VIEWPOINT

Promoting Social Prescribing in Psychiatry—Using Shared Decision-Making and Peer Support

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Psychiatric care requires ongoing management of clinical and nonclinical treatments and services, including pharmacotherapy, psychotherapy, and psychosocial and well-being activities. Recreational or leisure activities, such as gardening and social groups, and programs in the community, such as supportive housing and supported employment, are examples of nonclinical psychiatric rehabilitation services. Many of these services were developed in line with the principles of personal recovery, focusing on community participation, learning new skills, peer support, and lived experience and emphasizing support for individuals within their local communities. Psychiatrists and other psychiatric care professionals are often less familiar with psychiatric rehabilitation services in the community, instead centering their care on clinical options even in the face of ongoing debates about their limitations. As a result, nonclinical services in mainstream psychiatric practice remain relatively underused, and patients' limited access to and use of nonclinical services has traditionally been via self-referral or based on the recommendation of social care workers who work outside the psychiatric medical system.

A social prescription is a plan based on the patient's preferences, goals, and needs and the local availability of services. Social prescribing (SP) is a novel approach to integrate referral of nonclinical community services and activities into health care that has shown diverse psychological, psychiatric, physiological, and behavioral benefits.[1,2] SP helps primary care physicians and other community-based clinicians expand the available treatment options for patients through nonclinical services in their community that patients might otherwise not use. While numerous models exist, the prescription of nonclinical services and supports is typically made not directly by clinicians, but by link workers, who are nonclinical professionals with extensive knowledge of local community resources. Link workers receive patient referrals from clinicians and help patients decide on a social prescription. Social prescribing is most advanced in the UK, where it is incorporated into the National Health Service as the national model of personalized care, and it is also proliferating worldwide.[1,3] In the US as well as in Canada, Scandinavia, Australia, and New Zealand, dozens of local pilots are underway.[3]

Given the growth in unmet mental health needs, the potential worsening of psychiatric symptoms among individuals with an existing mental health diagnosis, and the growing burden on psychiatric services, the potential contribution of SP to psychiatry is promising. Yet the implementation of SP in mental health and psychiatric services lags behind that in primary care.[4] We offer a novel use of 2 existing practices and resources already available in psychiatry, shared decision-making (SDM) and peer support, to promote SP of nonclinical services and programs.

The Promises and Challenges of Integrating SP in Psychiatry

Social prescribing is fully aligned with the principles of modern psychiatric care. Key mechanisms of SP include emphasizing what matters to the individual, increasing belonging and community inclusion, reducing loneliness, improving emotional processing and regulation, and supporting behavioral adaptations.[5,6] The high rates of nonadherence to psychiatric medications and disengagement from traditional psychiatric services, the growing calls by service users for alternative recreational approaches (such as exercise and music), and shifts in thinking about the concept of recovery, such as moving from the notion of cure or symptom remission to a personal journey of finding and maintaining hope, agency, independence, social connectedness, and integration—all set the stage for wide implementation of SP in psychiatry. Additionally, SP can support mental health alongside traditional pharmacotherapy and psychotherapy, helping address biopsychosocial factors associated with mental illness. It can also improve mental health by expanding treatment options for patients and helping them navigate existing services.

Despite these promises, SP programs and research are sparse in psychiatry compared with primary care. The Plus Social program is Australia's first SP pilot for individuals with mood and psychotic spectrum disorders. Plus Social has shown improvement in biopsychosocial health outcomes.[7] The INSPYRE program, currently underway in the UK, focuses on child and adolescent mental health services and is investigating how SP can be embedded, evaluated, and scaled for this population. The drawbacks of the inadequate SP programs for psychiatry contribute to their limited implementation in routine psychiatric care, which is based on evidence, needs, settings, and populations in primary care.

SDM and Peer Support Can Promote SP in Psychiatry

Shared decision-making in psychiatry is central to developing person-centered decisions.[8] It can be used to implement SP along the psychiatric continuum of care. For example, SDM for SP can be applied in psychiatric hospitals and in-patient settings before discharge to help patients choose psychiatric services in the community. A recent study[9] evaluated a decision aid, the most common type of SDM tool, developed to present the different categories of nonclinical psychiatric services and supports available in a community. The decision aid was used by patients, psychiatrists, and other nonmedical clini-

cians (eg, social workers, occupational therapists) to develop a social prescription between patient and clinician addressing the pros and cons of each nonclinical service. The social prescription, together with traditional prescriptions for psychiatric treatments, led to more personalized, informed, and value-based decision-making associated with greater knowledge of and engagement with nonclinical services in the community. Of note, the SDM intervention involved direct prescribing from the clinicians to community services and programs, rather than indirect prescribing as with traditional SP in primary care, in which a clinician refers to a link worker who does the prescribing. Direct SP has many potential economic, ethical, and therapeutic benefits; it saves time and resources and promotes early intervention at the point of care, minimizing the additional steps of contacting a link worker. The nature of the SDM process and the use of a decision aid can help not only patients but also clinicians, who are often less familiar with local options for nonclinical services, to engage in productive discussions, promote holistic care, and minimize fragmentation of care.

Peer support is an additional resource in psychiatry and has been an essential part of the mental health care workforce for years. Peer workers are well placed to deliver and facilitate SP, as they are essentially link workers with lived experience: they provide support, advice, and guidance about services and opportunities based on their experience and knowledge of local community resources. Evidence from studies on peer support suggests that improvements in biopsychosocial domains, such as empowerment, hope, quality of life, self-esteem, employment, and well-being, mirror outcomes obtained via SP. Supporting peer workers with SDM for SP, recently termed peer-led SDM for SP of nonclinical services, may optimize psychiatric services to empower and support the recovery process by integrating peer support and SDM.[10]

Conclusions

Nonclinical services and programs are essential psychiatric care, as they promote well-being, recovery, and community inclusion of individuals with mental illness. Social prescribing helps integrate nonclinical supports in primary care, and there is a need to optimize its use in psychiatry. SDM and peer support are existing and accepted practices in psychiatry that can be better used to promote direct and indirect SP in the field.

ARTICLE INFORMATION

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