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Social Prescribing is a bit of a well-kept Secret that's not meant to be a Secret: Stakeholders' Perceptions of Social Prescribing for Families with Young Children

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Research Article

Keywords: Social prescription, Play, Stakeholders, Thematic analysis, Families

Posted Date: March 26th, 2024

DOI: <https://doi.org/10.21203/rs.3.rs-3942815/v1>

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Additional Declarations: No competing interests reported.

Abstract

Social prescription (SP) is a community based non-medical intervention that is widely viewed as a viable public health initiative which will save healthcare workers time and money. Classically these interventions focus on loneliness in the elderly, however another transitional stage of the lifespan associated with loneliness is new parenthood. This study is based on an evaluation of the first SP creative play programme for families with 0-3-year-olds. It was identified that a gap in knowledge exists around stakeholders' understanding and views for this type of SP. A range of 12 different stakeholders, from general practitioners to members of parliament, with different power dynamics and roles were recruited and took part in a seven-question semi-structured interview. The interview addressed relationships between stakeholders, how they feel families might value or stigmatize SP intervention and their thoughts and experiences with SP. The interview transcripts were analysed using an inductive interpretive thematic analysis. There were three main themes that came from the transcripts; 1) *A New Offer: Getting it Right the First Time*, 2) *Barriers to Socially Prescribed Family Intervention* and 3) *Social Prescription for Complex Families*. Results are discussed in terms of the roll out of SP for families and what this means for stakeholders, quality control for the interventions and helping stakeholders have a better understanding of this age group's needs.

Introduction

There has been much interest in social prescription (SP) as a public health intervention by countries throughout the world¹⁻³ SP is a mechanism linking community members under primary care to non-medical social programs and services to provide non-medical support to vulnerable individuals^{4,5}. The support aims to foster different positive social and health outcomes for individuals covering a range of activities, material needs, health behaviours and social-emotional enhancement structured to be adapted to fit the community and participants by targeting things like wellbeing, depression and loneliness^{2,6}. SP intervention aims to save money for the National Health Service (NHS) by decreasing the number of appointments for a general practitioner (GP) and thus making general practice more sustainable⁷ This cost efficacy has been supported by some small scale studies and evaluations^{4,8}.

The elderly have been the focus of past SP programmes, however there are initiatives forming in the UK to look at SP from a lifespan approach targeting key life transition times⁹. One of these transition times which has also been found to be associated with social isolation and loneliness is the transition to parenthood, where chronic loneliness has been reported by approximately one third of parents in the UK and worldwide^{10,11}. In response to this statistic, the first play on prescription programme was created to offer a SP programme to new parents and their 0-30-month-old children (anonymous, Under review). The inaugural SP intervention was run in one of the most deprived wards in the UK coming out of the global pandemic in 2021 when some parents had not had the opportunity to attend programmes for families. Its aims were to foster social bonds, lessen isolation and improve confidence in parenting and play behaviours for parents with less social support.

It was identified in the evaluation of the first cohort of the play on prescription programme, that to have a more impactful service, there needed to be a better understanding of the different stakeholders advocating for family SP, their motivations and perceptions and how they interacted as referral rates were lower than expected (anonymous, under review). In the UK, SP programmes can only be accessed through stakeholder or self-referral according to NHS guidelines¹². There are many different stakeholders associated with SP, especially when incorporating families. One of the issues with how many stakeholders are involved in the process has to do with their diverse interests, unequal power and different knowledge of the practice¹³.

In the past, researchers have looked at stakeholders' and patients' views of SP (e.g. ^{1,14,15}). Moore and colleagues¹ examined GP's and health professional's engagement with SP finding that there was a disconnect between the positive perceptions of the practice and the referral rates. While Araki and colleagues¹⁴ performed a review of literature around patient perspectives finding that patients were also mainly positive about the programmes, but there needed to be a more joined up approach to these services from the patient perspective. To date there have not been any studies that have looked at how SP for families is viewed, as this is a newer practice. There is also no research to our knowledge of various different stakeholders' perspectives on SP in the UK. Being able to look at an array of stakeholders in the family SP arena may elucidate researchers and service providers to the specific modifications that need to be implemented for SP to become more effective. It could also focus on what policy implications would need to be addressed to improve SP not just for families, but as a model itself.

Thus, the aim of this study is threefold;

1. To understand better how a variety of prescribers and stakeholders view SP family interventions.
2. To increase understanding of relationships between these prescribers and stakeholders, and
3. To examine how practitioners and families may value or stigmatise SP intervention.

Method

Participants and Data Collection

There were 12 stakeholders (10 females) in diverse roles aged between 23 and 66 ($M = 43.33$, $SD = 13.04$) participating in the study. More detailed stakeholder information can be found in table 1.

Stakeholders were recruited using snowball sampling. Interested parties were initially identified through the organization providing the play on prescription programme. Participants were given a link to a Qualtrics informed consent form and a pre-interview survey were participants provided a pseudonym.

Interviews were set up over email and occurred virtually or in a quiet area in the organisation's café. Interviews began with the researcher reminding the participant of the purpose and context of the study

and their right to withdraw. The researcher then told participants the recording was beginning and asked for their pseudonym. This was followed by a semi structured interview lasting between 11-43-minutes.

Ethics Approval and Consent to Participate

All experimental protocols were approved by York St. John University ethics board on 15/03/2023 (reference - ETH2223-0088). All experiments were performed in accordance with the British Psychological Society code of ethics.

Pre-Interview Questionnaire

The pre-interview questionnaire consisted of 8 questions; the first asking about whether the participant wanted the transcript for approval before analysis. Demographic questions followed with gender, age, and ethnicity information, then 4 questions about the individual's employment; their title, the setting that they are in, the groups of people they interact with, and the length of time they have been working in the field. Finally, the participant was asked for a pseudonym to pseudo-anonymise the interviews.

Interview Structure

All interviews began with introductions and a reminder of the participant's rights. Recording began when asking for the pseudonym the participant had chosen for anonymization purposes. All questions were asked in order and can be found in figure 1. After answering all 7 questions and sub questions participants were thanked and given more information on how they would receive their transcripts if they requested.

Thematic Analysis

Once all interviews had taken place, a thematic analysis was carried out because of the in-depth nature of the interviews and the need to determine how stakeholders themselves understand SP for families in a comprehensive way. The first author used an inductive, interpretive thematic analysis following Braun and Clarke's^{16,17} six step approach. This approach begins with 1) a familiarization of the 12 interviews. This was done by re-reading the transcriptions of the interviews that were approved by the participants. After re-reading the 12 transcriptions 2) the first author created an initial coding scheme with 12 main codes and subsequently 3) analysed how the different codes combined creating themes (e.g. Infrastructure and trust in the system). There were 9 main themes identified. 4) After a review of the initial themes they were consolidated and three themes were created, two with 1 sub-theme. 5) Themes were named and then 6) the final report was written.

Positionality Statement

One key consideration when researching using thematic analysis is the subject positioning and reflexivity of the researcher. We are aware that this will inform the researchers' positions throughout the life of the study. With this in mind, the first author is an upper middle-class mother of two young children. She has participated in various programmes that cater to children and parents, thus having "insider" knowledge on how it feels to be a parent in a group of parents that are engaging in a programme together, however she has never been SPed a play programme. The first and second author take the stance that SP creative play programmes are beneficial to their participants.

Results

Although the interviews came from a variety of stakeholders with different roles, unequal power and diverse skill sets, the 12 participants had similar thoughts on SP for families, and SP practice in general. There was an overwhelmingly positive view on SP for young families with children 0-3-years-old, although all of the participants also acknowledged the weaknesses of this type of intervention. There were three main themes identified in the corpus of data all pertaining to both families and the stakeholders themselves; 1) *A New Offer: Getting it Right the First Time*, 2) *Barriers to Socially Prescribed Family Intervention* and 3) *Social Prescription for Complex Families*. The second and third theme also had one sub theme each 2a) *Complexity of Evidence* and 3a) *Covid-19 and Peer Support*. Stakeholders postulated on how families might use the SP play provision and also spoke about themselves, so each theme also resulted in perspectives on service users and stakeholders.

1) *A New Offer: Getting it Right the First Time*

This theme encompassed the presentation, normalization and the meaning of SP programmes for families. It featured stakeholders' perspectives on what SP was, is and could be in terms of both their viewpoint and the families that would use the services. All 12 participants unanimously viewed SP initiatives as valuable and needed, although they voiced this from their own perspectives. For example, MP1 explained, "*What's not to like about something that is going to help kids, help the families, help the parents?*" knowledge may be limited about the intricacies of SP, but he was sold on the idea.

The early help development officer adds her perspective about the need for SP for families on the ground, "*We definitely, definitely feel like it's something that is worthwhile continuing and actually adds a lot of value to the offer of children's services.*" This viewpoint echoes in other stakeholders. For example, the social prescriber 1 doesn't hesitate to say, "*I think there's actually like a massive gap for it and I think it is necessary and I think it's definitely needed.*"

Promotion and how SP was presented to the families was one area many interviewees believed was integral to the success or failure of the initiative. GP2 spoke about how she introduces the concept to her patients, ensuring she presented the programme she would send them to in a positive way:

"I try to explain to them that mind and body don't go separately, they go together and wellbeing goes together with mind and body and that social prescribers, what they do is look into other forms of wellbeing that, they are not purely medical."

While the specialist health visitor uses another strategy that has worked for her consistently suggesting that *"'This would normally cost.' And I said, 'but it's just available at the minute, and hopefully and see what you think.'"*

The consensus among the stakeholders was that normalizing SP in general and for families was one way forward. SP for families with 0-3-year-olds is a very new practice and, *"we're essentially six years behind because it's very, very new to us in children's services."* (early help development officer). Some stakeholders mentioned that families may feel there was a stigma while others did not feel the families they worked with would feel any differently about a SP play experience specifically. The acting service manager reported, *"the more social prescribing there is out there and the more there is available actually becomes more normal, less scary and that stigmas then removed."* The mental health commissioning manager added that one of the things that play on prescription may have going for it is that play groups already *"so normalized for young children."*

Although stakeholders themselves found SP valuable, these concepts were also discussed in terms of interviewee's opinions on how families may understand SP. Many spoke about families not knowing what SP was or that it could be available to them for no cost. The public health portfolio lead explained, *social prescribing is a bit of a well-kept secret that's not meant to be a secret.* While social prescriber 2 talks about how, *"obviously not many people know what social prescribers are, and the children and family seems new."* While the maternity voices representative agreed, *"the barriers are they don't know they are there."*

Some stakeholders postulated that once SP is more mainstream and normalised one of the worries would be expectations of outcomes that are above and beyond what is realistic in their minds because of the medical implication of the word prescription. For example, MP1 pointed out that he'd be worried people would be misled into thinking the intervention would, *"be the solution to all problems...I think expectations should be managed that this intervention with this opportunity, this play MAY help, rather than will."* While there were others that opposed this and thought play was not medicalized inherently, so did not fear this outcome. The health visitor explains, *"a play intervention it's not sort of seen as medicalized. Or yes because a lot of the things that we do refer to are a very medicalized or hospitalized."*

Finally, stakeholders themselves warned that when carrying out a programme, everything done from promotion to the quality of the intervention itself would need to be done right the first time. The acting service manager pointed out, *"it is an amazing option as long as it's done in the right way."* and as MP 2 states, *"You may only have one crack at this."*

2) Barriers to Socially Prescribed Family Intervention

This theme encompassed a range of structural issues and sustainability worries which were voiced by the stakeholders. It was agreed that infrastructure needed to be well organized and specialized for real buy-in to SP for families with infants. The disconnect between stakeholders' own roles also falls under this theme and their own thoughts about what families of 0-3-year-olds need in SP as well as how families might feel about the infrastructure and even government on a whole while engaging in a SP programme for families with very young children.

One of the standout infrastructure issues, no matter what perspective the stakeholder was coming from, was that of funding infrastructure which would make SP more sustainable. The maternity voices representative explained community services are trying to provide mental health wellbeing for new families, but, *"they haven't got funding to provide it, they are looking at other ways to provide it and social prescribing has come up as a possibility."* While GP1 worried about play on prescription being just another initiative coming across his desk explaining, *"what you learn as time goes by, very often this initiative fails, but you've created a number of expectations"*. Coming in from a policy and sustainability angle, MP2 warns:

"Clearly having a strategy to sustain it is absolutely crucial or else you're just throwing money down the drain. And I think there is too much of that which goes on. It's like let's put some money in. Let's invest. And then you move on, you've ticked that box."

The mental health commissioning manager pointed out that one way to sustain SP being its unique place within the system. She told the researcher, *"its got a huge role in children and young people's lives, but it has to tie into the wider system."*

Another issue that came up in many discussions was the strain of healthcare work and how this makes everything harder for stakeholders and thus new family SP programmes. The public health portfolio lead describes this strain in her interview saying, *"everybody's too busy and at capacity all the time."* She goes on to explain the work environment where social prescription might be viewed as *"fluffy"* because of the holistic nature of the initiatives concluding, *"I think sometimes clinicians, it- we all work differently don't we, and they don't- some of them will see it like that, and others just see as, no that's how- we prescribe that, that's the answer, that's what we'll try first."* Social prescriber 1 acknowledges the workloads on healthcare workers looking at the benefits of her job. *"It takes pressure off GPs and everything because we're able to give them constant meetings that some people need."* Even the GPs themselves talked about their workload where GP1 reminds, *"I don't have 20 minutes. I don't have- I sometimes have 7 minutes and that's what I have."* The GPs also spoke about disconnect with SP for families as GP2 states, *"usually young children are managed by the health visitors."*

While time constraints and money were readily spoken about, one topic that some of the stakeholders seemed to know little about was infancy. This was most likely because for many, this stage of life was not in their remit. For example, GP1 explained he couldn't speak to issues faced by 0-3-year-olds. Many of the stakeholders reverted to talking about "young people" and those of school age when discussing SP for families. The first 1,001 days were only mentioned in the interview with the early help

development officer who later went on to tell a story about trying to find research around, *“social prescribing, but for children...At the time we had that done, there was very little.”* This disconnect could be one reason why SP for families of very young children is not understood by all stakeholders and even families themselves.

Another infrastructure issue which came up was the trust that families with infants might or might not have in the system. The mental health commissioning manager saw this as a potential issue with uptake explaining, *“families, especially in areas of high deprivation, have a general mistrust of the council.”* This mistrust also was mentioned by almost every one of the interviewees explaining families were afraid of the council taking their children. As an intervention to improve this trust, the acting service manager described how provisions like play on prescription have worked well for families that don't trust the system, because usually when being referred into services this is a negative, but with a programme like play on prescription, *“they got education going through and they also got a positive experience of working with professional agencies.”* She believes SP of this sort could really improve those fears and mistrust.

2a) Complexity of Evidence

One of the inherent problems with the rollout of SP around the world has been that there is a lack of evidence base. The funding and rollout of health initiatives are usually grounded by an evidence base. Talking about the expectation of measurable change for a play on prescription initiative brought out opinions on the quantifiability of the intervention. For example, social prescriber 2 spoke about seeing a confidence in families that have gone into SP but not being able to note down a numeric change, *“There's always a lot of change in sort of behaviour themselves. When they know they've got support, they're happier.”* While MP2 argued that, *“I think data is important and looking at that, but that comes through, often stories rather than just hardcore data.”* The mental health commissioning manager agreed saying that yes, there are standardized measures that can be used because *“NHS England is really driving for measurable things, but actually there are other things we can't capture.”* She gave an example of a woman with an increased risk of crisis put into a SP programme explaining, *“we can't prove that it stopped her from going into a hospital bed.”* One thing that stakeholders agreed on was the idea set forth by the public health portfolio lead about the quantifiability of SP for families of infants, *“even if we can't measure it, it's still important, isn't it?”*

3) Social Prescription for Complex Families

The final theme was that of the complex profile of needs in many families. The family system and spectrum of different needs must be taken into account in this type of SP where there is not only one person coming into the programme. To have utility there needs to be an extra layer of having a bespoke nature for each family. The complex needs of the parents and families coming into the SP programmes was spoken about by many stakeholders. Around this issue is the idea of severity. Where stakeholders explained that parents have to have very acute issues usually to be given intervention. The maternity voices representative explained,

"It's the severe end of depression that is targeted with perinatal health and the groups that are set up, but it's that low to moderate depression that is, I think increased particularly over covid. There is a great big gap."

GP2 also talked about the complex nature of her patients that are new parents explaining, *"many of these patients they don't only need the social prescriber, they need mental health, they need CAMHS."* In order to facilitate SP for all of these different families, the early help development officer explained how they actively tailor programmes to meet needs of specific families, *"it's completely bespoke. It is quite difficult to explain exactly what they do because it is very different for every family."*

Because the interviews were based around a play on prescription model, almost all of the interviewees touched on play itself and its therapeutic nature. There was also discussion on families being taught how to play. It was acknowledged that every family's circumstances and relationship with play would be different. The acting service manager's dialogue around play shows how imperative she thinks playing is for families, *"Play, it's really important and we've got so many kids who are...sat with a tablet, generally in a highchair or if they're out in a buggy so development's delayed. And that importance is missed, that understanding is missed."* The health visitor agreed, *"a lot of parents don't necessarily know how to play."* She later commented on watching parents with children in a creative practice saying, *"the kid would do a beautiful picture and they'd go, 'what's that? Doesn't look like anything.' And you think (pause) but to the child-"* And the public health portfolio lead also spoke about the ability for a play on prescription programme to be able to;

"provide their role in play going forward, as well. So to understand how to maybe structure play or enable play in their home...I know a lot of the demographic, and I think sometimes they just don't know."

After consideration of how a play on prescription model could help parents who have gone through Covid-19 and are beginning to return to activities with their infants, MP2 states, *"if people can divert into more creative spaces, more therapeutic spaces either in the school environment or outside that is a place of recovery."*

3a) Covid-19 and Peer Support

One of the events that has made family systems even more complex, is the Covid-19 pandemic. This subtheme involves the concept of SP as an intervention for families recovering from the pandemic. Every stakeholder saw isolation as a major issue in the pandemic, but one that hit new parents particularly hard as much of new parenting is made easier through family and community peer support. MP1 explains how play on prescription might foster peer support;

"developing their own community network, you know, that whole kind of mumsnet kind of playgroup, mums kind of thing. There might be some incidental benefits that come from that incidental networking of people with shared problems."

While the mental health commissioning manager explained that new parents need that peer support whether it is coming from inside the house or somewhere else. Later talking about how *“during lockdown, they didn’t have this opportunity to make peer group support. And, you know what if there’s no one else their age that’s having children or that they know?”*

Discussion

This study set out to better understand how stakeholders conceptualise SP family creative play interventions, their relationships with other stakeholders and the value or stigma that they and service users place on SP for families. The results suggest that in many ways the interviewees were very connected in their opinions and thoughts on SP for families. There were no stark disagreements on any of the concepts or meanings around SP even with interviewees that came from very different backgrounds and perspectives. Instead, there is a permeating idea that SP on a whole and specifically interventions for 0-3-year-olds is new, useful, and at a stage where it needs to be presented/carried out in the most beneficial way the first time. There are going to be barriers and complexity to families involved, but the interventions on a whole are worthwhile. Conversations revolved around three main themes; *A New Offer: Getting it Right the First Time, Barriers to Socially Prescribed Family Intervention and Social Prescription for Complex Families.*

Many ideas around the value placed on SP has been found in other studies that looked at adult programmes (e.g. Moore et al., 2022). The gap in SP for the first 1,001 days was also discussed as stakeholders felt that this only added to the value of a play on prescription programme. Moving forward, it may be beneficial to examine other arts on prescription programmes for adults and work together with stakeholders to determine what areas are the most important ways to present and normalize SP for families. One way could be to present taster sessions for families and stakeholders. This idea is congruent with literature examining patient perspectives on SP processes and procedures¹⁴. Fortunately for this initiative, “playgroups” have been normalized already¹⁸, so a more structured, developmental approach with creative play on prescription may have more uptake than other SP programmes.

Barriers seemed to overlap considerably around infrastructure and systems relating to SP in the first 1,001 days. Mostly stakeholders spoke about issues with structure and funding as well as family mistrust of the system. This was specifically in relation to the council taking one’s children. These are not new issues for stakeholders or families^{2,7}. Furthermore, there has long been a disconnect between stakeholders because of the strain on the NHS. It is a well-known fact that the NHS has been strained. Policy and their long-term plan reflect this strain^{12,19}. It would be prudent for those interested in setting up SP for families to understand that there will be infrastructure barriers and policy makers to advocate for more emphasis on SP for this age group.

Although all of the stakeholders had positive things to say about SP, many of them doubted that a full picture of the benefits were quantifiable. As Bickerdike and colleagues⁷ has pointed out, the impact of SP programmes on a whole has been hard to measure in a scientifically rigorous fashion. The issue of

standardization comes up around this matter of measurement. With many medical interventions standardization is a necessary, but it is much harder to accomplish with a non-medical SP intervention for families. The extent to which the SP intervention is providing families with resources will also depend on the quality of the provider and may differ. The provider was deemed high quality by the stakeholders, so this may have impacted answers.

Another key finding was around the complexities of the families using SP, especially after Covid-19. Indeed, post Covid-19 isolation has seen an increase in perinatal depression and anxiety worldwide ²⁰. One way to improve mental health that was suggested in interviews was to emphasise peer support networks through the SP creative play programme. Thresholds around prescribing perinatal medical mental health intervention are usually extreme, so SP initiatives for new parents and their infants could be a way forward in beginning a journey of health intervention. Furthermore, the bespoke nature of the creative play intervention is an important factor in its delivery ²¹, so personalization for each parent and child would potentially improve skills, provide peer support or encourage confidence depending on what the individuals needs are. Not only are families complex coming out of Covid-19, but with technology, less free play and leisure time, parents lack understanding of their roles in their children's play behaviours ²². Stakeholders had a strong belief that parents need to re-learn how to creatively play with their children. Doing so in a safe and comfortable SP environment can help them to improve their own dyadic relationship with their child as well as be open to other health signposting ²³.

For some of the stakeholders that did not work with very young children, there was an absence of talk about these critical 1,001 days. Many stakeholders seemed unfamiliar with how an intervention would work for a very young child, and related SP interventions more to school aged children or even teenagers. This could have been because they were inexperienced with this age group, or potentially because SP for this part of the lifespan is still not a well-known entity. One of the GPs even commented that he felt unable to talk about 0-3-year-olds as he didn't deal with young patients this age, and the health visitors were more involved. This should be taken into account as a potential barrier in terms of SP policy and creating a space for young families in SP. It could also be considered as a limitation to this study that some of the stakeholders would not have ever worked with very young children and families in terms of SP provisions.

There are also a few other limitations that should be considered. The first is that all of the interviewees came from similar geographic locations. This could impede generalizability of the results. Another limitation is the interpretation of the data could have been biased as the researcher is a parent of two young children herself. She also is an advocate for creative play on prescription. These biases were acknowledged in the data collection, and interpretation phases of the study. There were only four interviewees out of the 12 that were willing to look over their transcripts to make sure that they agreed with what was said previously. All stakeholders were presented with the opportunity to hear the results in the form of a talk.

Overall, this study shows that even though relationships between prescribers and stakeholders may sometimes be disjointed, they so share a view that there is value and need for creative play on prescription SP programmes, but with an uncertain road ahead for their development. There are a few ways that this research informs future public health practice. The first is that the roll out of SP for young families is in a unique position where uptake could be high and stigma low, however the way that organizations promote and carry out these interventions will be paramount to their success. Quality control in the form of protocols or training would improve the potential to impact families. To this end, there are also barriers both in terms of infrastructure and evidence for SP programmes efficacy. There is a complexity of evidence pertaining to arts interventions which is unlike medical interventions²⁴. Finally, public health stakeholders would benefit from an understanding of why SP for families with young children is particularly important. This could complement their knowledge and positive attitude of SP in general.

Declarations

Data Availability Statement

The dataset generated during the study are available from the corresponding author on reasonable request.

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Tables

Table 1. Information on Stakeholders Roles and Careers

Title	Description of Role
Children & Family Social Prescriber 1	A 28-year-old female working with children and their families for the office of children & family social prescribing. She has been working in this role for 8 months.
Public Health Portfolio Lead	A 36-year-old woman in public health working with people 0-19-years-old. She has worked in public health for the past 2 and a half years.
Specialist Health Visitor Infant Feeding	A 62-year-old female working in the community with parents going through the early postnatal experience. She has worked in this field for the past 20-years.
Acting Service Manager	A 39-year-old female working in supported housing for the past 18-years. She works in supported housing with families and those with complex needs.
Senior Mental Health Commissioning Manager and Population Health Fellow	A 30-year-old woman working in the health sector with people of all ages. She has been working in the field for the past 9 years.
General Practitioner 1	A 48-year-old male doctor working with patients in a general practice in a deprived area. He has been a GP for the past 22 years.
General Practitioner 2	A 46-year-old woman doctor working in a GP surgery located in a deprived area of North England. She has been working as a GP for 20 years.
Early Help Development	A woman 43 working for the local authority for the past 22 years.

Officer	She works mainly with children, young people and families.
Children & Family Social Prescriber 2	A 23-year-old female working with children and families for the past 7-months in a deprived area of North England.
Member of Parliament 1	A 48-year-old male working as a member of parliament for the past four years. He works with all his constituents and other people in the United Kingdom.
Member of Parliament 2	A 51-year-old woman working as a member of parliament for the past eight years. She works with constituents and stakeholders in the United Kingdom.
Maternity and Neonatal Voices	A 66-year-old female that is in health and education. She has worked with new parents for 18 years.

Note: All participants worked in the north of England

Figures

1) What is your understanding of and relationship with social prescribing? Have you used social prescription yourself? Please expound on why or why not.

IF YES:

1a) Can you tell me to what extent have you referred into a social prescribing programme with an expectation of significant, measurable change for your client groups?

1b) Is it due to lack of alternative routes for help and support, or genuine trust that this will help?

IF NO:

1d) Would you use social prescribing in principal? Why or why not?

1e) Is it hard to get in touch with families to prescribe, or are families not on your radar.

Do you think that they wouldn't benefit, or perhaps not use the programme?

2) Can you tell me how you feel about the social prescribing of families as an option for a route to support. e.g. usually, we see older people being SP

3) For those setting up social prescribing programmes specifically for families, what kind of safeguards do you need professionally to feel that the programme is a credible opportunity?

3a) What do you think the unique benefits or drawbacks are to working with an organisation like (the one providing the play on prescription)?

4) What do you consider to be the main impacts on families from Covid-19?

4a) Would you look at SP as a potential Covid-19 intervention?

4b) Do you think Covid has changed how you see these types of interventions?

5) How do you think families that you work with might value or stigmatise SP?

6) Tell me about how useful you think social prescribing is for families.

6a) What would you expect the outcomes of engagement for SP play interventions to be?

7) How do you think (the organisation providing play on prescription) could engage and connect with stakeholders and prescribers more in the future?

Figure 1

Interview Questions and Prompts