Why Social Prescribing Won't Help US, Older Adults Post-COVID-19

Hopefully in the not-so-distant future, it will once again be safe enough to for older adults to resume their pre-COVID-19 lives, including regular appointments with their doctors.

As part of their visit, albeit in-person or via telehealth, doctors across the nation will most likely being asking older adults about their level of social engagement and will encourage them to be socially active. While this practice may already be common in some clinics, we will now see social prescribing in America on a scale that has never been seen before.

Essentially, social prescribing is a referral from a medical professional to community-based, social engagement programs. Social prescribing is different than social work, because it is not necessarily related to a patient's chief medical complaint. While case planning may contain some recommendations about social engagement, the ultimate goal may not be directly related to reducing social isolation and loneliness long-term.

Social prescribing begs a few questions: How should doctors responsibly and ethically encourage socialization? Do community-based programs have the capacity to accommodate all these new referrals? And what about potential, unintended consequences of poor social prescribing practices? In America, we simply haven't dedicated the adequate resources to answer these questions about social prescribing, or responsibly implement its practice, on such a large scale.

As a former group therapist working with older adults, I've witnessed the many benefits of social engagement programs first-hand, even if these benefits are difficult to quantify. However, I have also experienced first-hand that social engagement programs are often unstable, underfunded, and understaffed. In American society, where we are moving towards increasingly privatized models of care, people that may benefit the most from social prescribing may simply not have access to social programs.

The social risks associated with COVID-19 and loneliness overlap considerably. Vulnerabilities include, "Low SES, depression, poor martial quality, infrequent contact with friends and family, few social roles, lack of participation in voluntary organizations, physical health symptoms, and physical limitations" (Hawkley et al, 2008; Savikko et al, 2005, as cited in Cacoppo et al, 2010). Loneliness has been demonstrated to have clear effects on physical, psychological, and cognitive outcomes. If steps are not taken to bolster social engagement programs, older adults experiencing transient loneliness may be at risk of transitioning to chronic loneliness, even when social distancing measures are lifted.

It should be noted though that social isolation does not equal loneliness. In fact, early evidence from the COVID – Social Study UK at University College London suggests that older adults may be more resilient to the effects of loneliness during social distancing than younger age groups. While these results offer cautiously optimistic evidence that social distancing measures do not significantly affect levels of loneliness in the general population of older adults, they may not accurately represent groups at the highest risk. Due to selection bias and misrepresentation (i.e. self-selection and poor weighting), results from these surveys are unlikely to be generalizable. Other large surveys are being conducted may be more inclusive and representative.

It may also be that increases in loneliness will be a post-COVID-19 phenomenon. Groups experiencing a disproportionate loss-of-life may have downstream effects at both an individual and community level.

The loss of a loved one due to COVID-19 may have a particularly profound effect on experienced loneliness, due to social distancing measures that have restricted end-of-life arrangements and interfered with normal bereavement. As a result, levels of chronic loneliness among surviving spouses and partners may actually rise after the pandemic has ended.

It is also clear that the rates of COVID-19 infection, hospitalization, and deaths also disproportionately affect Black and Brown communities in the United States. The overrepresentation of severe cases in these communities is in no way attributable to biological differences and is instead an effect of several social, economic, and health disparities derived from structural inequality and racism.

Some communities in particular have been torn apart by COVID-19 and it just so happens that these are the same communities which have been enduring systematic disinvestments for decades. Nursing homes and adult day centers with funding for one, underpaid and overworked activities person; community arts and cultural programs that aren't adequately funded, limiting the scope, reach, and quality of services; and a lack of consideration in the built environment for older adults, that may even prevent them from leaving their homes.

How then can we improve social engagement and reduce loneliness among the most at-risk older adults? Alderwick et al (2018) goes as far to suggest that it may be unethical to screen patients for social resources without a plan for adequate and appropriate linkage to social programs, and that doing so without appropriate linkage could potentially result in harm and distrust. Even where social programs do exist, there may be many unmet needs caused by incongruous services, which are not culturally specific or may not offer services in the appropriate language.

We must consider what interventions will be most effective in a very heterogenous population. Given a variety of social factors, interventional approaches must be implemented without jeopardizing individual autonomy, or increasing levels of stigmatization, especially among older adults. Future, public health policy and interventions should be aimed at alleviating distress in underrepresented communities that have been disproportionately affected by COVID-19. And there is no better way to do that than by engaging the community itself.

Stable institutions should put in the work to build strong community partnerships and let the community take the lead. On a city, state, and federal level, funding for arts and cultural programming should be increased and more broadly distributed to disadvantaged communities. Resources for social engagement such as internet, connected devices, and technology training should be provided to those in need as a health benefit.

Lastly, the expansion of virtual conferencing may offer a novel way for people to stay socially engaged. One such opportunity is offered through the Arts & Minds program, which has shifted their in-person museum sessions online. Their mission is to provide programming for those with cognitive impairment and caregivers – they do so in both English and Spanish. Virtual programming may have the ability to substantially improve access and reach for social programs. Arts & Minds facilitators are especially well-trained and experienced with the population they serve. Research in standardization and best practices for social prescribing and social programs should be a funding priority, so that the effects of social prescribing models can be evaluated for both health and economic outcomes – or as Bickerdike et al (2017) states "when, by whom, for whom, how well, and at what cost".

Perlman and Peplau (1984) wrote that while loneliness may never be completely eliminated from society, it is a worthwhile goal to prevent transient loneliness from turning into chronic loneliness. Preventing and treating chronic loneliness can prevent dysphoria and would likely contribute to improved physical, psychological, and cognitive health among older adults. The long-term effects of social distancing measures as a public health tool are currently unknown, but the social, economic, and personal health effects are only just becoming apparent. We should invest in social engagement programs now, before patients receive a prescription that they're unable to fill.

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