P5: *It's working with individuals in a holistic, non-medical way, to find out what's important to them and what changes they would like to make.*

This theme is aligned to a solution-focused principle around establishing a

preferred future for people. This revolves around listening to the patients' narratives about their preferred future and so "*what matters*" to them:

P1: *It feels like it's quite a profound thing about talking to someone, hearing their story, hear what matters to them, the meaning that they give to their lives, and what they would like to be different.*

This is individualized and personalized for each patient, and as such can only be established by the patient themselves and not something decided by the SPLW.

P8: *So, the role of a social prescriber is giving time for people to explore what matters to them and focusing on personalization, and individual needs rather than outcomes and meeting them where the patient is at rather than where we expect them or need them to be if that makes sense.*

4. Discussion

This research was interested in the mechanism of action and framework underpinning SP that promotes and facilitates behavior change for patients. From the narratives and discussions of the SPLWs it was clear that the framework was one of a strengths-based and solution-focused approach. The emphasis is placed on asking about personal strengths, social resources, and previous successes when working with clients [26]. There is a growing body of research, including review papers and meta-analysis (e.g., [27]), which have found that a solution-focused approach can be effective in various contexts, including depression [28], anxiety [29], stress [30] and bereavement [31]; the types of issues that the SPLWs tend to come across.

The solution-focused approach is a goal-focused evidence-based therapeutic approach, based on positive psychology principles and practices; underlying it is that it helps clients change by constructing solutions rather than focusing on problems. In its most basic sense, this approach is based on promoting hope, eliciting positive emotion, and is future-oriented for formulating, motivating, achieving, and sustaining desired behavioral change [32]. There are key principles that underpin the solution-focused approach that were observed in the SPLWs' narratives, including: a focus on solutions; an assumption that positive change will happen; the use of a collaborative working alliance; being pragmatic and flexible; the future is negotiated and created; and asking questions rather than telling clients what to do [33]. It was clear that utilizing patients' strengths, building solutions and focusing on the future and what can be achieved underpinned SP. The mechanics of SP comprised being goal, action and solution-orientated, not problem-focused. Taking this approach has been found to increase self-confidence and promote positive mood [34], decrease negative affect, increase self-efficacy and insight and understanding into the patient's needs [35]. The SPLWs, many of whom had no formal training in the solution-focused approach, followed these principles in the work that they did, and in doing so enabled patients to engage with social resources and change their behaviors, to achieve successful outcomes. Embedded within social prescribing is a goal-di-

rected approach, where the SPLWs work collaboratively with their patients, who understand their own circumstances, to facilitate pragmatic solutions that are realistic and fit the patient's specific needs.

The SPLW role for supporting healthy lifestyle behavioral change was based on the premise that they are the expert in the conversation of change, and so they guide the patients to facilitate change. In solution-focused therapy, the hierarchy tends to be more egalitarian and democratic than authoritarian, and while facilitators lead the sessions, they do so from one-step behind [36]. This was observed in the current research, where the SPLW role was described as supporting and guiding patients, and not "telling" patients what they had to do. In part this was achieved through their approach of asking questions, not "selling" or forcing answers or solutions on the patients. Research has found that solution-focused questions result in increased self-efficacy, goal approach and action steps [37]. In the narratives it was observed that the SPLW utilized a variety of questions associated with solution-focused approaches, including questions that are open-ended, future-focused, nudging what is working, coping questions and those about previous successes. The mechanism observed was that SPLWs made questions the primary communication tool, and as such their questions were not simply used for information gathering but were an overarching intervention in their own right [32].

The overall attitude of the SPLW was positive, trusting, respectful and hopeful, and their role was about connecting with the client to develop a relationship from which they could co-create solutions. A key factor was the therapeutic alliance (TA) as a mechanism underpinning the SPLWs' approach. The TA has been described as a collaborative and affective bond that is formed between the therapist and client [38]. TA is viewed as an important and required factor common to all therapies; it is a decisive and integral factor for establishing positive therapy outcomes [39]. The TA is associated with positive outcomes across various therapies [38] [40]. SPLWs therefore do well to employ efforts that foster and develop the TA, thereby promoting positive outcomes for their patients.

Motivational interviewing (MI) underpinned SP—this approach was taken knowingly and unknowingly by SPLWs. Some had received formal training on this, while others had not, yet they still appeared to use aspects of this approach. MI enhances intrinsic motivation by exploring the values patients hold, understanding what has or is working, and emphasizes leading patients to their own solutions [41]. MI is collaborative, person-centered and goal-orientated, and aims to increase personal motivation and commitment to change by eliciting a person's own personal reasons for change, with acceptance and compassion, and identified benefits of change [42]. MI is underpinned by 5 key principles: expressing empathy, avoiding arguments, developing discrepancy, resolving ambivalence and supporting self-efficacy [43]. Utilizing MI and these principles enables SPLWs to guide clients to think about their reasons for change and encourage them to make fully informed choices using strategies such as reflective listening, shared decision-making ad eliciting change talk [43]. This suggests

that MI training should be a core requirement for the SPLW role.

The mechanisms underpinning the approach were also guided by the role of the patients. Patients were given the time and the space to talk about themselves and offer their own narratives and "stories". It has been suggested that the client is the expert on themselves, as no-one knows their own lives better [44]. Therefore, through enabling the patients to talk and discuss themselves with the SPLW, they can establish their preferred future and what they need to achieve it [37]. The approach was also based on agency, self-management and empowerment. Here empowerment is about letting the patient have as much control as possible over the actual change-process itself [45] so they should actively participate in the problem formulation, the solution to the problems and then the actions itself to solve them [46]. The SPLW is then primarily the enabler or facilitator. This approach emphasizes that it is the individuals themselves have the personal and internal means to make change and achieve positive outcomes; empowerment respects the right for autonomy [46].

The findings promote an underlying mechanism of SP as solution-focused and strengths-based. However, these findings must be understood within the limitations of the research undertaken. This research does not seek to generalize beyond the type of settings in which it took place, which may not generalize to other services providers or initiatives, or services. Participants self-selected to participate, which can introduce bias. The sample included only SPLWs and not the patients themselves or the community providers, and their viewpoint may well have offered different or further insight in the mechanisms underpinning SP. Future research therefore needs to examine these findings from patient and community provider perspectives to establish if their experiences support these findings.

5. Conclusion

The findings identify that SP is underpinned by a solution-focused strengths-based approach whereby SPLWs adopt a respectful, non-blaming and cooperative stance, working towards the clients' goals that have been identified by the clients. Given that a solution-focused intervention is more of an approach than a formal step-by-step intervention, a framework could be developed for SPLWs, comprising the principles and techniques of the approach, including: problem-free talk; questioning (the miracle question, exception questions, coping questions, scaling questions [37]); compliments; tasks; solution talk; goal and solution development; and presupposing change. MI also needs to be a feature of the SPLWs' approach, with training provided for this alongside the solution-focused approach. These principles and techniques can then be embedded into practice to facilitate successful healthy lifestyle behavioral change and ultimately result in positive outcomes for those accessing the service.

Conflicts of Interest

The authors report there are no competing interests to declare.

References

[1] Bickerdike, L., Booth, A., Wilson, P.M., Farley, K. and Wright, K. (2017) Social Prescribing: Less Rhetoric and More Reality. A Systematic Review of the Evidence. *BMJ Open*, **7**, e013384. https://doi.org/10.1136/bmjopen-2016-013384

[2] Costa, A., Sousa, C.J., Seabra, P.R.C., Virgolino, A., Santos, O., Lopes, J., Henriques, A., Nogueira, P. and Alarcão, V. (2021) Effectiveness of Social Prescribing Programs in the Primary Health-Care Context: A Systematic Literature Review. *Sustainability*, **13**, 2731. https://doi.org/10.3390/su13052731

[3] Pilkington, K., Loef, M., Polley, M., Simmons, R. and Portillo, M.C. (2017) Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes. *Journal of Medical Internet Research*, **19**, e20. https://doi.org/10.2196/jmir.6431

[4] Wilson, P. and Booth, A. (2015) Evidence to Inform the Commissioning of Social Prescribing: Evidence Briefing. The University of York, Centre for Reviews and Dissemination, York. https://www.researchgate.net/publication/276265365_Evidence_to_inform_the_commissioning_of_social_prescribing

[5] Pretty, J. and Barton, J. (2020) Nature-Based Interventions and Mind-Body Interventions: Saving Public Health Costs Whilst Increasing Life Satisfaction and Happiness. *International Journal of Environmental Research and Public Health*, **17**, 7769. https://doi.org/10.3390/ijerph17217769

[6] Husk, K., Blockley, K., Lovell, R., Bethel, A., Lang, I., Byng, R. and Garside, R. (2020) What Approaches to Social Prescribing Work, for Whom, and in What Circumstances? A Realist Review. *Health and Social Care in the Community*, **28**, 309-324. https://doi.org/10.1111/hsc.12839

[7] Payne, K., Walton, E. and Burton, C. (2019) Steps to Benefit from Social Prescription: A Qualitative Interview Study. *British Journal of General Practice*, **70**, e36-e44. https://doi.org/10.3399/bjgp19X706865

[8] Eaton, S., Roberts, S. and Turner, B. (2015) Delivering Person Centred Care in Long-Term Conditions. *BMJ*, **350**, h181. https://doi.org/10.1136/bmj.h181

[9] Kimberlee, R., Ward, R., Jones, M. and Powell, J. (2014) Measuring the Economic Impact of the Wellspring Healthy Living Centre's Social Prescribing Wellbeing Programme for Low Level Mental Health Issues Encountered by GP Services. https://uwe-repository.worktribe.com/output/926277/measuring-the-economic-impact-of-the-wellspring-healthy-living-centres-social-prescribing-wellbeing-programme-for-low-level-mental-health-issues-encountered-by-gp-services

[10] Health Education England (2016) Social Prescribing at a Glance. https://www.hee.nhs.uk/sites/default/files/documents/Social%20Prescribing%20at%20a%20glance.pdf

[11] Cunningham, K.B., Rogowsky, R.H., Carstairs, S.A., Sullivan, F. and Ozakincia, G. (2022) Social Prescribing and Behavior Change: Proposal of a New Behavior Change Technique Concerning the "Connection" Step. *Health Psychology and Behavioral Medicine*, **10**, 121-123. https://doi.org/10.1080/21642850.2021.2019584

[12] Frostick, C. and Bertotti, M. (2019) The Frontline of Social Prescribing—How Do We Ensure Link Workers Can Work Safely and Effectively within Primary Care? *Chronic Illness*, **17**, 404-415. https://doi.org/10.1177/1742395319882068

[13] Tierney, S., Wong, G., Roberts, N., Boylan, A.M., Park, S., Abrams, R., Reeve, J., Williams, V. and Mahtani, K.R. (2020) Supporting Social Prescribing in Primary Care by Linking People to Local Assets: A Realist Review. *BMC Medicine*, **18**, Ar-

ticle No. 49. https://doi.org/10.1186/s12916-020-1510-7

[14] Wood, E., Ohlsen, S., Fenton, S.J., Connell, J. and Weich, S. (2021) Social Prescribing for People with Complex Needs: A Realist Evaluation. *BMC Family Practice*, **22**, Article No. 53. https://doi.org/10.1186/s12875-021-01407-x

[15] Griffiths, C., Hina, F. and Jiang, H. (2022) Social Prescribing through Primary Care: A Systematic Review of the Evidence. *Open Journal of Preventive Medicine*, **12**, 31-58. https://doi.org/10.4236/ojpm.2022.122003

[16] Teodoro, I.P.P., Rebouças, V.C.F., Thorne, S.E., de Souza, N.K.M., de Brito, L.S.A. and Alencar, A.M.P.G. (2018) Interpretive Description: A Viable Methodological Approach for Nursing Research. *Escola Anna Nery*, **22**, e20170287. https://doi.org/10.1590/2177-9465-ean-2017-0287

[17] Bhaskar, R. (2008) A Realist Theory of Science. Routledge, Oxon.

[18] Denzin, N.K. and Lincoln, Y.S. (2005) Introduction: The Discipline and Practice of Qualitative Research. In: Denzin, N. and Lincoln, Y., Eds., *The SAGE Handbook of Qualitative Research*, 3rd Edition, Sage, Thousand Oaks, 1-32.

[19] Letourneau, N. and Allen, M. (2006) Post-Positivistic Critical Multiplism: A Beginning Dialogue. In: Cody, W.K., Ed., *Philosophical and Theoretical Perspectives for Advanced Nursing Practice*, Jones and Bartlett Publishers, Boston, 221-231.

[20] Clark, A.M. (1998) The Qualitative-Quantitative Debate: Moving from Positivism and Confrontation to Post-Positivism and Reconciliation. *Journal of Advanced Nursing*, **27**, 1242-1249. https://doi.org/10.1046/j.1365-2648.1998.00651.x

[21] Lynn, P. (2016) Principles of Sampling. In: Greenfield, T. and Greener, S., Eds., *Research Methods for Postgraduates*, John Wiley & Sons, Chichester, 244-254. https://doi.org/10.1002/9781118763025.ch24

[22] Braun, V. and Clarke, V. (2021) Thematic Analysis: A Practical Guide. Sage, London.

[23] Taylor, G.W. and Ussher, J.M. (2001) Making Sense of S&M: A Discourse Analytic Account. *Sexualities*, **4**, 293-314. https://doi.org/10.1177/136346001004003002

[24] Silverman, D. (2015) Interpreting Qualitative Analysis. Sage, London.

[25] Shenton, A. (2004) Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information*, **22**, 63-75. https://doi.org/10.3233/EFI-2004-22201

[26] O'Connell, B., Palmer, S. and Williams, H. (2012) Solution-Focused Coaching in Practice. Routledge, Hove. https://doi.org/10.4324/9780203111734

[27] Franklin, C., Zhang, A., Froerer, A. and Johnson, S. (2017) Solution Focused Brief Therapy: A Systematic Review and Meta-Summary of Process Research. *Journal of Marital and Family Therapy*, **43**, 16-30. https://doi.org/10.1111/jmft.12193

[28] Ramezani, S., Khosravi, A., Motaghi, Z., Hamidzadeh, A. and Mousavi, S.A. (2017) The Effect of Cognitive-Behavioral and Solution-Focused Counselling on Prevention of Postpartum Depression in Nulliparous Pregnant Women. *Journal of Reproductive and Infant Psychology*, **35**, 172-182. https://doi.org/10.1080/02646838.2016.1266470

[29] Stallard, P. (2017) Low-Intensity Interventions for Anxiety Disorders. *The Lancet Psychiatry*, **40**, 508-509. https://doi.org/10.1016/S2215-0366(17)30186-4

[30] Grant, A.M. (2017) Solution-Focused Cognitive-Behavioral Coaching for Sustainable High Performance and Circumventing Stress, Fatigue, and Burnout. *Consulting Psychology Journal: Practice and Research*, **69**, 98-111. https://doi.org/10.1037/cpb0000086

[31] Gray, S.W., Zide, M.R. and Wilker, H. (2000) Using the Solution Focused Brief Therapy Model with Bereavement Groups in Rural Communities: Resiliency at Its Best. *The Hospice Journal*, **15**, 13-30. https://doi.org/10.1300/J011v15n03_02

[32] De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E. and Berg, I.K. (2021) More than Miracles the State of the Art of Solution-Focused Brief Therapy. Routledge, New York. https://doi.org/10.4324/9781003125600

[33] Grant, A.M. and Cavanagh, M.J. (2018) The Solution Focused Approach to Coaching. In: Cox, E., Bachkirova, T. and Clutterbuck, D., Eds., *The Complete Handbook of Coaching*, 3rd Edition, Sage, London, 35-51.

[34] Wehr, T. (2010) The Phenomenology of Exception Times: Qualitative Differences between Problem Focussed and Solution-Focussed Interventions. *Applied Cognitive Psychology*, **24**, 467-480. https://doi.org/10.1002/acp.1562

[35] Grant, A.M. and O'Connor, S.A. (2010) The Differential Effects of Solution-Focused and Problem Focused Coaching Questions: A Pilot Study with Implications for Practice. *Industrial and Commercial Training*, **42**, 102-111. https://doi.org/10.1108/00197851011026090

[36] Cantwell, P. and Holmes, S. (1994) Social Construction: A Paradigm Shift for Systemic Therapy and Training. *Australia and New Zealand Journal for Family Therapy*, **15**, 17-26. https://doi.org/10.1002/j.1467-8438.1994.tb00978.x

[37] Neipp, M.C., Beyebach, M., Nuñez, R.M. and Martínez-González, M.C. (2016) The Effect of Solution-Focused versus Problem Focused Questions: A Replication. *Journal of Marital and Family Therapy*, **42**, 525-535. https://doi.org/10.1111/jmft.12140

[38] Martin, D.J., Garske, J.P. and Davis, M.K. (2000) Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review. *Journal of Consulting and Clinical Psychology*, **68**, 438-450. https://doi.org/10.1037/0022-006X.68.3.438

[39] Messer, S.B. and Wampold, B.E. (2002) Let's Face Facts: Common Factors Are More Potent than Specific Therapy Ingredients. *Clinical Psychology*: *Science and Practice*, **9**, 21-25. https://doi.org/10.1093/clipsy.9.1.21

[40] Horvath, A.O., Del Re, A.C., Flückiger, C. and Symonds, D. (2011) Alliance in Individual Psychotherapy. *Psychotherapy*, **48**, 9-16. https://doi.org/10.1037/a0022186

[41] Stermensky, G. and Brown, K.S. (2014) The Perfect Marriage: Solution-Focused Therapy and Motivational Interviewing in Medical Family Therapy. *Journal of Family Medicine and Primary Care*, **3**, 383-387. https://doi.org/10.4103/2249-4863.148117

[42] Miller, W.R. and Rollnick, S. (2013) Motivational Interviewing Helping People Change. 3rd Edition, The Guildford Press, New York.

[43] Resnicow, K. and McMaster, F. (2012) Motivational Interviewing: Moving from Why to How with Autonomy Support. *International Journal of Behavioral Nutrition and Physical Activity*, **9**, 19. https://doi.org/10.1186/1479-5868-9-19

[44] Lightfoot Jr., J.M. (2014) Solution Focused Therapy. *International Journal of Scientific & Engineering Research*, **5**, 238-240.

[45] Laverack, G. (2009) Public Health, Power and Empowerment. 2nd Edition, Palgrave MacMillan, Basingstoke. https://doi.org/10.1007/978-1-137-12238-4_2

[46] Tengland, P.A. (2012) Behavior Change or Empowerment: On the Ethics of Health-Promotion Strategies. *Public Health Ethics*, **5**, 140-153. https://doi.org/10.1093/phe/phs022