Social prescribing – are drugs or people the better cure?

Thomas Christie
Medical student

I am a fifth-year medical student at the University of Oxford, Green Templeton College. Outside of medicine I enjoy rugby and rowing, and am also a keen writer, currently working on this years' medical school pantomime. The reason I wrote this essay is largely due to the way the medicine course is organised at my university. The first three years of our course are almost entirely lecture based, with a major focus on reviewing scientific papers, and understanding the molecular underpinnings of different diseases and the drugs that treat them, but often neglecting the impacts of disease, and other avenues of treatment. The idea of social prescriptions was something that I did not really encounter until my fourth year, when we had our first hospital and community placements. The argument in my essay, that all treatments should be evaluated equally based on outcomes instead of separated by method (with drugs given priority), is based on my experience in general practice, where the importance of other forms of treatment became apparent to me. I hope you enjoy reading it.

The title for the 12th BHMA student essay competition was Social Prescribing – are drugs or people the better cure? *Students were asked to radically and critically consider the future of healthcare in the context of social prescribing. Thomas Christie was awarded the £250 prize for his 'clear and direct style of writing' and also his 'decision to borrow from Michael Marmot to ground the complex issues that familiar individual experiences entail'. Judges were impressed by his emphasis on the necessary balance between understanding and working with the complexity of human communities, and the very different kind of complexity of pharmaceuticals.*

I recently read the book *The Healthcare Gap* by Michael Marmot (2015), and one passage in particular stuck with me. It is a conversation between a patient with relapsing depression and her physician.

> ***Patient:*** *Oh doctor, my husband is drinking again and beating me, my son is back in prison, my teenage daughter is pregnant, and I cry most days, have no energy, difficulty sleeping. I feel that life is not worth living.*
>
> ***Doctor:*** *Let's try swapping the blue pills you were taking for these red ones.*

Though this passage refers to a single conversation from over 30 years ago, anyone involved in healthcare today will recognise it. It is a conversation that represents the limits of medicine; doctors do not always have a cure. This position of powerlessness is something that has haunted doctors since the beginning of the profession, and will continue to until its death. The phrase 'we did all we could' is of no comfort to anyone.

The last century offered doctors some of the first truly effective weapons in the fight against disease, effective medication. Drugs like antibiotics and chemotherapy agents, and more recently antibody therapies and antidepressants, have provided proven and effective treatments for many diseases that were virtually untouchable before. Drugs such as Imantinib and cisplatin have reduced the mortality rates of certain cancers by orders of magnitude, and vaccines have wiped out some diseases entirely, and have reduced others to vanishing scarcity.

Drugs have not, however, by any stretch of the imagination cured all illnesses. Medicine lacks treatments entirely for many diseases, and the available therapies for others are often only marginally effective and can be burdened with side-effects. Most would agree that for the case above, new and improved antidepressants are

unlikely to help this woman; at best, they would treat the symptoms, but not the causes, of her condition. Unfortunately, this is the case for the majority of patients that we try to treat. Drugs are not equipped for the infinite complexities of the human condition. Antibiotics can treat infections – but when we look beyond the infection we might see that it occurred in a 77-year-old woman recovering from a hip operation. Investigating further we find she broke her hip when she fell down the stairs in her house, she has glaucoma and can't see well. And we discover that she was found only by chance hours later, her husband had recently died and she now lives alone. As the complexities of this case increase, we begin to appreciate how limited antibiotics alone are in their ability to improve the life of this patient.

> Medicine lacks treatments entirely for many diseases, and the available therapies for others are often only marginally effective

Luckily drugs, referrals and operations are no longer the only tools in a doctor's arsenal; medicine has branched out. Instead of waiting for a frail patient to come into A&E with a fractured hip, we can send them to a falls clinic. Instead of treating the injuries of a young adult who self-harms, we can send them for counselling and involve social services. Instead of trying a depressive patient on more and more antidepressants, we can assign them CBT or light therapy. Even better, these methods seem to work with and enhance the effects of drugs; studies have shown that light therapy and antidepressants both improve depression, but a combination of the two is better than either treatment alone (Lam *et al*, 2016).

Another set of resources can be found in what is known as social prescribing, a term that refers to local non-medical services that can serve to better one's life. This rather broad classification normally refers to activities such as volunteering, art activities, and sports, but can also encompass things such as legal aid and nutritional advice.

Schemes for which studies have been conducted do seem capable of having positive effects on health and well-being. A study in Bristol (Kimberlee, 2013) found that social prescriptions resulted in decreased levels of anxiety and better reported health, and another in Rotherham (Dayson and Bashir, 2014) showed that these schemes reduced the hospital admission risk of patients after four months. As a consequence of these results, and off the back of some NHS policy papers (NHS, 2014), some forms of social prescription are being accepted as valid forms of treatment, and are being prescribed with increasing regularity in the UK. It is important to note that many current therapies started outside the field of medicine, and gradually joined with it as their effectiveness was proven; psychiatry and physiotherapy, to name just two.

Despite the potential benefits of social prescriptions, they are far from perfect. The detractors of social prescribing often describe them as ineffective, unproven, and expensive. While many may see these criticisms as unfair, they are difficult to argue against, as so few trials exist for these treatments. In order to be comfortable prescribing these therapies, GPs and others in primary care need to be sure that they work. One of the most commonly prescribed social therapies for alcoholics is a recommendation to attend Alcoholics Anonymous meetings. This organisation claims that its famous 12 step programme results in a 75% cure rate for participants, and it currently has over 2 million members worldwide. However, the actual rate of 'cure' has been estimated to be closer to 5–8% (Dodes and Dodes, 2014), and AA actually ranks 38 out of 48 methods for alcohol addiction treatment (Glaser, 2015). Imagine how many more people could have been cured if they had been sent to the other, better programmes, instead of to the most popular one. Even worse, unproven therapies may have damaging side-effects, in the same way as drugs. For years people experiencing traumatic events were treated with psychological debriefing (talking back through a traumatic event in its immediate aftermath), in order to decrease their risk of developing PTSD. Both doctors and patients thought it was incredibly successful, and it became widely practiced. Later, however, several RCTs revealed that this therapy actually increased the risk of developing PTSD compared to controls (Rose *et al*, 2002).

> A study showed that these schemes reduced the hospital admission risk of patients after four months

We need these therapies to undergo comprehensive evaluation so doctors can determine their usefulness, otherwise we risk wasting the patient's time, the NHS's money, and potential QALYs (quality adjusted life years). For these therapies to be thought of in the same way as drugs, they will have to go through the same review process.

There has traditionally been a large amount of resistance to the prescribing of these types of social therapies, from within medicine and outside it. The main reason for this is perfectly demonstrated by the question around which this essay is based. *Are drugs or people better?* This title immediately raises two assumptions. The first, that only one can be chosen – there is no potential for collaboration – and the second, that the two things are fundamentally different. And this is how they are regarded within medicine, as a second option to try if the drugs don't work, or more often, as treatment for the mind,

where drugs are treatment for the body.

This division is artificial – the mind and body are not separate entities; what affects one affects the other. In the age of holistic medicine, we should be regarding drugs and social prescriptions both simply as treatments, and should be evaluating them not by the medium in which they are delivered, but by how effective they are. This means that not only should these social prescriptions be treated with the same significance as drugs, they should be subject to the same degree of scrutiny. Randomised controlled trials, producing unbiased results, are needed to determine the uses and limitations of these therapies as treatments, in the same way as drugs are evaluated.

This is not to say that these therapies will replace drugs. They could, however, be another piece of equipment in a doctor's toolbox, prescribed in the same way as drugs are now, by their effectiveness. A future in which social prescriptions are given alongside drugs would offer more opportunities for patients to be effectively treated, and give doctors more tools with which to do their jobs. Returning to that opening conversation, imagine how it would look in a brave new world where drugs and social therapies are valued the same and prescribed together.

> ***Patient:*** *Oh doctor, my husband is drinking again and beating me, my son is back in prison, my teenage daughter is pregnant, and I cry most days, have no energy, difficulty sleeping. I feel that life is not worth living.*
>
> ***Doctor:*** *Let's try swapping the blue pills you are taking for these red ones. I'll also put you in contact with the local legal counselling service to see what we can do about your husband. There is a mother and daughter pregnancy counselling service you could attend as well. There's also a new trial that I might be able to get you on, looking at the impact of art therapy on people with relapsing depression. Would you be interested?*

Medicine is about preserving people's health and wellbeing. By accepting social prescriptions as another method with which to achieve this goal, medicine will expand its ability to treat patients in need, and doctors will have to face situations in which they have nothing to offer less and less.

References

Dayson C, Bashir N (2014) *Evaluation of the Rotherham Social Prescribing Pilot.* Centre for Regional Economic and Social Research, Sheffield Hallam University. Available at: https://www4.shu.ac.uk/research/cresr/ourexpertise/evaluation-rotherham-social-prescribing-pilot (accessed 30 May 2018).

Dodes Z, Dodes L (2014) *The Sober truth: debunking the bad science behind 12-step programs and the rehab industry.* Boston, MA: Beacon Press.

Glaser G (2015) The false gospel of alcoholics anonymous. *The Atlantic.* [Online]. Available at: https://www.theatlantic.com/magazine/archive/2015/04/the-irrationality-of-alcoholics-anonymous/386255/ (accessed 30 May 2018).

Kimberlee R (2013) *Developing a social prescribing approach for Bristol. Project Report.* [Online] Bristol Health & Wellbeing Board. Available a: http://eprints.uwe.ac.uk/23221/1/Social%20Prescribing%20Report-final.pdf (accessed 30 May 2018).

Lam RW, Levitt AJ, Levitan RD, Michalak EE, Cheung AH, Morehouse R, Ramasubbu R, Yatham LN, Tam EM (2016) Efficacy of bright light treatment, fluoxetine, and the combination in patients with nonseasonal major depressive disorder: a randomized clinical trial. *JAMA Psychiatry* 73(1):56–63.

Marmot M (2015) *The health gap: the challenge of an unequal world.* London: Bloomsbury.

NHS England (2014) *NHS five year forward view.* Available at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 30 May 2018).

Rose S, Bisson J, Churchill R, Wessely S (2002) Psychological debriefing for preventing post-traumatic stress disorder (PTSD). *Cochrane Database Systematic Review* (2):CD000560.

Swimming with Fish by Maya Cockburn www.mayacockburn.com